

Bournemouth University

**Using Policy Analysis to Explore the Reciprocal Impact of Health
Policy on Public Health Nursing and Public Health Nursing on
Policy.**

Judith Anne Gleeson

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Abstract

The overall aim of this study was to explore the reciprocal impact of health policy on public health nursing and public health nursing on policy. This study uses a new approach to considering public health nurses' engagement in policy: one which puts public health nurses, as actors in the policy process, at the centre of the investigation. The overall philosophical lens through which the research was conducted was critical social theory and the methodology was a grounded theory influenced research design.

The study adopted a three stage data collection and analysis process: primary data (questionnaires and interviews), detailed policy analyses of two specific White Papers and secondary data (extant documents). The data were collected and analysed through a grounded theory approach in order to answer four research questions:

1. What do public health nurses know about policy, specifically in relation to two English Department of Health White Papers: *Creating A Patient-Led NHS* (DOH 2005) and *Our Health, Our Care, Our Say* (DOH 2006)?
2. How do they engage in the policy process?
3. What affects their implementation of policy?
4. Is there a policy-practice gap?

A triangulated approach to data collection and analysis was used. Primary data were collected through questionnaires and follow up telephone interviews with public health nurses (health visitors and school nurses) in four PCTs and one social enterprise in five different geographical areas of England.

Further data from detailed policy analyses using frameworks by Popple and Leighninger (2008) and Walt and Gilson (1994) were also considered. Finally, secondary data from extant documents including newspapers, websites and organisational documents were reviewed.

At the end of the research process, it was possible to answer the four research questions. In addition to this, new knowledge and theory emerged around three main themes:

- i) A proposal for a new combined framework for policy analysis which leads to a comprehensive and analytical account of policy content and context combined with a detailed consideration of the role of public health nurses as actors in the policy process.
- ii) Theories as to why and how public health nurses lack influence in the policy process.
- iii) Analysis of the effect of lack of resources on inhibiting practice innovation in response to policy agendas.

Consideration of these theories led to several recommendations for practice. Throughout the research process, there was continued interaction between the three phases of data collection, analysis and theory development.

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If we think of health as something broadly defined and influenced, we begin to arrive at the inescapable conclusion that to be concerned with health is to be concerned with the social context, and that nursing is, indeed, a political act.

Canadian Nurses' Association, 2000

Chapter 1

Introduction

Health policy has been defined as ‘a formal statement or procedure within institutions (notably governments) which defines priorities and the parameters for action in response to health needs, available resources and other political pressures’ (WHO 1998). Whilst the term ‘health policy’ is primarily concerned with health services and programmes, one should also consider broader ‘healthy public policies’ as a more effective way of achieving lasting changes in public and population health. This language encompasses the idea of ‘health in all policies’ as seen, for example, in Sweden (Swedish National Institute for Public Health 2005) and views healthy public policy as the responsibility of all government departments in addition to the Ministry of Health, including: education, transport, social security and employment.

Health policy is an area of social policy. The term ‘social policy’ includes policy decisions and actions which influence welfare or are intended to address social problems (Toward 2008). The policy areas encompassed within social policy in the UK are health, social security, personal social services, education and housing. Hunter (2003) has argued that the term ‘health policy’ has two distinct meanings: health care policy and policy for health (or public health policy). The second definition aligns with the idea of ‘healthy public policies’ as discussed above.

This research study is primarily concerned with the first meaning: health care policy which encompasses the delivery and resourcing of health care. In this sense, health care policy is concerned with how organisational, human and financial resources are, or may be, mobilised to treat people who have health challenges. Hunter (2003) argues that the two areas of health policy (policies for health, and health-care policy), whilst overlapping to some extent, are actually quite distinct. A policy centred on health would have an 'upstream' focus around enabling the conditions necessary to keep populations healthy (for example, healthy school meals, subsidized public transport systems), whereas health-care policy 'tends to take as its starting point a 'downstream' preoccupation with service delivery matters' (Hunter 2003: 5).

Buse *et al.* (2005) identify four distinct phases of the policy process: problem identification and issue recognition, policy formulation, policy implementation and policy evaluation. Rather than just focusing on the evaluation stage, this study will evaluate policy in all four domains. Buse *et al.* propose 'problem identification' as the first phase of the policy process. After the earlier work of Blumer (1954), Buse *et al.* are referring here to the need to view health policy in terms of social problem construction. Blumer argued for the need for '...meaningful clarification of basic social values, social institutions, modes of living and social relations' (Blumer 1954: 3). So, for example, in contemporary social policy, if a policy analyst were to analyze government policy around HIV treatment in low income countries, they would first have to clarify the 'problem', which may be around lack of funding for and access to anti-retroviral drug treatment.

The conceptual framework for this study is critical social theory, including the theoretical analysis of policy-making, implementation and evaluation. One example of a critical social theory approach is that I consider policy not as

neutral, but rather as an expression of values by a politically dominant group (Schellenberg 2000). In the case of health policy, the politically dominant group might be the government, managers or particular groups of health care professionals. Social policy can be a means of controlling and rationing scarce health resources and it concerns itself with both the allocation of values themselves and the actions that allocate these values (Ham 1992).

Howlett and Ramesh (1995) distinguish between policy study, a neutral view of policy which may be presented by government and public institutions, and policy analysis. Policy analysis entails a more critical approach which looks at, for example, how power relations impact on the policy process. In line with the critical social theory paradigm in which my research is situated, I am mostly concerned with policy analysis in my work.

By evaluating the impact of two specific White Papers: 'Creating A Patient-Led NHS' (Department of Health 2005) and 'Our Health, Our Care, Our Say', (Department of Health 2006a), the study draws on the existing literature and generates new theory through a grounded theory approach. Throughout the remainder of this document, the White Papers have been abbreviated to CAPLNHS and OHOCOS respectively.

I commenced a PhD Studentship with Bournemouth University in October 2006, and the original title of the project had been pre-determined as: 'What are the impacts of the Creating A Patient- led NHS White Paper (Department of Health 2005) on public health nursing practice in England?' Because of my background in health visiting practice and education, as well as post-graduate work in policy studies, this area of research immediately appealed to me. As I embarked on the initial phases of the study, a significant White Paper which was a blueprint for shifting the focus of care from acute

care to primary and community settings was published- OHOCOS (Department of Health 2006a). Key to this paper was an emphasis on chronic conditions and public health. I decided, with the support of my supervisors, to include this paper alongside the initial document, as I believed OHOCOS, like CAPLNHS, was likely to be very influential on public health nursing practice. Also, it was difficult to separate out policy strands from the two White Papers as they were so closely linked in policy terms. Throughout the course of the research, the focus shifted to a detailed policy analysis of the two documents; only part of this analysis was concerned with the impact of the two documents on public health nursing practice. A greater part of the analysis came to focus on public health nurses as actors in the policy process; that is, how did they engage in policy development, interpretation, implementation and evaluation?

The investigation of the impact of policy specifically on public health nursing activity is a relatively under-researched subject area in the UK context (Schellenberg 2000). The studies which have been carried out have been largely North American (Gebbie *et al.* 2000; Greipp 2002). The focus in such studies has been mainly on how nurses can become more active in policy-making. Traditionally, policy-makers, on the one hand, and public health managers and practitioners, on the other, have worked in two separate spheres. Walt (1994) identified the need to bring together the two worlds of abstract policy development and analysis in universities and public health nursing practice, which is one of my aims in this study. Perhaps partly because of the disconnected worlds of policy makers and those who implement policy (such as public health nurses), policy formation and implementation become disconnected. Similar to the 'theory-practice gap', which is often alluded to in nursing, one can identify a potential 'policy-practice gap'. There can be a divergence from the original policy which occurs during the implementation

process. Final outcomes in practice terms may be very different from those intended by policy-makers.

My initial research question was to consider the impact of the two documents CAPLNHS and OHOCOS on public health nursing practice in England. However, during the course of the research, this changed to a focus on how public health nurses actually engage (or not) in the policy process. The overall research question was to explore the reciprocal impact of health policy on public health nursing and public health nursing on policy.

My research questions were:

- What do they know about the policies?
- How do they engage in the policy process?
- What affects their implementation of policy?
- Is there a policy-practice gap?

This appears to be a novel approach to the investigation of public health nurses and their interaction with policy. I did not find previous studies in the literature which asked this combination of questions. My work was novel in that it attempted to arrive at a detailed and comprehensive understanding of the complex reciprocal relationship between public health nursing and the policy domain.

The Context of the Study

An important challenge when engaging in policy research is the constantly shifting terrain of health policy. It is very difficult to identify particular papers

and look at their effects in isolation. When I attempted to contextualise two particular policies in a broader framework, one of the difficulties was the sheer number of policies emerging from the last Labour government. As Hunter (2007) comments,

...in public health as in other policy domains the government has shown great restlessness with an endless stream of strategies and reports. (Hunter 2007: 27).

Because of the constantly shifting policy terrain, it was essential that I kept up to date with contemporary public health nursing practice throughout the research process. One way I attempted to do this was by reading the professional journals (such as *Community Practitioner*, *Nursing Times*, *Health Service Journal*), as well as the media (*The Guardian*), government websites (www.doh.gov.uk), and current academic literature, as well as talking to colleagues in public health nursing practice and education settings. Although my aim was to provide a 'snapshot' (fixed in time) of what was occurring at the time of data collection, I continued to be mindful of the *context*- both when data collection took place, and subsequent to data collection. One of the reasons I enjoy the study of social policy is its constantly evolving and dynamic nature. However, while being interesting, this can also create a significant challenge for the researcher.

The research for this study took place in five primary health care organisations in England. In as much as the results are generalisable, one could argue that they are only generalisable to this context, although some of the findings might be pertinent to a wider UK context.. Much of the existing research carried out on the relationship between public health nursing, policy and practice has been done in North America. I discuss this research in both

the literature review and in the analysis, and attempt to make links between my findings in a UK context and the broader applications to an international context. However, I acknowledge that one should exercise caution when attempting to extrapolate from UK data in this way. Discussion of context occurs in the 'recommendations' section.

Introducing The Actors In The Policy Process

When considering the role of the nurse in the policy process, one needs to be aware of the possible contradictions between the nurse's role as carer and politically engaged professional. Whilst the two are not mutually exclusive by any means, there is a history of nurses being viewed as handmaidens or as ministering angels which appears to limit their adoption of a more active, politically engaged role. Cheek and Gibson (1997) believe that professional stereotypes and images of nurses as primarily concerned with 'caring' may be seen to conflict with a more assertive role of an engaged policy maker and facilitator. Adams and Nelson (2009) argue that descriptions of nursing frequently emphasize service, altruism, emotional connection and relationship- what Gordon and Nelson (2006) term the 'virtue script'. This also entails nurses being encouraged 'to do their work quietly and out of the limelight- to aspire to be invisible' (Adams and Nelson 2009: 6).

Health visitors, school nurses, health protection nurses and sexual health advisors can be registered under the 'Specialist Community Public Health Nurse' part of The Nursing and Midwifery Council register. In September 2010, there were 25,800 nurses on this part of the register (known as the 'third part' of the register- part one being nurses and part two midwives). Of

these 25,800 public health nurses, 20,000 were health visitors. (Clover 2010 b).

The public health nurses who were included in my research study were health visitors and school nurses. The context of their work is different; with health visitors largely focusing on health promotion of 0-5 year olds and their families, but also working with other groups such as ante-natal women or older people. Their education and training prepares them to carry out health need assessments in communities and to work with all groups at a population level, but service cuts in recent years have necessitated an increasing focus on the 0-5 population and their families. Health visitors can be attached to primary health care practices, or health centres, with a geographical population, or work from Children's Centres or as part of a Sure Start team. School Nurses are often based in Community Health Centres, and their population is drawn from the schools in which they work. Many public health nurses are registered under the Nursing and Midwifery Council's 'Specialist Community Public Health Nurse' part of the Register, though this is not the case for all public health nurses. As the NMC stipulates:

This part of the Register [Specialist Community Public Health Nurse] is not about the 'job title' but the competencies and skills used to work with disadvantaged groups to address health inequalities and promote public health. (NMC 2008).

The NMC also states that all nurses and midwives on the SCPHN part of the Register are equal and must meet the required academic and practical standards and competencies for registration. In order to qualify as health visitors, qualified nurses have to undertake a post-registration full-or part-

time educational programme in an accredited higher education institution. School nurses also have access to similar specialist community health nursing courses. However, such courses have not been mandatory for school nurses. Therefore, there are practising school nurses who have not undergone a formal post-registration course (although they do receive in-service education). These nurses are not able to register on the SCPHN part of the Register. In the context of this study, it is important to consider the differences in the two groups of nurses (health visitors and school nurses) in terms of educational preparation for the roles, what roles are expected in practice, and different contexts of practice.

This discussion of education and training as well as registration as a SCPHN is not intended to impose a hierarchical framework on the professions. Rather, it is relevant in the context of the research, in that certain expectations are put onto the role of the Specialist Community Public Health nurse in terms of their engagement in policy. As the NMC states:

A specialist community public health nurse works with both individuals and communities. In addition to their regular duties as a nurse, they deal with issues regarding local population health, **including policy development**. (NMC 2008, my emphasis).

The NMC's (2008) working description of a specialist community public health nurse is the definition used by its Professional Practice and Registration Committee:

Specialist community public health nursing aims to reduce health inequalities by working with individuals, families and communities promoting health, preventing ill-health

and in the protection of health. The emphasis is on partnership working that cuts across disciplinary, professional and organisational boundaries that impact on organised social and political policy to influence the determinants of health and promote the health of whole populations.

Those participants in my study who were specialist practitioners and therefore worked to this remit (all the health visitors and half of the school nurses who are on this part of the Register) considered social and political policy as key influences on their practice. The policy component of their work is explicitly stated in the case of health visitors. The four 'principles of health visiting', first published in 1977, but still influential on practice (CETHV 1977; Twinn and Cowley, 1992) are the following:

- the search for health needs
- the stimulation of an awareness of health needs
- **the influence on policies affecting health** (my emphasis)
- the facilitation of health-enhancing activity.

This research study was undertaken in a particular political and economic context, with public health nursing services subject to severe reductions. This became a crucial factor when it came to analysing my data, as will be explored later.

Having introduced the research project, in the following Chapter I will now go on to present a review of the Literature in the area of policy making and public health nursing.

Chapter 2

Literature Review

The first stage of the research work was to carry out a literature review. The initial literature review was conducted between October 2006 and July 2007, but new literature was read and incorporated into the work during the course of the study and subsequent writing-up period (October 2006- September 2011). The purpose of the initial literature review (2006- 2007) was to familiarise myself with the current terrain of knowledge around health policy in relation to public health nursing. I wanted to gain more understanding of the reciprocal impact of health policy on public health nursing and public health nursing on policy and I hoped that I would find some initial understanding of this complex phenomenon in the literature. Although I was taking a Grounded Theory approach to the research, I was aware that some of the classic grounded theorists do not advocate a detailed initial Literature Review in case it biases the researcher. I was guided throughout the process by the Grounded Theory approach advocated by Charmaz. Charmaz (2006) believes that, although a detailed initial literature review may not be carried out, the research process is nonetheless informed from the outset by 'sensitizing concepts' and general disciplinary perspectives. I found that undertaking the literature review helped me to understand context and develop my thinking about concepts before going on to collect data.

In carrying out the literature review, CINAHL, Medline and Web of Science were the data bases used. Search terms included: 'public health nurses',

'policy', 'policy analysis', 'nurses and politics'. Google and Google Scholar were used to search for government documents and policy papers. I electronically searched key journals and looked at conference proceedings and unpublished papers and theses (via British Library database). Initially, I read widely and then I started the process of choosing which references to include in the literature review, based on relevance and congruence with critical social theory embedded in the articles.

Rather than simply describing the literature, I have attempted to provide a critical analysis. I have grouped the literature around several key headings which were derived from my thematic analysis. This thematic analysis consisted of in-depth reading of the literature to uncover key emergent themes and subsequent grouping of articles with similar themes in the organisation of the literature review. The headings were chosen to reflect the identified themes, but I have included only those pertinent to my area of research. One aim of the literature review is to 'set the scene' for the work that follows and to put my work in the context of a wider discourse around policy and public health nursing. The headings that I have chosen to structure the literature review are the following: Approaches to Policy Analysis, Public Health Nurses as Actors in The Policy Process, Policy Implementation: Exploring The Policy-Practice Gap, and Gaps In The Current Literature.

When reflecting on the literature and structuring the Literature Review, I considered the critical appraisal framework proposed by Heller *et al.* (2008). This framework was devised by the authors because they believed that few existing critical appraisal frameworks had a public health focus. Criteria which were of particular relevance to public health were added to well-established appraisal parameters. The checklist is organised using the 'ask, 'collect',

‘understand’ and ‘use’ categories of the Population Health Evidence Cycle.

This breaks down under the following headings:

- The study question (ask)
- The study design, sampling, exposures, outcomes, confounders and other aspects of internal validity relevant to the study type (collect)
- The interpretation and population relevance of the results (understand); and
- The implication for implementation in the reviewer’s own population and public health practice (use).

Unique components present in Heller *et al.*’s (2008) appraisal framework that are not found in others include, in the ‘use’ section, questions such as: ‘What are the public health and policy implications of the findings?’, as well as more traditional parameters around study design, sampling and so on. Heller *et al.* (2008) believe that the checklist could be particularly applicable to studies considering public health policy issues, and where the populations or interventions proposed, in the research study, may not be similar to those where the policy is to be applied.

At the time of the study, although this was a relatively new appraisal checklist or framework, there had been some preliminary research carried out regarding its usefulness for evaluating public health research studies. It was piloted by a combination of 21 public health professionals, research staff and postgraduate students. Of the 21 public health professionals that piloted the checklist, 20 said that they found the checklist useful and 18 would use it or recommend its use in the future. There was good agreement amongst respondents with a consensus of answers when appraising the literature using this framework.

As well as using the above appraisal tool as a framework when evaluating research studies, I was also guided by Blaxter *et al.*'s advice (2001) on critical reading: including the need to go beyond mere description to find relationships between different writings; indicating similarities and differences between texts; acknowledging the need to be aware of potential power relations in research; and recognizing the possible effects of researcher bias and the need to view research as a 'contested terrain' rather than an absolute truth. As well as possible bias in other studies being reviewed, I should also acknowledge my own lens and possible biases 'in producing one of a variety of truths' whilst undertaking this work. (Parker, 2012, personal communication). Whilst my background in public health nursing brings possible benefits in terms of insight, it may also bring a bias through pre-conceived ideas or assumptions.

Approaches To Policy Analysis

Pal (2006) defines policy analysis as 'the disciplined application of intellect to the study of collective responses to public problems' (14). Pople and Leighninger (2008) discuss three dimensions of policy analysis. The three dimensions are purpose (for example, in academic social science research, the purpose is to construct theories for understanding society), consumer (in journalistic policy analysis, for example, the consumer is the public), and method (a social planning approach to policy analysis might include methods such as survey research, public forums, expert and/or citizen panels). Pople and Leighninger (2008) recommend that, when reading policy analysis literature, the reader or researcher should identify which approach to analysis the author is using. These approaches (as proposed by Weiner and Vining

2004) cover a broad spectrum from academic social science research through applied policy research, social planning, agency planning/policy management, journalistic, practitioner policy analysis, and citizen policy analysis.

Jansson (2000) describes the traditional, rational approach to policy analysis, introduced in the 1960's. This approach developed when economists and systems analysts first became involved in policy analysis, and attempted to bring a more rigorous, empirical approach to comparing and contrasting policy alternatives or to evaluating existing policies. In the rational approach, policy analysts first study a problem or issue, then identify objectives they wish a policy to achieve and translate this into one or more criteria. They then choose between a variety of policy alternatives depending on how well they are likely to meet the criteria. The criteria might include, for example, efficiency, effectiveness or cost effectiveness. Jansson comments that the rational approach has its advantages: for example, it leads to decisions that are based on empirical data (as opposed to 'best guesses') and it enables policy analysts to systematically structure their work. However, his critique of the rational approach is that it can lead to a 'relatively static analysis of complex phenomena'. (Jansson 2000: 43). Jansson suggests that, if a rational approach to policy analysis is adopted, then the analyst should also add a range of contextual factors such as political, value-based methodological issues to their original rational analysis. Hawkesworth (1988) suggests that rationalists overstate the 'scientific' nature of their work. Hawkesworth argues that analysts' own values will impact on the process (for example their attitudes and ideology around social welfare provision); yet these values are not explicit within the rational empirical approach. In order to take these wider contextual and ideological factors into account in policy analysis, Jansson suggests that, rather than stick to rigid approaches, analysts should

place differing emphasis on rational, political and value-focused criteria. These differing emphases can be used 'sequentially and iteratively'.

In a paper looking specifically at health policy analysis in low and middle income countries, Walt *et al.* (2008) argue that, in order to improve health policy analysis in this context, researchers need to employ existing frameworks and theories of the public policy process more extensively, make research design explicit and be clearer about how their own power and position influences the knowledge they generate. They contend that there is little scholarly work that 'explicitly explores the methodological challenges for researchers studying the health policy process' (Walt *et al.* 2008: 309). Although they say that there is a consensus among scholars that policy analysis is useful (for example, in informing health reforms), they also argue that there has not been much attention given by scholars on how to actually 'do' policy analysis, including what research designs, theories or methods might best inform the process.

Where policy analysis initially focused on the government or public sector, and on politicians, bureaucrats and interest groups, in the past ten years there has been an acknowledgement by scholars that there is a much larger group of stakeholders in the process. These might include the private sector (including for-profit and not-for-profit organisations), and policy decisions may well be influenced by global decisions and actions, as well as domestic ones. Rather than being a top down, bureaucratic process. Walt *et al.* (2008) cite the work of Hajer and Wagenaar (2003), who argue for a more deliberative policy analysis process. In their view (Hajer and Wagenaar) policy analysis has to become more 'deliberative': 'less top down, involving expanded networks, and more interpretive, taking into account people's

stories, their understandings, values and beliefs as expressed through language and behaviour.’ (Walt *et al.* 2008: 309).

Walt and Gilson (1994) present a ‘simple analytical model’ for health policy analysis:

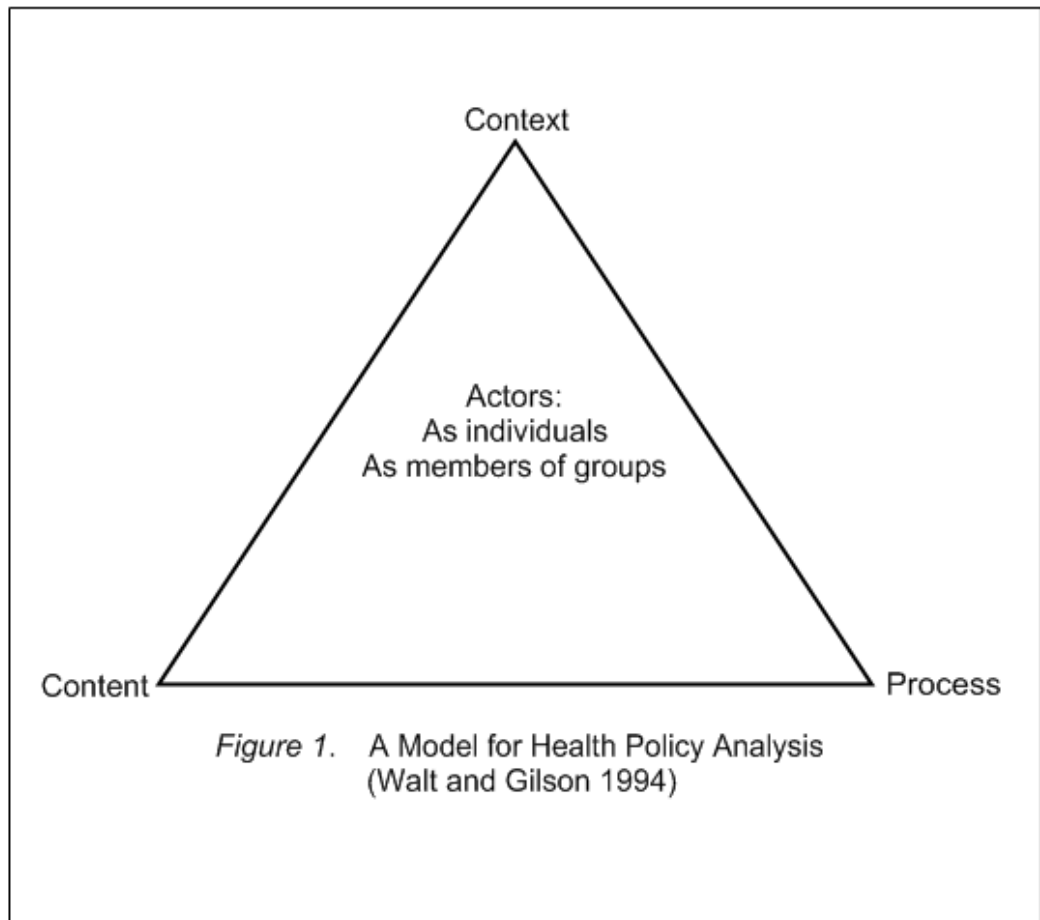


Figure 1: A Model for Health Policy Analysis (Walt & Gilson 1994)

Although this model is presented in Walt and Gilson's 1994 paper in relation to reforming the health sector in developing countries, it can be applied across low, middle and high income countries and there are examples in the literature where it has been applied in this way (Toward 2008). When employing this model, the nature of the country/sector where the policy is being implemented would be assessed under 'Context'. Clearly there would be some important contextual differences between high, middle and low income countries, but also some commonalities as well.

Central to Walt and Gilson's (1994) model is the need for policy analysts to look at actors within the policy process. These actors can be individuals or groups involved in producing and/or implementing policy. As well as 'Actors' and 'Context'; the other dimensions included in the model are 'Content' and 'Process'. Walt and Gilson believe that their model can be used to help policy-makers and researchers better understand the process of health policy reform and to plan for more effective implementation. They say that the model can be used both retrospectively and prospectively: in my study, it was used retrospectively, as outlined in the methodology chapter. A second model or framework for policy analysis used in my work to analyse two specific health policies is one proposed by Popple and Leighninger (2008). These two social work professors from the United States developed 'a systematic framework for studying and understanding policy in all its dimensions'. (Popple and Leighninger 2008: 37). They devised a framework which they intended to be used at any level, from one specific policy to a general policy area. (For an overview of the framework, see Popple and Leighninger's Policy Analysis Outline in Appendix 4).

I found this framework for policy analysis very helpful as it breaks down the potentially complicated and overwhelming task of detailed policy analysis into

a series of clear and comprehensive questions under a range of broad areas or domains. The broad areas include:

- Delineation and overview of the policy under analysis,
- Historical Analysis,
- Social Analysis,
- Economic Analysis,
- Political Analysis,
- Policy/Program Evaluation, and
- Current proposals for policy reform.

Popple and Leighninger (2008) say that it is not always necessary to apply the whole framework when undertaking a policy analysis. Whilst a review of the literature found that Popple and Leighninger's work is quite widely cited and used (Farrell 1995; Pozzuto and Arnd-Caddigan 2008), I was unable to find any specific critiques of their framework. However, I would argue that as a model it is both systematic and comprehensive, and encourages the policy analyst to address in detail many of the contextual factors such as social and economic factors that are so crucial to the policy process (but were ignored in the traditional, rational approach to policy analysis as discussed earlier). Popple and Leighninger encourage a high level of analysis and a refusal to take policy at 'face value'. For example, under the domain of Social Analysis, they pose the question: 'What theory or theories of human behaviour are explicit, or more likely, implicit in the policy?' In answering the questions in the framework, the analyst must draw on knowledge from the disciplines of psychology, sociology, policy studies and economics, amongst others.

It is also important at this juncture to highlight some of the challenges of the Popple and Leighninger model. Specifically, the model leads the policy analyst

to produce a very detailed and analytical account of the actual policy itself (within its economic and social context), but it does not provide the policy analyst the requisite knowledge necessary to move in the direction of *implementation* of the policy, nor to take into account the role of actors in the process (a key part of Walt and Gilson's 1994 model) in both the shaping and implementation of policy. I suggest that using a combination of the two models is a more beneficial approach that produces a comprehensive analysis of policy content, context and implementation.

Whilst not always a feature of traditional policy analysis models, implementation is important for the policy analyst to consider. Analysing policies as stand-alone documents without reference to implementation could be interpreted as an 'academic exercise'. Whilst not to devalue the benefit of policy analysis as an academic endeavour, I would argue that a comprehensive policy analysis would need to at least consider implementation as part of the context. Implementation is a key and necessary part of the policy process (Howlett and Ramesh, 2005) and the analyst needs to consider both the context and content of the policy itself and any potential or actual factors connected with the implementation of that policy. As discussed below, Schram (1993) considers a study of policy implementation to be a key part of postmodern policy analysis.

My approach to policy analysis within this research aligns with a critical social theory paradigm: I wanted to get beyond a description of policy content within a simplistic model of implementation. The aim of my policy analysis was: a) to appraise critically and question both what the policies are aiming to achieve and how they came to be produced within a certain social and economic context, and b) to consider how public health nurses as key actors interact with the policy process. Whilst this critical theory paradigm is

dominant, I also draw from postmodern policy analysis. Characteristic of the postmodern approach, I attempt to *deconstruct* the policies, looking at how they are framed in terms of language, and how this reflects the political discourse of the time. I do not take the policies at face value. Furthermore, a consideration of the social construction of policy, a feature of both a critical theory and a postmodern approach, is central to my work. Schram (1993) writes that postmodern policy analysis ‘...may be understood as those approaches to examining policy which emphasize how the initiation, contestation, adoption, implementation, and evaluation of any policy are shaped by the discursive, narrative, symbolic practices which socially construct our understanding of problems, methods of treatment and criteria for success’. (Schram 1993: 252).

Schram (1993) and others (Danzinger 1995) view postmodern policy analysis as more authentic and complete than the traditional ‘scientific’ or ‘positivistic policy paradigm’ (Schram 1993). An example of this completeness can be seen in the work of Connolly (1991), who comments that a postmodern approach to policy analysis would look at questions such as how a government or society itself should be held responsible for the very social problems it seeks to ameliorate through policy. A traditional approach to policy analysis would overlook such issues. As mentioned above, traditional policy analysis models’ focus on the stand-alone policy focused mainly on policy content. They failed to take into account the importance of the broader social context, in which the policy would be implemented, and any drivers or barriers to successful implementation. In my work, I adopt a postmodern perspective to policy analysis, taking into account the broader political factors which in this case were barriers.

Popple and Leighninger (2008) characterise policy analysis into three approaches: descriptive analysis, process analysis and evaluation. Descriptive analysis consists of four types: content, choice, comparative and historical. Process analysis is less concerned with policy content and more concerned with how a policy comes into being. This approach looks at the contribution and interaction of different actors in the policy process. Popple and Leighninger say that these actors may include public officials, bureaucrats, media, professional associations and special interest groups who represent those likely to be affected either positively or negatively by a particular policy. Interestingly, although this list of actors is comprehensive, it is 'top down' and does not mention key actors in the social policy process: health and social care professionals and workers who are responsible for implementing the policies at the grass roots level.

The third approach to policy analysis is evaluation, which has become increasingly emphasised. Popple and Leighninger (2008) give a clear rationale for the importance of evaluation:

If there is a theme that describes social welfare policy in recent years it is increasing scepticism. Voters, elected representatives, bureaucrats, and academics have all ceased to assume that social welfare programs are good simply because they have good intentions. One result is a demand for evaluation of all aspects of social welfare policy. Rather than simply describing or explaining social welfare policy, evaluation is intended to judge it. The evaluation process may judge a policy's logical consistency, empirically evaluate its effectiveness and

efficiency, or analyze its ethical character. (Popple and Leighninger 2008: 57).

In this research study, I have incorporated elements of all three approaches (descriptive, process and evaluation) using policy analysis models proposed by Popple and Leighninger (2008) and by Walt and Gilson (1994). Popple and Leighninger's model is largely descriptive, but does have some questions which relate to evaluation and some to process (for example, questions relating to the power base of policy stakeholders and opponents). Walt and Gilson's model centres on the policy analyst being concerned with three areas: context, content and process. At the centre of this model are actors in the policy process. These actors can be individuals or members of groups. As a researcher coming from a critical social theory perspective, it was this aspect of Walt and Gilson's model that most appealed to me and the consideration of public health nurses as actors in policy became central to my study.

Continuing with the critical social theory paradigm, I have tried to be critical of the policies themselves. Where Popple and Leighninger in the quote above assume that all policies have 'good intentions', I would also argue that, depending on the ideological and political viewpoint of the policy analyst, policies cannot always be interpreted as 'good', or even as 'well intentioned'. For me, aspects of CAPLNHS and OHOCOS that speak to a consumerist model of health care delivery may be well intentioned from a government perspective, but a social critical theory perspective would question whether the outcome is desirable. For example, in the current National Health Service (NHS) reforms, (Lansley 2011) we see government ideology threatening to dismantle the NHS and many health professionals and analysts, as well as the public, do not view these proposed changes positively.

Macinko and Silver (2012) suggest an agenda for improving the measurement and analysis of state health policy in the context of improving population health in the U.S. Of particular interest to the authors are 'interventional' approaches or policies which focus on restricting exposure to potentially harmful environments for health or encouraging healthy behaviours. Macinko and Silver argue that an effective strategy within health policy analysis would include both 'intradomain' and 'interdomain' analysis which takes into account incremental and inter-agency policy making. They give an example of a variety of policies (administered by a range of state departments) to reduce alcohol consumption: this might include for example imposing sales tax on alcohol, incorporating alcohol abuse training for state workers or increasing funding for treatment and rehab services. Effective policy analysis would involve looking at incremental policy development in all these domains, including the inter-relationship of the different departments. They also suggest that effective policy analysis should involve identifying what factors best explain variations in the adoption of various health policies. External determinants of policy adoption might include new knowledge or scientific evidence, the geographic region in which states exist, the need to comply with nationally accepted standards, and the positioning of states for resources in relation to one another. They state that internal factors affecting adoption of policy could include factors such as the demographic characteristics of a state's population (educational attainment, racial composition, 'urbanicity' and political ideology). Whilst this is an interesting point, the authors do not elaborate in their paper on why they think these particular internal factors are relevant and how they might impact on policy adoption. Whilst elaboration of this would enlighten the reader, I believe that their argument that effective policy analysis should involve a consideration of

inter-disciplinarity and the internal and external drivers and barriers to policy adoption is sound and could also be applied in a UK context.

In an extensive review of emerging trends in theoretical frameworks of the policy process, Nowlin (2011) discusses new theories to emerge between 2008-2010. One of these is the social construction and policy design framework. This is focused on the 'way that attitudes regarding the target population of a policy can influence the type of policy that is created' (p.51). This framework also looks at how policy itself can impact the way that target populations are viewed. Nowlin says that the social construction and policy design framework (first developed by Schneider and Ingram) has been found to have utility both for scholars and practitioners, particularly in the area of health and welfare policy. For Nowlin (2011), traditional research on policy design focuses on the way in which problems are defined. The social construction and policy design framework argues scholars should also focus on the way in which target populations of a policy are defined. This argument has resonance and could also feed into the debate about target populations and stakeholder engagement in the policy process (see next section of literature review below).

Carlson (2011) in a comprehensive essay in *Policy Studies Journal* discusses recent trends and innovations in public policy analysis in the United States. Included is an overview of three main developments in public policy analysis: the move towards social experimentation, the use of meta-analysis and Monte Carlo simulation in benefit-cost analysis and the rise of institutional actors that promote the practice and dissemination of high-quality policy analysis. Having described the three innovations Carlson (2011) goes on to discuss the impact of each on public policy analysis.

Carlson (2011) argues that in recent years policy research has become concerned with 'identifying the causal effect of a policy or intervention on one or more outcomes of interest' (p.15). This pertains to the 'social experimentation' domain, and Carlson gives examples of questions which social policy analysis may be concerned with regarding the social effects of policy decisions: do charter schools increase student achievement? Does the relocation of families from public housing projects to low-poverty neighbourhoods result in improved labour market outcomes? (p.15). From a critical social theory perspective, I see such research as valuable and worthwhile in that it is necessary to try to evaluate the actual impact of policy in terms of its effect on society. However, as Carlson argues, whilst a range of research designs may be employed in an attempt to demonstrate social outcomes, 'in many of these designs...a causal interpretation of any estimates requires strong assumptions' (p.15). In other words, it may be difficult to show a causal link between policy and its social outcomes. For this reason, Carlson advocates the use of experimental designs such as RCT's (treatment and control groups). Carlson goes on to consider the advantages, drawbacks and influence of RCT's on public policy analysis.

Carlson (2011) then goes on to discuss two recent developments in health policy analysis which assist researchers to develop a benefit-cost analysis: these are the use of meta-analysis and the utilization of Monte Carlo simulation. Monte Carlo simulation also involves large-scale quantitative methods: conducting a specified number of trials, usually 10,000 or 100,000, that perform a specific function. In cost-benefit analysis, Monte Carlo simulations are most often used to estimate net benefits. When Monte Carlo analysis is used to calculate net benefits, the proportion of estimates greater than zero is the probability that the policy will have net positive benefits.

In the context of my study, which is mainly qualitative in nature, these first two developments described by Carlson (RCT's to show social effects and cost-benefit analyses) are a counterpoint. Carlson offers convincing arguments for the role of large scale quantitative studies in social policy analysis.

The third development which Carlson refers to is the importance of institutional supporters of policy analysis. He argues that policy analysis as an academic discipline has been somewhat marginalised in the past, partly due to the fact that within academia it has lacked a 'single disciplinary home'; instead residing in various academic fields including political science, economics, sociology, law and others. However, Carlson argues that in recent years 'policy analysis' as an academic discipline has become more mainstream and influential and this has been partly due to influential institutional supporters of policy analysis such as the Washington State Institute for Public Policy.

Walt *et al.* (2008) discuss the importance of policy researchers being aware of where they stand in the process in terms of their 'positionality': that is, whether they are insiders or outsiders to the policy network and or policy process. Advantages of being an 'insider' include easier access and the ability to understand context and processes in a way that outsiders cannot. However, 'outsiders' as policy researchers also have advantages:

...the outsider's advantage lies in curiosity with the unfamiliar, the ability to ask taboo questions, and being seen as non-aligned with sub groups. (Walt *et al.*, 2008: 314)

As essentially an outsider, living outside of the UK whilst conducting my research, I think I was able to ask difficult questions and to ask for clarification where needed, rather than assuming I understood all the organisational and contextual issues. I was also not aligned with any sub-groups, although as a public health nurse by profession I did tend to identify with the public health nurses in my study. However, Walt *et al.* (2008) also highlight the fact that increasingly funders are mandating policy researchers to engage in research translation, ‘...forcing them to become policy actors’. My research was not funded by an outside agency, so in that respect I did not feel ‘forced’ to become an actor in the policy process. However, I believed that knowledge translation would be an important component of my work following the research analysis and grounded theory formation. This aligns with the critical social theory perspective behind my work. For me, it would be important to disseminate my findings regarding how public health nurses engage in the policy process to practitioners and managers and to make my recommendations for action (discussed in Chapter 10) both clear and ‘actionable’.

Continuing with this idea of making health policy analysis and research amenable to concrete ‘action’, Exworthy (2008) makes a case for conceptual models in policy analysis to be used to allow the analyst both to *understand* policy, but also to effectively *intervene* in policy. In this case, he focuses specifically on policy relating to addressing the social determinants of health. According to Exworthy (2008) some potentially helpful conceptual models include Kicker *et al.*'s (1997) work on policy networks, Sabatier's (1997) Advocacy Coalition Framework (ACF) and Dahlgren and Whitehead's Action Spectrum on Health model (2006). Although such models and frameworks may prove useful to the policy analyst and policy researcher, Exworthy notes that there are some particular challenges and considerations when

conducting research on the Social Determinants of Health (SDH) policy process. These include the long-term nature of policy development as opposed to the short-term nature of much policy research, the attribution difficulties of determining cause and effect in policy, the fact that the 'opaqueness' of policy-making is problematic for researchers, the challenge of capturing the views of multiple stakeholders and the need for large-scale longitudinal research to capture the complex nature of policy making around SDH. Although Exworthy does offer some solutions to these challenges, he also acknowledges that many of them, both to do with policy analysis and policy implementation, are not easy for researchers to articulate or to address.

Public Health Nurses As Actors In The Policy Process

Stakeholder Engagement in Policy Making

In investigating the overall aim of this study (to explore the reciprocal impact of health policy on public health nursing and public health nursing on policy) it is necessary to review the literature around stakeholder engagement in policy making. The 'stakeholders' referred to in this literature can encompass a range of individuals, including the general public, service users, professionals and service managers amongst others. In looking at the literature around general stakeholder engagement, one can draw some pertinent conclusions before going on to look at public health nurses' (as one type of stakeholder) specific engagement in policy. *Lavis et al.* (2009) provide some practical guidelines around organising and using policy dialogues to support evidence-informed policy making. Policy dialogues as explored by *Lavis et al.* are a

means whereby policy making is informed by research evidence supplemented by ‘...the views, experiences and tacit knowledge of those who will be involved in, or affected by, future decisions about a high-priority issue’ (p.1).

In terms of policy *implementation*, Pope *et al.* (2006) also advocate a ‘dialogue’ between research and policy making and management. The authors argue that ‘...local partnerships, critical dialogues and reinterpretation in context will be what make a difference in the world of healthcare management and policy making’. (p.47). In this statement, the authors acknowledge the important potential role of stakeholders in policy implementation, and to some extent in policy making (through knowledge translation which seeks to bring academic findings from such sources as systematic reviews into professional practice, usually through policy changes). However, it is significant that they refer to the role of managers, but not to the role or potential role of practitioners, in this process.

Oxman *et al.* (2009) propose a range of strategies that can be used to engage the public (patients and citizens) in evidence-informed policy development. The authors see the potential benefits of this engagement as the establishment of policies that take account of users’ ideas and concerns, improved implementation of policy, improved access and better health. More broadly, they also propose that ‘public engagement can be viewed as a goal in itself by encouraging participative democracy, public accountability and transparency’ (p.1). As an example of comprehensive engagement with civil society groups in order to inform and engage them in policy development and

implementation, they discuss the effective work done by the UK National Institute for Health and Clinical Excellence (NICE).

As Oxman *et al.* note, although laudable, a problem with attempting to engage patient groups in policy is that many such groups have an advocacy/campaigning mandate around a particular health issue, and may not be prepared to engage in broader health policy issues. Oxman and el discuss a number of strategies that can be used to encourage and elicit stakeholder involvement, including media campaigns, written consultation, interviews, and focus groups. Whichever method is adopted, they stress that it is important to plan and evaluate the strategies used.

Although I found a body of literature on the importance of stakeholder involvement (patients/users and the general public) in policy formation, there was little literature on the specific engagement of health professionals (including nurses) in the policy process. Although health professionals are also health care users and members of civil society, and so their views could be captured this way, I believe there is still a need to identify and promote health professionals' unique insights and experiences into health policy formation, implementation and evaluation.

One way forward might be to develop intentional proposals within health Trusts and other organisations to recognise and harness health professionals' potential contribution to policy and propose strategies to move forward. In doing this, much can be learnt from the work cited above in terms of how this can be best managed- for example, through focus groups and questionnaires. As Oxman *et al.* (2009) say, we need to ensure that the involvement moves beyond tokenism to real engagement.

In his work on stakeholder engagement in policy making, Chaney (2012) uses an actor-centred institutionalist perspective to assess the impact of user involvement by individuals from NGO's in government policy formulation in Scotland and Wales following devolution. He found that records of legislative proceedings in Scotland and Wales showed that devolved governance arrangements were facilitating access to the policy process for previously marginalised groups such as LGBT people (lesbian,gay,bi-sexual,transgender). However, whilst his findings were mainly positive, Chaney also found that conducive 'institutional mechanisms' were required in order to facilitate such user involvement, particularly involvement by marginalised groups:

Interviewees questioned the adequacy of political and institutional leadership in relation to the mainstreaming strategies. They spoke of a lack of strategic oversight and 'ownership' of the governments' mainstreaming agendas as well as shortcomings in opposition and backbench scrutiny. (p.476)

In terms of how this relates to public participation in policy making within the health service, I believe the need to involve marginalised group is an important consideration. Furthermore, as Cheney found in his study, there is a need to look at enhancing organisational contexts and structures to really facilitate the involvement of both service users and service providers (including professionals such as public health nurses). Cheney calls for increased evaluation of the effectiveness of public participation within the policy process in government. I believe this is also transferable to the health context. Where managers are seeking to increase the involvement of healthcare users and providers in policy making, there needs to be a robust evaluation of this process.

The Role of Nurses In Policy Making and Implementation

One of the challenges of conducting research into the implementation of health policy and its effect on practice is that one is dealing with the different paradigms of social knowledge and political knowledge, and with the different domains and perspectives of policy-makers, managers and practitioners (in this case public health nurses). Hewison (1999) sees nursing, as a distinct area of study in the field of health policy, as being an 'emerging area of analysis' and implies it is a necessary one. However, he also believes that it is a problematic area, as it can contain contradictions and culture clashes. He cites the example of the introduction of the New Public Management ethos in the 1980's and 1990's as clashing with traditional nursing discourse around issues such as 'caring'.

Swanson's (1991) theory of caring includes five dimensions: knowing, being with, doing for, enabling and maintaining belief. From the 1990's onwards, some nursing theorists have advocated for the centrality of the 'new caring' within nursing practice and nursing education. Kirby and Slevin (1992) proposed 'a new curriculum for care' in pre-registration nursing courses in the UK centred on the foundational elements of 'caring' (authenticity of being, conscience, commitment, presence, compassion, empathy and empowerment).

The concept of 'caring' as a foundational and irrefutable concept in nursing has been critiqued. For example, Barker *et al.* (1995) see it as problematic because it is reductionist, has religious overtones in the way it is presented (particularly in North American nursing theory) and can present nurses as

being the sole professional group to lay a legitimate claim to 'caring'. They also see it as potentially limiting in that it may prevent nurses from developing and evolving:

We believe that the 'caring' movement.....is an unnecessary distraction from the continued exploration of the boundaries of nursing. (Barker *et al.* 1995: 396).

However, Antrobus (1997) appears to be supporting the centrality of 'care' within nursing when she asks whether health policy can 'attempt to impose a mechanistic, scientific and masculine culture on a service oriented to health and care?' (Antrobus, 1997: 447). She perceives an incompatibility between nurses' professional identity as 'carers' and some types of health policy, which she deems 'masculine'. In 1997, Antrobus and Brown stated that 'analysing health policy and understanding the implications for nursing is in essence the study of nursing against the backdrop of other vested interests.' (Antrobus and Brown 1997: 313). In this analysis, some health policy (such as managerialism) is seen as a direct threat to the 'caring' paradigm inherent within nursing.

Power relations are highlighted by Blaxter *et al.* (2001) in their framework for critical reading of research. They believe power relations can have an impact on research findings in terms of affecting the viewpoint of researchers, but they do not include the impact on research participants. It is also pertinent to reflect on the relative powerlessness of nurses compared to some other professional groups (physicians, for example). Although the power relations may have changed somewhat since 1997, it is difficult to assess to what extent. If public health nurses do feel relatively powerless, this could impact their ability to implement change. One could speculate that the recent cuts in

numbers of health visitors, and a failure to date of government to meet its commitment to have a specialist school nurse in each secondary school and its cluster of primary schools by 2010 (Unite /CPHVA statistics in May 2008 reported 'one health visitor job lost every 27 hours') (Community Practitioner, 2008 a), has affected public health nurses' morale and ability to implement policy. Coyle (2008) refers to the underfunding of health visiting and school nursing as leading to a '...diminished, demoralised workforce on the brink of suffering the fate of the long-departed dodo'. (Coyle 2008:2)

In general, the role of public health nurses in policy-making and implementation has not been widely researched in the UK, but some empirical studies have been carried out in the United States and Canada which have sought to evaluate to what extent nurses become involved in the policy-making process. Gebbie *et al.* (2000), in a U.S. study, carried out a qualitative analysis of the career experiences of 27 U.S. nurses who were active in health policy at the national, state, local or organisational level. Using semi-structured interviews, Gebbie *et al.* aimed to find out what *specific* contribution to policy was made by these 27 nurses. Certain areas were chosen to be addressed by the researchers during the semi-structured telephone interviews: these included the policy experiences of the participants; the resources which contributed to involvement in the policy-making process; any suggestions on how to improve policy resources available to nurses; and the strengths and weaknesses of currently available information for policy work.

A positive aspect of the research design was that, while interviewers were matched to respondents primarily on the basis of their respective schedules/availability, it was decided that nobody would interview a respondent with whom they had current contact in case this affected the

responses. The content of the interviews was recorded via notes made during the interview which were subsequently transcribed. One could critique this design on the grounds of the extent to which these notes could be an accurate recording of what was said. Audio recording of the conversations would have produced a more accurate retrieval of data, including verbatim quotes. It is also not made clear in the report how soon following the conversations transcription took place. The more contemporaneous the transcription, the more authentic the data set. Ongoing transcription after each interview also lends itself to a grounded theory approach because the findings can influence later questions and subsequent avenues of inquiry (Bryman 2004).

Nevertheless, Gebbie *et al.*'s (2000) research revealed some interesting findings regarding the particular contribution of nurses to the policy-making arena. Because of their professional orientation towards encouraging autonomy in their patients and clients, and an ability to translate macro data into the individual patient experience, the authors found that nurses are able to assess the likely impact of policy directives on individual patients' lives. Furthermore, many participants believed that the problem-solving approach adopted by nurses in practice could be widely and usefully applied to the policy-making process.

An interesting finding in Gebbie *et al.*'s (2000) study related the respondents' subsequent involvement in policy-making to earlier experiences in their nursing education. Exposure to sociology, economics and political science during this period, as well as education in a school of nursing or university with an 'activist orientation' was positively correlated with subsequent involvement in policy-making as a career choice. Several respondents viewed their choice of clinical speciality as being influential. Midwifery and public

health nursing were found as particularly likely to engender an interest in policy and a questioning approach to practice.

Finally, this study highlighted a potential significant difference between the U.S. and the UK experience in terms of the provision of a process in the U.S. whereby committed and suitably qualified nurses are actively encouraged to develop their careers in policy. Several respondents noted the Robert Wood Johnson Health Policy Fellowship as having been very significant to their career development. This is an initiative where nurses are awarded a one year fellowship which enables them to work in health policy at a national level, including Senate committees on issues such as infant mortality and nurse practitioners. Whilst the UK has nurses (including public health nurses) employed in advisory and administrative capacities at the Department of Health, and sitting on Trust Boards, nothing like the Robert Wood Johnson Fellowship exists at the present time.

Cheek and Gibson (1997) critically examined the relationship between policy and nursing practice in an Australian context. The study investigated the way in which policy can be a result of social norms and expectations, including ideas about how particular professional groups should act. In this way, policy can be limiting and constraining for nurses if it does not allow scope for autonomy and professional judgement. They ask: 'how can nursing achieve the disciplinary status it so desires when its practice is being increasingly controlled?'(Cheek and Gibson 1997: 669). Furthermore, like Barker *et al.* (1995), Cheek and Gibson believe that professional stereotypes and images of nurses as primarily concerned with 'caring' may be seen to conflict with a more assertive role of an engaged policy maker and facilitator. Adams and Nelson (2009) argue that descriptions of nursing frequently emphasize service, altruism, emotional connection and relationship- what Gordon and

Nelson (2006) term the 'virtue script'. This also entails nurses being encouraged 'to do their work quietly and out of the limelight- to aspire to be invisible' (Adams and Nelson 2009: 6).

The above discussion aligns with the work of Antrobus and Kitson (1999), who argue that the populist view of nursing, reinforced by media portrayals, is that nurses are only concerned with operational issues related to direct care delivery. Cheek and Gibson (1997) argue that policy reflects 'dominant discursive frameworks' adopted by policy-makers and this in turn influences the way in which nurses and others view nursing. This links in with the importance given to 'Context' in Walt and Gilson's (1994) model for policy analysis discussed earlier. Although much of the 'policy' under discussion by Cheek and Gibson refers to nursing procedures at a hospital level, rather than state or national health policies *per se*, the points which the authors raise about the possible constraining influence of policy is a valid one.

Whilst certain overarching principles, for example, that of 'addressing health inequalities', may be accepted by a majority of public health nurses, Cheek and Gibson's paper highlights the need for a critical reading and understanding of policies in terms of how they reflect and drive forward the powerful agendas. . For example, they discuss the issue of policy and procedures delivered in a top-down process which results in nurses taking them up uncritically and automatically without questioning them:

Thus, nursing practice is regulated not only through legislation, but also through a hierarchical system of policy development stemming from enactment of that legislation. As a consequence policy statements abound in nursing departments, as evidenced by the presence of policy folders

in each unit/ward/department and the existence of policy committees whose stated purpose is to develop, monitor and review policy. Thus, policy is highly visible, taken for granted as being necessary, and portrayed as being of value and assistance to nursing and nurses. Consequently the need for, and value of policy is rarely challenged or questioned. Cheek and Gibson 1997: 669

Although Cheek and Gibson do not directly address the issue of nurses' (lack of) involvement in policy-making, one could conclude that their argument about the problem of policy and the agenda of powerful groups in society being 'imposed' upon nurses, so limiting their professional autonomy and discretion, could be partly ameliorated if nurses were to become much more actively involved in the policy-making process (as advocated by Gebbie *et al.* above).

The idea of policy as something which can be 'foisted upon' professionals in a top-down manner is interesting to reflect upon in light of research by Som (2005) into doctors' responses to the Clinical Governance agenda in the UK. Using a phenomenological approach, 33 doctors with responsibilities for clinical governance were interviewed using a semi-structured format. The aim of the study was to explore the response of doctors to clinical governance. Two research questions were formulated:

1. What is the response of doctors to clinical governance?
2. What are the reasons for that kind of response to clinical governance?
(Som 2005: 466).

Som (2005) aimed to collect in-depth information regarding the doctors' personal responses to the Clinical Governance agenda. He identified a lack of research around this issue. Som believed that it was essential to engage clinicians in policy implementation if the policy was to be a success. Som argued that doctors had successfully resisted health policy initiatives introduced in the NHS in the past, but he does not give any specific examples of such policies. Since Som collected his data in 2003, the ability of powerful groups to negotiate policy and reject aspects which they view as against their interests is a phenomenon that continues. An example is the successful negotiation in 2004 of the MPIG (minimum practice income guarantee) by General Practitioners. This contract included the ability to 'opt out' of out-of-hours services and resulted in bonus payments which brought their average annual salary to over 100,000 pounds. (Gaines 2008).

Key to Som's (2005) analysis and also pertinent to this research project is the fact that he identified doctors or clinicians as a '... highly skilled, professionally well qualified and well organised, powerful group of health staff'. While this description may be applied to others groups of health staff, including public health nurses, the key word which may be uniquely applied to clinicians within current structures is *powerful*. Nurses as a professional group have traditionally been in a less powerful position than doctors. However, there are signs of a growing political and professional confidence within nursing (Revill 2006). Part of my study will be an attempt to analyse to what extent public health nurses have the professional power to influence the implementation of recent health policy.

In his research concerning the implementation of the Clinical Governance agenda, Som (2005) found that doctors were largely unenthusiastic about this policy and unsupportive of attempts to implement it. One of the reasons for

this response was that the respondents (doctors) believed it was a management-led initiative, imposed on them within due consultation. His analysis found underlying tensions and issues of power and control in the policy implementation process. The primary source of tension was between an organisation attempting to bring clinical care within a management framework and doctors who were resisting the loss of their former 'bureau professionalism'. This tension between the paradigms of professionalism and managerialism has been examined widely within social policy theory (Le Grand and Bartlett 1993; Clarke *et al.* 1994; and Hughes and Lewis 1998). The idea of doctors resisting the imposition of health policies because they see them as imposed by management and a threat to their professional autonomy is echoed in Creek and Gibson's (1997) argument, where they frame the imposition of policy (mostly relating to procedures) on nursing staff as a potential threat to their professional status.

Toward (2008) believes that it is important for public health practitioners (including public health nurses) to develop their knowledge and understanding of policy and believes they should seek to influence policy as part of their role. In order to fulfil this remit, she recommends that public health practitioners develop their skills in three key areas proposed by Spicker (Spicker 2006, cited in Toward 2008): strategic thinking and political skills; communication; and research. In the realm of strategic thinking and political skills, Toward (2008) argues it is important for practitioners 'to be aware not only of the content of policy but also of the macro level wider context, and the political and power dimensions of policy.' (Toward 2008:137).

As well as at the micro level, Toward (2008) also sees a role for public health practitioners in policy at the meso and macro level. This role centres on the second area identified by Spicker: communication. At the meso level,

practitioners need well developed communication skills to actively engage with the policy making and implementation agenda. Toward gives an example of a practitioner employed by a PCT working across inter-professional boundaries with a local authority and a voluntary sector organization. Another example might be health visitors who join a Steering Committee for their local Sure Start initiative. As well as this, she argues that public health practitioners should develop their communication skills in order to become actively involved in policy at a meso level; the implementation stage. Toward writes:

The balance needs to be shifted away from a top-down to more of an assertive bottom-up mindset on policy implementation, which is underpinned by a belief that practitioners can exert influence and effect change.

(Toward 2008: 138).

Toward (2008) argues that public health practitioners who develop skills in these areas of strategic thinking, communication, and research in relation to policy, will grow more confident in their ability to contribute to policy and strategy development and implementation. It is important that they do so because, as she points out, this is the fifth principle of public health practice (NMC 2004 a) and this principle underpins the proficiencies for specialist practice registration. Toward argues that the underlying purpose in contributing to policy development and implementation is to improve health and wellbeing:

This [improving health and wellbeing] should be the goal of all public health practice and is the compelling reason

why practitioners should strive to influence policy throughout their working lives. (Toward 2008: 138)

When considering the specific role of public health nurses as stakeholders in the policy process, one can be informed by the literature on 'evidence informed policy-making' discussed in the previous section (Stakeholder Involvement in Policy Making). Researchers such as Lavis *et al.* (2009) and Pope's (2006) recommendations on how stakeholders can be actively engaged in policy making and implementation through policy dialogues can be applied to the case of health professionals. Managers and policy makers could use these findings to consider specifically how nurses might become engaged in policy dialogues.

The Effect of Health Policy on Public Health Nursing Practice

In the following section, I review some of the practice development literature. In this context, practice development literature can offer possible explanations for the effect of policy on public health nursing practice. Practice development literature can help to elucidate the way in which policy-practice gaps may come about. This knowledge will eventually feed into one of my research questions: 'Is there a policy-practice gap?'

Croghan *et al.* (2004) carried out a survey on school nursing practice focusing on policies, working practices, roles and value perceptions. The aim of the research was to analyse school nursing practice in relation to the expectations of first line managers and policy-makers in government in order to discover any potential practical or ideological areas of conflict. Implicit in this analysis seems to be the idea of a potential policy-practice gap as discussed earlier.

Forty-six school nurses in the West Midlands region of the UK were randomly selected and asked to complete a questionnaire concerning personal characteristics, experience, training and working practices. The thirty-eight nurses who completed this questionnaire were subsequently interviewed. The self-reported practices of school nurses were compared to the expected practices as stipulated by managers (from job descriptions) and the governmental agenda for school nursing obtained from an analysis of 'various official sources' (Croghan *et al.* 2004: 377).

An interesting facet of this research is that the researchers attempted to locate the study within a theoretical framework whereby they employed Silverman's (2002) concept of 'sensitizing resources'. It is not entirely clear from the report, but it seems that the four 'sensitizing factors' used in this research were chosen by the team following focus group meetings with staff. The knowledge obtained from the focus groups then sensitized the researchers to the various researchable issues which they could look at in the questionnaires and follow-up interviews. These four areas were:

- the historical sphere
- the political sphere
- the cultural sphere; and
- the contextual sphere.

A further aim of the research, as well as the one outlined above, was to 'assess the usefulness of this theoretical framework in providing an explanation of current issues relating to school health nursing practice and practitioners' (Croghan *et al.* 2004: 378). The authors went on to explore the evolving role of school nursing in relation to the four spheres. This is essentially an examination of how health policies have impacted on school

nursing practice since the election of the UK Labour government in 1997 and considered this question in terms of the historical, political, cultural and contextual sphere. When examining the complex relationship between policy and practice, I would argue that such a framework would be very helpful for the researcher. It would enable him or her to go beyond a linear examination of policy and practice to a more complex, three dimensional analysis. When conducting research into how community health nurses implement policy, it is pertinent to address issues of history, politics, culture and context.

The authors contend that the reorganisation of the health services at this time brought about a change in emphasis from a reactive to a proactive approach, with public health at the forefront of policy. Early policies from this new administration, including *Saving Lives: Our Healthier Nation* (Department of Health 1997), saw an important role for school nurses in health promotion and public health (as distinct from one to one interventions based on a medical model). A key policy which they identify as being potentially very influential on school nursing practice was the 2006 Public Health Practice Development Document For School Nurses (Department of Health 2006), the first policy to define school nursing as 'child centred public health'. This document can be seen as distinct from, but complementary to, the 'family-centred public health' function, which was a phrase first coined in relation to health visiting practice in 2001 by the Department of Health in their 'Health Visitor Practice Development Resource Pack' (Department of Health 2001 a). This was a function which subsequent policies continued to promote. (CPHVA 2001; RCN 2002).

Croghan *et al.* (2004) found two barriers to school nurses implementing new policy were lack of confidence in new procedures (in this case, carrying out needs assessment) and lack of time (many of the school nurses in the study

were working part-time). Interestingly, whilst Croghan *et al.* analysed how school nurses changed their practice in response to changing policy agendas, they did not look at the role of school nurses as active agents in the policy process. It appeared that policy was something that was done 'to them' as opposed to 'with them'. Croghan *et al.* observed that the school nurses' practice '...covered what employers and policy-makers required'.

In a study published in 2004, Abbott *et al.* (2004) sought to evaluate the extent to which health visitors were ready and able to take on a family-centred public health role. The authors set the emerging role in context; affirming that the origins of health visiting were in public health, although, throughout the 20th century, the role was adopted as an increasingly individualised model of practice. Although published in 2004, the paper was based on semi-structured interviews carried out in 2001 (at the time of the shift to the family-centred public health function discussed above). The interviews were with senior nursing/health visiting managers, chief executives and directors of public health in five case-study PCTs in London, and informants were from a range of national organisations related to public health and to primary care. Among other questions posed to respondents in a wider study about public health capacity within primary care in London, the capacity of health visiting was investigated. Researchers asked the question posed in the 2001 Department of Health document: 'is health visiting, as it currently exists, ready, willing and able to make the necessary changes to realise this vision?' (Abbott *et al.* 2004: 339). This is still a relevant question in light of the extent to which public health nurses (health visitors and school nurses) are ready to take on the new challenges outlined in CAPLNHS (Department of Health 2005) and OHOCOS (Department of Health 2006a).

In terms of Abbot *et al.*'s (2004) study design ('collect'), there are weaknesses. The authors conceded that the sample size was small (9 respondents). The wider study covered a number of issues about the public health capacity and function of PCTs, though not all of the respondents actually spoke about public health nursing per se. However, their conclusions were that health visitors did not have the range of skills needed to fully address a public health mandate and:

Progress will require more courage and creativity among frontline health visitors; but this in turn requires more imaginative management to facilitate and support a family-centred public health approach. (Abbott *et al.* 2004: 341).

Abbot *et al.* (2004) found several barriers preventing the public health nurses in their study from fully embracing their new public health function promoted by policy at that time. These barriers were attitudinal (health visitors were found to be 'over-concerned with autonomy, yet not prepared to offer leadership'), skills-related (public health nurses were found to be lacking the skills and capacity to adopt the new public health approach) and resource-related (there were many vacant caseloads at the time the study was carried out). From this work, it is clear that policy mandates are not enough in themselves to produce practice changes. There may be a number of barriers (such as those found by Abbott *et al.* in their study) which prevent the smooth transition of policy into practice.

One might assume that policy has some impact on practice, but, in fact, the relationship between policy and practice is is complex and non-linear. This is

the rationale for including practice development literature in the literature review for this study. The y research question is about examining the reciprocal relationship between public health nursing and policy and it is pertinent to my work to consider what the practice development literature reveals about the extent to which policy is taken up in practice and what some of the barriers to this uptake might be. Understanding new policy and engagement in new policy development may be something that public health nurses are or wish to be involved in. However, the next part of the process is *policy implementation*. An examination of the literature on practice development helps to illuminate the complex processes involved in developing practice; in this case, in response to policy directives.

Clarke and Procter (1999) examine the nature of the 'ambiguity' of practice development in both research and practice as inquiry ('ask'). It was also indicated that there is a range of opinion about the position of research activity within professional practice: ranging from the idea that it should be firmly embedded within practice to a situation where it is '... the exclusive remit of external agents in which practitioners and their practice are relegated to the status of 'being researched'' (Clarke and Procter 1999: 975). Clarke and Procter also raised questions about the generalisability of data around practice development, as this data is context-bound; reflecting, for example, the particular structure of the organisation where the practice development is taking place in the usage of data ('use'). I concur that this type of research (into practice development) creates a 'methodological challenge' in the collection of data. This relates to the work of Croghan *et al.* (2004) discussed above, which also highlights the importance of context in any research concerning practice development.

Clarke and Proctor (1999) conducted a series of focus groups over a ten week period with participants from varied professional, academic and practice backgrounds. The aim of the research was to look at some of the problems encountered by both practitioners and researchers who were studying practice development. The seminars revealed that there were tensions and perceived divisions between practice and the development of practice and research. A key theory to emerge from the data was that 'practice development activity finds itself rejected by both practice and research as non-compliant with explicit or implicit definitions of good practice and good research' (Clarke and Procter, 1999: 976). The division between practice and research was caused by the fact that practice emphasised the use of research findings in having a direct impact on therapeutic patient care, whereas research emphasised a 'technical rational' model, where generalisability of research findings was expected. Divisiveness is an issue also raised by Heller *et al.* (2008) in their proposal of a new framework for assessing and critiquing research into public health issues: that is, that traditional experimental designs and critiquing tools which have a more clinical focus may not be appropriate. Heller *et al.* argue that evidence-based medicine can be criticised for focusing on efficacy and neglecting issues such as implementation. There is a need for including such parameters as context in public health studies which include implementation issues. Clarke and Proctor (1999) believe that the knowledge found through research around practice development is likely to be very context-specific.

I find these arguments compelling in terms of how they attempt to illuminate some very real problems and potential problems in research around practice development. However, I would question the authors' blanket assumption that all researchers who attempt to provide insights into practice

development adopt a quasi- experimental, rational approach. However, I do concur with their concluding statement that:

No-one would argue that practice development research is not a legitimate activity, and yet it is owned wholly neither by practice nor research environments since it sits slightly outside the parameters of each (Clarke and Procter, 1999: 975).

The study of practice development can be bound up with the study of policy, in that researchers may need to consider the impact of any policy on practice. However, McCormack *et al.* (1999) recognise the status of practice development as being somewhat unique, needing its own conceptual framework based on a critical social science philosophy. The authors believe that this philosophy would help to engender real changes in practice by enabling individual growth and development, empowerment of practitioners and, crucially, 'the generation of cultural change that sustains continuous growth and innovation in practice' (McCormack *et al.* 1999: 255).

Like Clarke and Procter (1999), McCormack *et al.* (1999) call for greater collaboration and synergy between practice settings and academic institutions. The research part of their model is divided up into three 'interfaces': the client/patient interface, the organizational interface and the strategic interface.

In terms of bringing the two domains of academia and practice closer together, research into practice development is both inductively generated from derived knowledge and deductively tests derived knowledge. Related to Heller *et al.*'s (2008) framework for critiquing research with a public health

focus, this type of research could apply across different populations and different domains of public health practice ('use').

At the level of the organizational interface, McCormack *et al.* (1999) highlight the importance of evaluation of organizational systems. They also advocate the creation of partnerships between practice settings and academic institutions in order to create opportunities for the generation of knowledge through practice development. For maximizing response rates and encouraging ownership of the research by participants, this would be beneficial.

In an example of research into the direct effect of policy on public health nursing practice, Condon (2008) aimed to assess the extent to which national child health promotion policy was reflected in health visitors' practice across the United Kingdom. A survey was carried out in 2005 of health visitors' Child Health Promotion Programme (CHPP) practice. The main change in practice advocated by this policy was a more streamlined, focused programme of intervention, targeted at vulnerable groups in the population. The CHPP was itself based on two key policy documents: the fourth Hall Report (Hall and Elliman 2003) and The National Service Framework for Children, Young People and Maternity Services (Department of Health 2004).

In order to answer her question, a large-scale cross-sectional survey was carried out. A postal questionnaire exploring local practice and policy was sent to a random 10% sample of Health Visitors registered with the NMC. The initial response rate was 45%, but this increased to 64% after one postal reminder. This equated to 1043 questionnaires for analysis. As a large survey, the data analysis was primarily through a quantitative approach: nominal data were analysed by looking at frequencies and associations between key

variables. The chi-square test was used for comparisons between groups of respondents, and significance determined using $P < 0.05$. Most respondents were practising health visitors (86%); 9% were other early years practitioners and 5% managers.

A limitation of the study was that it purported to be looking at health visitors' practice 'throughout the United Kingdom', but the numbers of respondents from outside England were very low: 5% of the sample were from Wales, 3% from Northern Ireland, and 1% from Scotland. The author does recognise this limitation in her paper, but, in light of these numbers, it may have been appropriate for Condon to focus just on the results from England. A significant finding is that her overall results revealed a clear 'policy-practice' gap as far as implementation of the CHPP was concerned. Health visitors were largely acting as 'street level bureaucrats' (Lipsky 1980, cited in Condon 2008), adapting the policy at the implementation stage. For example, many were continuing to make routine contact with children after the first year, contrary to the recommendations of national policy. Drawing on previous social theories (Lipsky 1980; van Meter and Horn 1975), Condon explains the lack of implementation thus:

In this way, professional discretion becomes the ultimate arbiter of how much policy changes influence service delivery. Without implementation at ground level, the final stage of the policy process remains incomplete, and the intended effects of the policy change are prevented from reaching clients and service users. (Condon 2008: 5).

Although these references that Condon draws on are older (1980 and 1975 respectively) they remain seminal works in the area of policy implementation.

Another interesting finding in Condon's (2008) work was that there was a statistically significant difference between the responses of managers, health visitors and early years practitioners in terms of their level of agreement and compliance with the policy's recommendations of targeted visiting only after the first year. Managers' views tended to be more supportive than the other groups regarding the recommendations in the policy for targeted visiting only after one year of age. However, it was not possible for Condon to explain further from her data how this affected health visitors' practice.

Although a large survey, Condon (2008) rightly concluded that the sample size was still small in relation to the total number of NMC registered health visitors (about 10%), and so one must be cautious in extrapolating findings to the whole population of practicing health visitors. In this study, Condon does succeed in addressing her research question, of 'does health visitors' practice follow policy?' in relation to child health promotion, as applied to England, if not to the UK as a whole.

Condon (2008) also raised some very pertinent issues for further research-issues which were beyond the scope of a large-scale, quantitative survey such as she conducted. Whilst her research lead her to conclude that there were barriers to policy implementation, either at local Trust policy level or at individual practitioner level (perhaps linked to the traditionally quasi-autonomous nature of health visiting practice), she was unable to glean from her research a detailed understanding of why there was this policy-practice gap; beyond the finding that many practitioners do not appear to be 'on board' with the changes. She recommended that further research be done, of a more qualitative nature, which explores the reasons behind the 'identified gaps in policy translation and practice' (Condon 2008: 12).

Policy Implementation: Exploring The Policy-Practice Gap

Hill and Hupe (2002) identify the 1970's as a time in which a 'distinct approach to the study of implementation' emerged. At that time, there was a growth in policy evaluation studies. Although there had been previous scholarly inquiry into how policy was enacted 'on the ground', it was in the 1970's that we first began to see this phenomenon expressed as 'implementation'. In order to distinguish the implementation phase, Hill and Hupe (2002) suggest that we consider an overall process of policy *formation* (rather than policy making). The term 'policy making' is the policy process as a whole, and policy formation is an early part of this, followed by the implementation phase.

Hill and Hupe (2002: 9) view Easton's political system model (1953) as being 'one of the most influential models of the relationship between politics and administration'. In this model, 'Inputs' go into the political system and produce 'Outputs' and 'Outcomes'. Hill and Hupe (2002) point out that there is often confusion between the two terms. The need to distinguish between outputs and outcomes is also identified by Lane and Ersson (2000), who see outcomes as being the final results (intended or otherwise) of policy:

Outcomes are the things that are actually achieved,
whatever the objectives of policy may have been.
Outcomes are real results, whether intended or
unintended.... (63).

Some writers (Chapman 2002; Pfeffer 1992; Cowley *et al.* 2009) have commented on the 'implementation gap' between policy objectives and the actual outcomes. For Chapman (2002) this phenomenon is 'one of the more intractable dilemmas of modern government'. Pfeffer (1992) has two principal explanations for the difficulty of successful implementation. Interestingly, one of his explanations is that changing social norms have affected traditional ideas of 'formal authority'. This explanation holds that the traditional 'chain of command' may have broken down within organisations and this can affect the way in which policy directives and changes in practice are implemented within an organisation. The second reason is that it may be difficult to find a common vision within an organisation whose members may be 'increasingly heterogeneous'. Furthermore, Pfeffer argues that traditional policy models, which emphasise a mechanistic and rational approach, are not appropriate for getting to grips with 'the complexities intrinsic to health policy'.

As Hunter (2003) noted, although the mantra of New Labour during their second term of office was 'delivery! delivery! delivery!', the 'management model adopted to steer and enact the government's policies did not prove 'fit for purpose'.' (Hunter 2003: 15). Reflecting Pfeffer's (1992) stance, Hunter's (2003) critique of the New Labour government's implementation of health care policy is that it largely failed because they '...remained wedded to an outmoded, hierarchical, linear rational model of command and control' (Hunter 2003: 15). He goes on to criticise it for an over-emphasis on targets, performance indicators and short term outputs, as opposed to longer-term, more enduring policy outcomes. Further, Hunter argued that when one is looking at overarching social problems such as health inequality, for example, a lack of 'joined up thinking' between different government departments (in

this case, health, education, social services and work/employment) impeded implementation.

Cowley *et al.* (2009) examined the range of health visitor provision across different locations in England. They focused specifically on the policy-practice gap around the provision of services to families ante-natally up until the children were at least three to four years of age. They assert that, in the four or five years prior to 2008, English government policy had highlighted the importance of health interventions at this life stage, as well as issuing clear policy directives to narrow health inequalities. The authors wanted to determine whether identified variations in service provision were related to need, levels of deprivation, availability of other services in an area or other factors. They found that there appeared to be a policy practice gap in that government policy was clearly mandating a need to address health inequalities, but there was no relationship between levels of deprivation and amount and nature of health visiting services. However, interestingly they also found an element of 'street level bureaucracy' at play here, in that their survey data offered evidence that individual health visitors focused on their most deprived clients (although the services had not been explicitly structured to do this).

Summary of Current Literature and Identified Gaps

The literature review focused on three broad categories of: approaches to policy analysis, public health nurses as actors in the policy process and policy implementation. It took an extensive review of the literature to find policy analysis frameworks that I felt would help me achieve the aims of my research: that is, to use policy analysis findings as data to help understand the

reciprocal impact of health policy on public health nursing and public health nursing on policy. In the end, I chose to use Popple and Leighninger's (2008) framework supplemented by Walt and Gilson's (1994) approach. I chose the former because it is comprehensive and covers a range of perspectives and lenses for carrying out the policy analysis: including psychological (human behaviour), sociological (social values), instrumental (policy goals), political and economic. The rationale for starting with Popple and Leighninger's framework was that it gave me a detailed understanding of the policies themselves (CAPLNHS and OHOCOS). This detailed understanding was necessary in order for me to assess the extent to which public health nurses themselves understood the policies.

The data collected from the policy analyses using Popple and Leighninger's framework (particularly around a psychological and sociological perspective) helped me understand my primary data and how public health nurses actually engaged with and implemented these policies. For example, I asked questions about the psychological motivations and influences of the public health nurses: Why did public health nurses not see a central role for themselves as policy makers? Central to this critical social theory-based study was a sociological analysis. Important questions from a critical perspective, for example, were to ask about how traditional hierarchical and power relationships hindered nurses' involvement in policy.

The supplementation of Popple and Leighninger's framework by that of Walt and Gilson's (1994) was beneficial because of the centrality that they (Walt and Gilson) give to the role of the Actor in the policy process. Many traditional approaches to policy analysis focus exclusively on the policy content and do not address the crucial role of individuals and groups in policy making, interpretation and implementation. Because the reciprocal

relationship (between public health nurses and policy) was central to my investigation, Walt and Gilson's model was helpful in providing a framework through which to conceptualise this relationship.

In terms of published studies which examine the specific role of public health nurses as actors in the policy process, there are very few. Because there are few published studies, and those which do exist are in a North American context, I hoped that my research could truly be seen to be generating 'new knowledge' in this crucial area. Data on the public health nurse as Actor in policy emerged from the four types of data I collected and analysed: online questionnaires, telephone interviews, detailed policy analyses and analysis of extant documents. The use of a policy analysis framework which highlights the importance of actors in policy making and implementation (Walt and Gilson 1994) was particularly helpful in helping to contextualise and structure my findings for my research.

The final component of the literature review was to find and analyse published work relating to the policy-practice gap in nursing and specifically in public health nursing. In this component of the literature review, there was a dearth of published literature. Cowley *et al.*'s (2009) work was an exception and produced some insightful findings, as did the quantitative investigation into the effect of policy on public health nursing practice conducted by Condon (2008). The lack of much published research encouraged me to pursue my research in the belief that this was important work, with the potential to generate 'new knowledge'.

It is worth asking here if the comparative lack of published research in this area might have proved detrimental to my work in that there was little existing empirical evidence to base my work on. I would argue that this was

not an issue, partly because I was using a grounded theory approach. In this methodology, there is an emphasis on new knowledge and theory emerging from the data itself, and not from testing existing theoretical knowledge or constructs.

Interestingly, as well as a lack of research on the policy-practice gap, generally in the literature I did not find published examples of in-depth policy analyses of specific White Papers. It may be that some of this work is carried out for government departments and NGOs and remains unpublished. There are some examples, such as Chapman's (2002) Demos report which includes a number of NHS case studies to illuminate where implementation of health policies have led to disappointing results or even 'adverse effects'. Chapman recommends policy formation, implementation and analysis which focuses on a systems rather than a 'command and control approach'. For Chapman, a systems approach would involve the following:

- Interventions would be based upon learning what works, on an ongoing basis, rather than specifying targets to be met;
- The priority would be to improve overall system performance, as judged by the end- users of the system, not just by Ministers or civil servants;
- The policy making process would focus on the processes of improvement, rather than the control of the agencies involved;
- Engagement with agents and stakeholders would be based more upon listening and co-researching rather than on telling and instructing. Responsibility for innovation and improvement would be widely distributed; and
- Implementation would deliberately foster innovation and include evaluation and reflection as part of the overall design.

Another example of an in-depth evaluation of a specific policy is the national evaluation of the Sure Start project, a government initiative focused on multi-agency provision and intervention with vulnerable families with young children (National Evaluation of Sure Start or NESS project, Institute for the Study of Children, Families and Social Issues 2008).

Like Chapman, Hunter (2003) comments that traditional rational, linear models of policy making and implementation are insufficient and are not fit for the increasingly complex and multi-dimensional nature of the health policy context. For Hunter, '...the state of the evidence base reflects the absence of the politicization of policy'. (Hunter 2003: 27). This politicization for Hunter is about the need for policy analysts to take into account factors such as power relationships within organisations, and to move away from 'new public management' thinking...based on mechanistic, market-style liberalism in which people are treated in instrumental ways.'(Hunter 2003: 26). Chapman (2002: 23), in a similar vein, argues that 'a new intellectual underpinning for policy is required'.

Condon (2008) recommends that further research is done, of a more qualitative nature, which could explore the reasons behind the 'identified gaps in policy translation and practice' (Condon 2008: 12). A key component of my research is to provide an in-depth, qualitative analysis of the reasons for adherence to or diversion from two key policy documents. Although my study is smaller than Condon's in terms of sample size, a qualitative approach lends itself to more depth of analysis, partly addressing the recommendations for further research identified by Condon. My work will include verbatim quotes from participants, which can lend richness to the data and provide useful insights into the practitioner perspective.

Having presented and critically evaluated a range of literature pertinent to my research area, in the next chapter I will discuss the research philosophy which underpins my work: critical social theory.

Chapter 3

Research Philosophy

Critical Social Theory

Let us return for a moment to the statement from the Canadian Nurses' Association (2000) quoted earlier:

If we think of health as something broadly defined and influenced, we begin to arrive at the inescapable conclusion that to be concerned with health is to be concerned with the social context, and that nursing is, indeed, a political act.

I came to this research with a background in public health nursing practice and theory, and the academic disciplines of sociology, social policy and population health and public health. I view health as both 'broadly defined' and nursing as potentially a 'political act' (CNA, 2000). This perspective goes further than an awareness of the social determinants of health (as defined and explored by the WHO 1986; Health Canada, 1998; Wilkinson and Marmot 2003; Raphael 2004). Recent research focusing on population health issues has attempted to go beyond a focus on health determinants to a critical

analysis of the 'social- structural influences that initially produce those particular determinants'. (Richmond and Ross 2008: 405). So I brought to this research a knowledge of sociology and social policy, as well as public health nursing practice, which was the 'lens' through which I approached the grounded theory process. A critical social theory perspective was also a part of earlier work I had done in both research and education.

As stated earlier, the overall ideological framework for my research was critical social theory. Polit and Beck (2010) provide a useful summary of the main 'qualitative research traditions', which have their roots in the following disciplines: anthropology (ethnography and ethnoscience), philosophy (phenomenology and hermeneutics), psychology (ethology and ecologic psychology), sociology (grounded theory and ethnomethodology), sociolinguistics (discourse analysis) and history (historical research). Initially, I chose to use grounded theory because, on researching different approaches, grounded theory seemed the most suitable methodology for addressing my research questions. At that stage, I was not aware that grounded theory is considered a sociological approach. As I got more immersed in the research process, I began to see that this was indeed the case and I was able to appreciate the congruency of critical social theory and grounded theory.

The main philosophical approach I have used in this work is critical social theory. This is because the interpretive paradigm (for example hermeneutics) does not explicitly address unequal power relations created by societal structures and relations, the economic system and citizens (Bryant 2009). Hermeneutics is not explicitly a political philosophy and I knew from the outset that a political perspective would be central to both my policy analyses and the analysis of my primary data.

A critical social theory perspective is concerned with a critique of existing social structures (Polit and Hungler 2010). From my own experience and observations while working as a public health nurse (in both practice and education) in various locations in England, I have experienced a feeling of 'policy overload' at times, and I was interested in finding out more about the way in which others engaged (or not) with the policy-making and implementation process. Did they too feel overloaded and unsure of how policy should or could impact their practice? I had an unsubstantiated theory from the outset of the project that a 'policy-practice gap' existed, and that this gap might be partly explained by the fact that public health nurses were not enabled to take an active role in either policy-making or implementation. However, in line with a grounded theory approach, this 'hunch' was not formulated as a formal theory or hypothesis at the beginning of the research process. However, as Charmaz (2006) notes, researchers are part of the social world they investigate and are influenced by this. Therefore, although not a formal hypothesis, my idea about the existence of a possible 'policy-practice gap' was the starting point for my grounded theory investigations. Although it did not explicitly bias my subsequent data collection, it directly informed one of my four research questions: Is there a policy-practice gap? This question demonstrates the critical social theory paradigm underpinning the research- I did not just wish to find out *if* such a gap existed, but (if indeed it did) *why?*

The preliminary literature search that I had carried out supported my idea of a policy-practice gap. Both Gebbie *et al.* (2000) and Greipp (2002) call for nurses to be more engaged in the policy-making process in a North American context.

My research approach also adopts critical social theory as the foundation of knowledge development. Critical theory includes a very broad range of social

theory constructs from the Marxist and feminist traditions through to postmodern and post-structuralist critiques of society. Kincheloe and McLaren (2000: 281) describe how critical theories have developed from early foundations in Marxist analysis to a range of theories which are concerned 'with issues of power and justice and the ways that the economy, race, class and gender, ideologies, discourses, education, religion and other social institutions, and cultural dynamics interact to construct a social system'.

Iatridis (2008) explores how critical social theory has drawn on the work of many theorists including Marx, Kant, Hegel, Weber, the Frankfurt school, Foucault, Habermas, Derrida, Freire and Giroux. For critical theorists, state welfare represents the dominant discourse of a ruling class with white, middle class interests. I was interested in finding out more about how this state welfare was mediated and implemented by front line public health nurses.

Further illuminating the link between critical theory and grounded theory, Gibson (2007) implies that a critical theory approach aligns itself well with grounded theory because grounded theory itself originated from a critique of the grand traditions of sociological theory. Despite the broad range of approaches which can be termed critical social theories, they are united in their desire to 'link explanation and criticism' (Gibson 2007: 440), and this is something that I sought to do throughout the research process.

Critical social theory has social, political and economic relations as the units of analysis (Gortner 2009). Bohman (1999) contends that critical theories are concerned with the problem of freeing people from things or situations that 'enslave'. He highlights the practical and political consequences of critical theory as opposed to the theoretical. I wanted to find out if public health

nurses were able to really engage with policy-making and implementation, or whether there were structural factors which 'enslaved' them and prevented them from moving forward in their practice in response to a changing policy agenda.

Comstock (1982, cited in Holter and Kim 1995) also explores this idea of barriers and constraints faced by social actors, seeing critical social theory as the lens through which to view these questions. For Comstock, critical social theory research starts from:

...the life problems of definite and particular social agents who may be individuals, groups, or classes that are oppressed by and alienated from social processes they maintain or create, but do not control.

For me, this statement suggests a Marxist perspective. Marx famously espoused a theory concerning the alienation of the workers (proletariat) from the means of production and their oppression by the bourgeoisie. Despite the rise of Post-Marxist schools, Derrida (1993) says that Marx is a 'spectre', and retains an enduring influence on our consciousness. He argues that there is 'no future without Marx'. Many of the public health nurses I interviewed talked about a feeling of alienation from the process of policy making and implementation. For example, one health visitor discussed how she felt that, although public health nurses in her area were consulted about policy, this consultation was not representative. Certain health visitors were asked by managers to sit on a committee looking at devising a new protocol for home visiting, but she felt that it was a 'selective' sample, where health visitors whose case loads in more middle class areas were selected. She felt that their priorities and perspectives may not necessarily have reflected those of the

health visitors working in more deprived areas. In this example, not only did that particular health visitor feel alienated from the process, but one could argue that her clients, who were socially deprived, also had less of a voice than other service users.

Foucault talked about the relative powerlessness of workers within the domain of 'work':

In itself, work possesses a constraining power superior to all forms of physical coercion, in that the regularity of the hours, the requirements of attention, the obligation to produce a result detach the sufferer from a liberty of mind that would be fatal and engage him in a system of responsibilities... (Foucault 1988: 247).

Foucault chose to equate 'worker' with 'sufferer'. Many of the respondents to my questionnaire actually did demonstrate 'liberty of mind' in their comments and responses. They were being creative and engaged in the wider political and policy agenda and were reflecting on their practice despite many barriers and constraints to doing this, not least because of resource limitations and sometimes extremely low morale in the workplace. One of the questions emerging from my study is: How do all public health nurses get the support they need to be creative in the workplace, to actively engage in the policy process and to know that they will be heard?

Holter and Kim (1995: 221) present seven steps of a critical research method as proposed by Comstock (1982, cited in Holter and Kim 1995).

1. Identification of specific social agent(s) who are interested in change of practice and able to participate in research.
2. Development of a hermeneutic understanding of participants' meanings of the situation.
3. Empirical analyses of social structures and processes of the context.
4. Construction of integrated understanding through the dialectics of individual interpretations and meanings within a specific context with its history, structures and processes.
5. Enlightenment of participants of their oppression by identifying the elements of truth in an ideology from the context of falsity.
6. Emancipatory education of participants in which participants themselves develop new understandings and actions.
7. Participation in critical education that is a theoretically grounded program of action for the elimination of further social injustice.

I incorporated elements of Comstock's approach in my methodology. I wanted to engage in an 'active', dynamic project, asking not just how things were for the public health nurses in terms of how they engaged in policy implementation, but why. Part of my approach reflected Step 2 of Comstock's process outlined above. Although my study did not adopt a hermeneutic approach, an understanding of participants' lived experience was used to supplement a critical understanding of their engagement in policy. In that way, I was able to take what participants told me about their lived experience of engaging in the policy process and interpret that through a political or critical social theory lens. A crucial component of grounded theory however is not the reproduction of lived experience, but the interpretation of it:

As we try to look at their world through their eyes, we offer our participants respect and, to our best ability, understanding, although we may not agree with them. We try to understand but do not necessarily adopt or reproduce their views as our own; rather we interpret them. (Charmaz 2006: 19).

Although I had not specifically identified participants who were interested in social change (as recommended in Step 1 above), it was important to have a self selecting sample who were interested in developing their roles as policy makers and implementers. They were also interested in exploring how and why they were constrained by their roles. One could assume that individuals who chose to take part already had some interest in and commitment to the policy agenda as it impacted their professional role.

As discussed earlier, I did encounter some issues regarding access to staff in one particular organisation. On reflection, the fact that one of the managers was particularly resistant to the research taking place in her organisation could have been because she felt that staff were not empowered to be influential in the policy process, for a variety of reasons. One of the key tenets of Comstock's proposed strategy, and one which is firmly embedded in the grounded theory literature (Gibson 2007) is the importance of context. Thus, both the policy context and factors to do with organisational context in each of the five sites was to prove significant. It is difficult to draw general conclusions as each of the sites had its own unique context and structure. However, I did find similar themes emerging across the five organisations: these themes will be discussed later.

The symbolic interactionist theoretical standpoint has been adopted in some studies with a sociological or social psychological perspective. This perspective focuses in on social interactions and how they are affected by the meanings social actors apply to actions and phenomena. Whilst this idea of 'meanings' is of interest to me, it was not a dominant theme within my work.

Whilst I adhere strongly to a critical social theory research philosophy and believe it to be most congruent with my own philosophical standpoint and aims of my research study, it is not without its critics. Gortner (2009), for example, appears unconvinced of the applicability of the philosophy to much nursing research. Gortner implies that in the past it may have been too radical, although she believes that 'in nursing's literature, critical rationality has taken a more moderate form of expression than was the case several years ago'. (Gortner 2009: 280). However, she asserts that she finds that, within the critical social theory perspective, '...the requirement for social and liberating action remains and is one of the key features this author finds troubling, especially for novice scholars'. (Gortner 2009: 280).

I disagree with Gortner's view. As a nurse educator involved in developing and delivering community health courses, I believe strongly in the need to develop a critical social theory perspective in undergraduate students. This is essential if they are to become thinking and autonomous professionals who can later engage, to greater or lesser extent, in the political and policy aspects of their role. This is supported by such writers as Gebbie *et al.* (2000). As discussed earlier in the literature review, the extent of nurses' involvement in policy-making depends on a critical social theory perspective being a part of their experience of undergraduate nurse education. Exposure to sociology, economics and political science during this period, as well as education in a school of nursing or university with an 'activist orientation' was positively

correlated with subsequent involvement in policy-making as a career choice. One could surmise that, even those who did not actually chose policy making as a subsequent career; nonetheless incorporated this greater awareness and political orientation into their work as nurses. This is borne out by the findings of nurse educators who have introduced concepts such as social justice into both theory and clinical components of their courses. For example, Kirkham *et al.*(2005) , in narratives from a qualitative study examining undergraduate nursing student learning in five 'innovative clinical settings' in Canada (corrections, international, parish, rural and aboriginal), found that students in these placements showed enhanced levels of critical awareness of socio-environmental issues and their impact on health; citing instances in their narratives of poverty and marginalization. This awareness lead to dissonance and soul-searching (critical engagement), and a renewed commitment to social change amongst the students. The authors believed that 'these findings suggest the potential for transformative learning in those settings.' (Kirkham *et al.* 2005: 12).Gordon and Nelson (2006) identified civic engagement as a key part of learning in nursing curricula.

Doane and Varcoe (2005), draw on the work of Browne (2000) and Kincheloe and McLaren (2000) to offer a succinct summary of some of the main assumptions and ideas behind a 'critical lens'. Because of the broad and complex nature of critical social theory, I found Doane and Varcoe's bringing together of some of the main facets of the approach in a list form to be extremely helpful as a starting point when planning and conducting my research:

- All knowledge is shaped by socially and historically shaped power relations.

- Facts can never be separated from values or ideology; there is no foundational knowledge that can be known outside of human consciousness, values and history.
- Every form of social order involves some form of domination and power.
- Belief systems treated as 'facts' by those in power act as barriers to conscious action and freedom.
- Mainstream research and practice generally maintains and reproduces systems of race, class and gender oppression.
- Certain groups in any society are privileged over others; oppression is most forcefully reproduced when people who are subordinated accept their social status as natural, necessary or inevitable.
- Language is central to developing knowledge and creating meaning.
- A critical lens can help see through objective appearances and expose underlying social relationships.
- By explaining and critiquing the social order, critical social theory serves as a catalyst for enlightenment, empowerment, emancipation and social transformation.
- Critically oriented knowledge ought to offer cultural or social critiques with a view to transforming the status quo. (Doane and Varcoe 2005: 62).

Drawing on Doane and Varcoe's list above, I could see how a critical social theory lens would enable me to understand and critique the social processes involved in policy making in the five organisations in my study- including public health nurses' involvement in that policy process. So, through the iterative grounded theory process that I had chosen to use, I aimed to gather what Charmaz calls 'rich data' and then analyze and interpret that rich data through a critical social theory perspective informed by Doane and Varcoe's

work. So for example, the questions I went on to ask and answer through my research were, amongst others:

- If public health nurses are not fully engaged in the policy process, is this connected to power issues? (corresponds to bullet points 1 and 4 in Doane and Varcoe's list above).
- What is really going on in terms of the social organisation of the PCT's or social enterprise in my study that helps or hinders engagement? (corresponds to bullet point 8)
- Is there a gender issue here? (corresponds to bullet point 5)
- What can we do to address the issues in my findings? (corresponds to bullet points 9 and 10).

Hunter (2003) believes that policy making and implementation is political. Both power issues and what he calls 'puzzlement and uncertainty' are part of this political dimension of policy. Hunter sees the continued domination of a medical model of public health (as opposed to a social model of health *care*) as an indication of powerful groups such as the NHS and central government setting the agenda, whilst organisations in the wider health debate, such as local government, are not given a voice. In terms of 'puzzlement and uncertainty' one of the issues for Hunter is that there remains a lack of evidence over what policy strategies might prove effective; so the government is tempted to employ a range of different strategies in the hope that at least one will work. For Hunter, one of the reasons why there has not been a real shift from health care to a broader concept of 'health' (which takes into account wider social determinants of health), is because of the difficulty of knowing what new interventions might be effective. I agree with Hunter's perspective because, both preceding the time of my research, during it and subsequently, there has been a deluge of new health policies in England. Some have been iterative, building on previous agendas, but others

have been reversals or U-turns, leading to a climate of ‘puzzlement and uncertainty’ for frontline staff. An example is the shift from GP fund holding, back to a role for PCT’s as the main agencies for commissioning healthcare, and subsequently the responsibility for commissioning devolved to health care professionals (predominantly G.P’s) once again.

In summary, in the research philosophy chapter, I have explored the underpinning philosophy that I have based my work on – that is, a constructivist grounded theory methodology underpinned by a critical social theory paradigm. The critical social theory paradigm was chosen because it reflects my academic and personal perspective and encourages the researcher to go beyond ‘what?’ questions to ‘how?’, ‘why?’ and ‘what can be done about it?’ Furthermore, there has been found to be a ‘good fit’ between the philosophy of critical social theory and the grounded theory approach (Polit and Beck 2010). Having discussed the underpinning philosophy for my work, I will now go on to outline the methodology used.

Chapter 4

Methodology

The overall aim of the research was to use a policy analysis approach to explore the reciprocal impact of health policy on public health nursing and public health nursing on policy. This was operationalised through asking four research questions:

- What do they know about the policies?
- How do they engage in the policy process?
- What affects their implementation of policy?
- Is there a policy-practice gap?

In order to address these questions, the conceptual framework for the study was critical social theory and social policy discourse around the theoretical analysis of policy-making, implementation and evaluation. By evaluating the impact of two specific White Papers on the provision of public health nursing services in England, I drew on this theory and ultimately generated new theory around the reciprocal relationship between policy and public health nursing in England. As discussed in the literature review above, the investigation of this relationship in the context of England is a new area of research activity. Another unique aspect of my study is that one of the five organisations I investigated was a social enterprise, as opposed to a PCT. This provided an opportunity to see whether an organisation based on more of a

private enterprise model would be unique in terms the reciprocal relationship between public health nurses and policy in its organisational culture when compared to the PCT's in my study.

The studies which have been carried out on the relationship of nurses to policy have mainly been in North America (Gebbie *et al.* 2000; Greipp 2002). The focus in such studies has been largely on how nurses can become more active in policy-making. In the past, policy-makers and public health managers and practitioners have often worked in two separate spheres. During the course of my research, I was interested in finding out about how these two policies affect practice in a direct way. I also wanted to understand more about the interface between policy and public health nurses in England: how much are they actively involved in policy making and implementation? Should they be more involved? What are the factors that help or hinder this process?

In terms of a policy-practice gap, there can be a divergence from the original stated policy which occurs during the implementation process. Final outcomes in practice terms may be very different from those intended by the policy makers. However, it should be noted that divergence from a stated policy may not necessarily indicate a policy-practice gap, but rather could be 'understood in other ways as policy development, policy growth or simply as implementation in the real world'. (Parker 2012, personal communication). It may be therefore that divergence from an original policy's intentions is not necessarily a negative or undesirable result. With this in mind, in order to explore the phenomenon of a possible policy-practice gap in relation to my data, I drew on a number of theoretical models of policy implementation and evaluation.

In line with critical social theory, I approached the study in the light of the different paradigms of political knowledge and social knowledge and the different domains of policy-makers and managers on one hand and practicing public health nurses on the other. The literature has some interesting observations to make here. For example, as mentioned earlier in the literature review, Hewison (1999) sees nursing, as a distinct area of study in the field of health policy, as being an 'emerging area of analysis'. However, the research area is not unproblematic, in that it can result in a 'culture clash'. Hewison (1999) cites the example of the introduction of the New Public Management ethos in the 1980's and 1990's as clashing with nursing discourse around issues such as 'caring'. Antrobus asks whether health policy can 'attempt to impose a mechanistic, scientific and masculine culture on a service oriented to health and care'. (Antrobus 1997a: 447). These were all considerations as I set about trying to carry out my research in what is a complex and largely under-researched area.

Using a grounded theory approach, my research examined and analysed data collected from four distinct sources. Primary data came from an initial on-line questionnaire which was then followed by detailed telephone interviews with a proportion of the initial survey sample. This primary data were supplemented by detailed policy analyses which provided a rich source of information both about the policies themselves and about the interface between policy and public health nurses. Finally, extant documents served to complete the picture in terms of exploring the reciprocal impact of health policy on public health nursing and public health nursing on policy. In using several data sources to enable me to have a complete a picture as possible, and to verify my findings, I took a triangulation approach. In triangulation, 'more than one method or source of data is used in the study of social phenomena'. (Bryman, 2004: 275)Using triangulation enabled me to reach

the point of 'data saturation' which Charmaz (2006) argues is an important feature of grounded theory work.

As well as the importance of triangulation discussed above, the four distinct phases of data collection also allowed me to build on successive data collection phases using an iterative approach. The analysis of the initial scoping questionnaires informed the interview framework. The iterative process then continued by an in-depth review of data from the interviews and the policy analyses which led to more questions around the reciprocal relationship between public health nursing and policy. These questions in turn were addressed by seeking out and analysing particular extant documents. Each phase of data collection built on the previous phase.

A major part of my study consisted of a detailed policy analysis of two White Papers: *Creating a Patient-Led NHS* (Department of Health 2005) and *Our Health, Our Care, Our Say* (Department of Health 2006). Two frameworks or models were used to guide this process of policy analysis. The first was Popple and Leighninger's Policy Analysis Framework (2008) and the second Walt and Gilson's Model for Health Policy Analysis (1994). Popple and Leighninger's framework helped me to structure a detailed analysis of both the content and the social and political context of the policy documents. This framework aligned well with my critical social theory approach as it encourages the analyst to think critically about the policies they are reviewing and to take nothing for granted. An example is the question posed in the Social Analysis section of the framework: 'What are the major social values related to the problem and what value conflicts exist?'

Use of an integrative approach combining Popple and Leighninger and Walt and Gilson's models allowed me to undertake detailed and holistic policy analyses as part of the data collection process. The two models are discussed further in Chapter 6 (Findings from Policy Analyses). The policy analyses were enhanced by the collection of both primary and secondary data concerning the interface between nursing and policy. The primary data were generated from an online questionnaire and follow up telephone interviews conducted with study participants. The secondary data came from a variety of 'extant texts' (Charmaz 2006): these texts included national newspapers, websites and Primary Care Trust (PCT) publications.

So, to summarise, the research examined data collected from four distinct sources. Primary data came from an initial on-line questionnaire which was then followed by detailed telephone interviews with a selection of the initial survey sample. Data from the detailed policy analyses proved a rich source of information both about the policies themselves and about the interface between policy and public health nurses. Finally, extant documents served to complete the picture in terms of exploring the reciprocal impact of health policy on public health nursing and public health nursing on policy. In using several data sources to enable me to have a complete a picture as possible, and to verify my findings, I took a triangulation approach (Bryman 2004).

Rationale For Choice of Methodology

The research methodology was a grounded theory inspired approach. Eminent classical grounded theorists Strauss and Corbin saw grounded theory as:

Theory that was derived from data, systematically gathered and analyzed through the research process. In this method, data collection, analysis, and eventual theory stand in close relationship to one another. (Strauss and Corbin 1998: 12).

Grounded theory is concerned with the development of theory from data. The approach in grounded theory is iterative, where data collection and analysis proceed alongside each other, repeatedly referring back and forth. (Bryman 2004). Theories are then allowed to arise out of the data, rather than in the traditional scientific method, where one starts with theories (hypotheses), and then goes on to test these by analysing data (deductive method). Because of the continual referring back and forth between data and theory which occurs during the G.T. process it can also be seen as a process of induction-deduction-verification (IDV) (Rees and Dickson 2009, personal communication). This is also supported by Bryman , who describes the two central features of grounded theory as being concerned firstly with the development of theory out of data and secondly that this process is iterative or recursive. (Bryman 2004: 401).

Data analysis is a complex process, but is broadly about searching for explanation and understanding. As discussed above, theory emerges, and continues to emerge, inductively out of the process of analysis. One method which helped me to structure the final findings out of the data during this complex process was to break down the process into four steps: concepts, theories, explanations and understanding. (Blaxter, Hughes and Tight 2001).

Although some quantitative data was generated during the course of the research (for example, the number of public health nurses who were familiar with a particular policy), the majority was qualitative in nature. The initial data which arose from the on-line questionnaire informed the schedule for the subsequent telephone interviews (see Appendix 3). During the process of undertaking the telephone interviews, there was constant comparative analysis, and responses to my questions led me to further modify questions and areas for discussion with subsequent interviewees. Influenced by Charmaz's (2006) approach, I chose to adopt a more flexible and less prescriptive approach to grounded theory than that originally proposed by the pioneers of this method, Glaser and Strauss. Charmaz contends that she, along with a growing number of scholars, have in recent years '...moved grounded theory away from the positivism in both Glaser's and Strauss and Corbin's versions of the method.' (Charmaz 2006: 9). She proposes a way of doing grounded theory which builds on the work of the early grounded theorists, but also takes into account theoretical and methodological developments of the past 40 years. Charmaz's text (2006) provides a clear overview of her approach, with worked examples. However, it is not rigid or prescriptive. She sums up her approach succinctly:

I view grounded theory as a set of principles and practices,
not as prescriptions or packages. (Charmaz 2006: 9).

Classical grounded theorists advised against the researcher carrying out an initial literature review, believing this could be a potential source of bias and militated against a truly inductive approach. However, after Glaser and Strauss went along different theoretical paths, Strauss' writing with Corbin (Strauss and Corbin 1998) was not so emphatic about the need to delay the literature review. The more recent grounded theorists (including Charmaz)

suggest that a literature review can be undertaken in the early stages, but that the researcher should take a critical view of that literature from the outset. As Charmaz (2006) argues, one should treat existing concepts and theories as potentially 'problematic', whilst at the same time realising the value of acknowledging other scholars' work. According to Charmaz (2006), Henwood and Pidgeon's (2003: 138) term 'theoretical agnosticism' can usefully be employed in the grounded theory research process.

Charmaz believes that, although a detailed initial literature review may not be carried out, the research process is informed from the outset by 'sensitizing concepts' and general disciplinary perspectives. The fact that there was limited published literature in my area of interest as I discussed earlier, is not a barrier in a grounded theory approach.

Charmaz' approach to grounded theory involves formulating a research problem and proposing opening research questions, followed by initial coding of preliminary data (corresponds to my Phase 1 scoping questionnaire data). Following this is a process of devising initial memos; raising codes to 'tentative categories'. Following this is another phase of data collection and focused coding (corresponds to the Phase 2 telephone interviews). This data lead to advanced memos which refine conceptual categories and may lead to theoretical sampling which seeks to collect specific new data (in my research, this involved seeking out further data from the policy analyses and extant documents). From these distinct phases of data collection and analysis through coding and memo writing, certain categories are adopted as theoretical concepts. Throughout the process, as guided by Charmaz (2000: 2006), I continually returned to and re-evaluated my data. Theory formation was on-going and continued throughout the research process.

The sampling method for participants in the initial scoping questionnaire was essentially a convenience sample. I was advised by the ethics committee to ask public health managers to pass on the initial scoping questionnaires to their staff, rather than emailing individual staff members myself directly. I hoped to elicit responses from ten public health nurses in each of the five organisations I approached. In the end, I did not receive this level of response, so had to use the questionnaires I could get (convenience sample). The final question that I asked on the questionnaire was 'Would you be willing to take part in a telephone interview during phase 2 of this research project?' Eight individuals said that they would be.

. Grounded theory, including Charmaz' perspective on grounded theory, emphasises a theoretical sampling approach, where 'initial sampling in grounded theory is where you start, whereas theoretical sampling directs you where to go.' (Charmaz 2006: 100).

Charmaz is not prescriptive in her idea of how theoretical sampling should occur:

'What you look for through theoretical sampling and *how* you conduct it depends on your purposes in doing it. Consistent with the logic of grounded theory, theoretical sampling is emergent. Your developing ideas shape what you do and the questions you pose while theoretical sampling.' (Charmaz 2006: 108)

The emergent or theoretical sampling process for me emerged throughout the four phases of data analysis (scoping questionnaire, telephone interviews, policy analyses and extant documents). In the original sampling

questionnaire, I asked all respondents if they would be willing to take part in the subsequent telephone interviews. The eight who said they would be included many who had given the fullest answers in the questionnaire responses. It seemed that they had a particular interest in the topic area and had more to say, so volunteering for the telephone interviews. In the telephone interviews, I used an iterative approach to follow up on themes which had previously emerged in the questionnaires. I was able to match initial questionnaires with the respondents in the telephone interviews: this enabled me to address particular ideas further in the telephone interviews with individual respondents in the telephone interviews depending on their questionnaire responses. The semi-structured nature of the telephone interview framework allowed for this flexibility.

This theoretical sampling approach continued into the policy analysis phase, where I sought to understand more about content of the two policies, their context and also more understanding of the public health nurses as actors in the policy process. Finally, I sought out extant documents to help explain how this engagement manifested itself. As well as an attempt to build knowledge iteratively throughout the process in line with a grounded theory approach, I also used theoretical sampling to seek out data that was 'contradictory or disconfirming from the initial data being collected' (Rosser 2013, personal communication). For example, where the respondents in the telephone interviews mostly said that they were disengaged from the policy process (for various reasons), I sought out extant documents (professional journals, e-petitions) which were evidence of public health nurses being actively engaged in policy.

In terms of theoretical sampling techniques, Charmaz' approach does not differ from other grounded theorists, including the traditional grounded

theorists such as Glaser and Strauss, and more recent grounded theorists such as Mays and Pope (2000):

Mays and Pope (2000) suggest that the researcher searches for contradictory or disconfirming sources of data or identifies exceptions to the patterns being described, in order to test out the findings from the study. These data sources can either be purposively identified at the start of the study and built into the sampling framework (purposive sampling) or identified during the course of the study in response to the analysis of the data (theoretical sampling). (Gerrish and Lacey 2010: 149).

Grounded theory research is a complex process. Glaser (2002) believes that many researchers lack the competence in conceptualization necessary to develop theory from data. For him, the way to truly understand and get to grips with classic grounded theory required an in-depth study of the theory of the method, together with direct experience of using it. I followed Glaser's advice on this, reading widely around the methodology of grounded theory and then taking the work of Charmaz as a 'blueprint' or map to help me whilst I embarked on an uncertain journey as a novice grounded theory researcher. Having experienced this process, I agree with Glaser's assertion that grounded theory takes time and is a 'delayed action phenomenon'. (Glaser 1998: 50). One needs to keep going and have faith that the inductive process will come good.

I found the words of Holton (2007) very helpful in keeping me going through periods of doubt about whether theory would in fact emerge in an inductive fashion:

Thus, the researcher must pace herself, exercising patience and accepting nothing until this inevitable emergence [of theory from the data] has transpired. Surviving the apparent confusion is important, requiring the researcher to take whatever time is necessary for the discovery process and to take this time in a manner consistent with her own temporal nature as a researcher.....Rushing or forcing the process shuts down creativity and conceptual ability, exhausting energy and leaving the theory thin and incomplete. (Holton 2007: 286).

Crucially, Glaser (2002) contends that it is not the aim of grounded theory to invent concepts, but rather to discover them in the data. He saw concepts as relating to 'latent patterns': these patterns discovered through the process of 'constant comparative method'. Charmaz (2000) concurs, but she also emphasizes the active role of the researcher in the discovery of these patterns:

The grounded theorist's analysis tells a story about people, social processes and situations. The researcher composes the story; it does not simply unfold before the eyes of an objective viewer. The story reflects the viewer as well as the viewed. (Charmaz 2000: 522).

This is interesting because it refutes the emphasis put by some methodologies on the need for the researcher to be 'objective'. When I started to review the

data and find patterns and themes within the stories, I found that my interpretations did indeed reflect me as 'viewer', as well as the research participants as 'viewed'. Bound up with my interpretations was my own experience both as a public health nurse and as an academic interested in policy making and implementation. In this respect, grounded theory acknowledges the perspective of the researcher and the way in which their perspective can potentially affect the interpretation of data. As long as this is acknowledged, 'researcher bias' need not necessarily be problematic in a grounded theory approach.

Through this grounded theory methodology and the use of semi structured questionnaires and telephone interviews, I aimed to learn more about issues around policy making and implementation from the perspective of the participants. I was interested in their experiences as actors in the policy process. This knowledge was then linked to the policy analyses in order to gain new understandings of both *how* and *why* policies were or were not interpreted and implemented in certain ways. I believe that this led to an enhanced policy analysis, one which included a focus on both content and process. As Walt and Gilson (1994: 353) note, 'focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge'.

Method

The overall aim of my research was to explore the reciprocal impact of health policy on public health nursing and public health nursing on policy. In order to do this, I posed the following four research questions:

1. What do they know about the policies?
2. How do they engage in the policy process?
3. What affects their implementation of policy?
4. Is there a policy-practice gap?

To answer these research questions, three distinct types of data were collected. The first was primary data (collected through on-line questionnaires and follow up telephone interviews), the second was data and findings which were derived from detailed policy analyses using two frameworks, and the third source was data gleaned from extant documents, including mass media, organisational documents and internet discussions.

Before primary data collection could begin, some preparatory work was undertaken. I contacted some key people in public health nursing policy, education and practice in order to determine the kind of developments that were taking place in public health nursing in response to CAPLNHS (Department of Health 2005) and OHOCOS (Department of Health 2006a). These key players included a public health nurse involved in policy at the Department of Health, academics working in the area of public health nursing and policy and managers (for example a Trust Safeguarding lead). From these individuals I got an initial idea of developments in this area, as well as contacts in various PCTs in England. I then drew up a data base of organisations and individuals working in a proactive manner in terms of some of the themes identified in the White Paper: new service models, emphasis on health promotion and supporting people with long-term health problems. Several of these organisations were initially approached and, from these, five research sites (4 PCTs and 1 social enterprise) were selected.

This approach used non-probability, purposive sampling methods (Miles and Huberman 1994) and attempted to pre-select areas of interest for further investigation, where ‘... the researcher already knows and selects particular ones [cases] because they are seen as instances that are likely to provide the most valuable data’. (Denscombe 2003: 15).

The inclusion of the social enterprise organisation was suggested by one of my research supervisors, and I agreed it would be illuminating to make a comparison between this organisation and the PCTs. As an exploratory study, which attempts to find the links between policy and practice, I wanted to highlight areas of particular interest and/or innovation, rather than provide a representative sample of public health nursing nationally. With a small sample size for the initial on-line questionnaire, I do not claim to be representative even of what is occurring in the particular PCTs under consideration in the study. Rather, from the initial questionnaire data, I drew out broad themes (and codes through a grounded theory approach) which were then used to inform the questions for the detailed individual telephone interviews. These interviews were planned to be conducted with respondents who, in Phase 1 of the data collection process, self-identified as being willing to be interviewed in Phase 2.

The first stage of the research process involved the identification of, and negotiation of access to, five research sites. These were chosen to reflect a range of urban and rural locations across diverse geographical locations in England, as well as being potential examples of innovative practice. The organisations comprised a PCT in the north east of England (urban population), a PCT in the north of England (mixed urban and rural population), a PCT in the south west of England (large town), a PCT in the Midlands (mixed urban and rural) and a social enterprise in the south east of England (mixed

urban and rural). The social enterprise was established in 2006 by two former Primary Care Trust directors. Six hundred and fifty nurses and therapists took a one pound not-for-profit share in the business, formally left direct NHS employment and sold back their skills as district nurses, health visitors, school nurses and therapists in a mutually owned social enterprise. The organisation received an initial three-year rolling contract worth 20 million pounds a year from their local primary care trust. Staff remained part of the NHS pension scheme and on the same terms and conditions as before. As part of their promotion of a mixed economy of care, the current Conservative- Liberal Democrat alliance government are supporting the establishment of further social enterprises. Recent government policy encourages a retention of a market model, through GPs once again becoming budget holders and purchasing services (as seen in GP fundholding in the early 1990's) and also through the encouragement of hospitals and acute services to move outside of the NHS and to become 'vibrant social enterprises' (DOH 2010).

Having identified suitable organisations to include, I then undertook the process of seeking overall ethical approval for my study through the South West Research Ethics Service, and local Research and Development approval to carry out my study in the five organisations.

Following a number of revisions, primarily related to documentation (more detail was needed in letters to participants) the study was given a favourable ethical opinion by the National Research Ethics Service on 23 August 2007. A key change I had to make to my research design as a result of advice from the National Research Ethics Service was that I was told that I could not approach managers to ask for their staff email addresses in order to email staff my questionnaire directly. For ethical reasons, it was advised that I go through the managers in each of the five organisations, asking them to forward the

questionnaires on to health visitors and school nurses in their teams. The ethics committee were very clear that I should not approach the nurses myself directly for reasons of confidentiality and protection of their personal information, including work email addresses that would not normally be in the public domain. In some ways, going through managers in this way was logistically simpler for me, but there were some problems connected with this approach.

Having the email originating from their manager would have given the survey greater legitimacy in the eyes of the participants; however, they may also have been concerned about confidentiality issues in terms of wondering about security of their responses- would the raw data be accessible to managers and others within their organisation as opposed to just the researcher? In addition, I encountered some barriers relating to the managers' gatekeeping role. As identified by Van Maanen and Kolb (1985: 11), 'Gaining access to most organisations is not a matter to be taken lightly but one that involves some combination of strategic planning, hard work and dumb luck'. Some of the managers were reluctant at first for me to proceed with the questionnaire within their organisation. In two cases, local Research and Development permission had been given, but managers were unsure about whether they wished to distribute the questionnaire to their staff.

In these cases, it took a lot of negotiation and clarification on my part. Understandably, some gatekeepers were concerned about letting an outsider come in and ask questions about policy and practice in their organisation. If it was perceived that I was in an 'auditing' or 'inspection' type role, this could be threatening. Following negotiations and clarifications of the purpose of the research, in the end the gatekeepers in all five organisations agreed to distribute the questionnaire to their staff.

Initially, the questionnaire responses trickled in slowly. I could not approach staff directly to ask them to fill in the questionnaires, so I had to go back to gatekeepers to 'chase up' responses, sometimes several times. I did not find this an easy process, but I was dependant on the gatekeepers and their goodwill in pushing my project forward (alongside a lot more pressing 'to do' items on their lists no doubt). Another strategy I used in the chasing up process was a 'snowballing' approach, where I contacted individuals who had answered the questionnaire and asked them to encourage colleagues to do so. This may possibly have helped where people were experiencing technical problems with accessing the questionnaire and so on. In all, this probably generated about another five or six responses.

Before being sent out to the five organisations, the electronic questionnaire was piloted. It was distributed to a small group of health visitors and school nurses who were accessed through a contact I have in public health nursing education. From the data received, I ascertained that the questions were understandable and clear to respondents. I received what I perceived to be an appropriate amount of data in response to the open ended questions. Therefore, following the piloting stage I did not make any amendments to the questionnaire.

Initially, as advised by the National Research Ethics Service, I sent an email to the gatekeepers (key contacts) in each of the organisations with an attached letter outlining the nature and purpose of my study. I asked them to forward a letter about my research (see Appendix 1) which included a link to the electronic questionnaire to staff within their organisation. The questionnaire

was to be distributed to health visitors and school nurses, both practitioners and managers.

Data were then returned to me directly from the respondents via an on-line questionnaire site (www.getfast.ca). This questionnaire was carefully designed to address the research questions and was structured around the three themes from the White Papers that I had decided to focus on (new service models, health promotion and support of people with long-term health problems). The questionnaire included a mixture of open and closed questions (see Appendix 2) and generated mainly qualitative data. Although questionnaires are sometimes more commonly associated with the collection of quantitative data, as Denscombe (2003) argues, they are also suitable for small-scale, qualitative research. Questions were devised to elicit a detailed overview of public health nurses' understanding of practice in relation to the White Papers. There was an emphasis at this stage on breadth of data, with the intention of more in-depth data being collected via the telephone interviews. The telephone interview questions were then generated from the responses to the questionnaire data (grounded theory approach). In this way, there was 'a broad initial approach (followed) by a more focused explanation of the issue once the baseline findings had established the most credible sources of information' (Bergen 2005: 4).

As Walt (1994) states, research studies on policy-making in the area of public health 'are often not open to experimental or even quasi-experimental methods' (Walt 1994: 234). My research approach was largely qualitative and non-experimental in design, but, by adopting a flexible approach, I was able to generate data which provided a descriptive overview of current public health nursing practice in relation to specific policies, followed by a more in-depth analysis of information garnered through the semi-structured

interviews. The approach was congruent with a qualitative research philosophy, where events and the social world are viewed through the eyes of research participants. Throughout the research, I adopted an interpretivist, as opposed to a positivist, approach. Interpretivism is an epistemological position in which the researcher is required to interpret the subjective meaning of social action (Bryman 2004).

My emphasis was on an inductive analysis of the relationship between theory and research, with the generation of new theory throughout the research process. Analysis of the data using grounded theory attempted to highlight, among other things, the range of issues which affect policy -making and implementation 'in the real world'.

At the level of the organizational interface, McCormack *et al.* (1999) highlight the importance of evaluation of organizational systems. As an 'outsider' in the organisations included in my study, it was difficult for me to get a detailed picture of the organisational systems and how they impacted on practice development. Some questions were framed to help me develop this vital understanding of organisational context. For example, in the questionnaire, I asked respondents if, in the previous two years, there had been any changes in the way in which their service was managed or delivered. Themes which then emerged deductively through their answers were then followed up in the telephone interviews.

Following McCormack *et al.*'s (1999) theory, one could argue that in order to gain a real understanding of the organizational issues which these authors deem to be essential, one would have to adopt an alternative methodology such as an ethnographic or action research approach, where the researcher

spends a protracted amount of time within the organisation. However, with the number of organisations I focused on in the project, as well as my geographical distance from the UK, this was not feasible.

When formulating my methodology, I was influenced by other researchers, not all of whom were from a classic 'grounded theory' background. Walt's (1994) assertion that an experimental or quasi-experimental approach may not be the best way to research policy helped me to feel confident in pursuing a more qualitative approach. McCormack (1999) led me to question whether, by not actually being present in the organisations, I would be able to gain enough understanding of context and organisational issues. By including questions related to organisational/ managerial issues in both the questionnaire and telephone issues, I kept the concept of context central. In the policy analysis phase, using Popple and Leighninger's framework also encouraged me to look at context in terms of the actual policy content.

The grounded theory approach informed the data collection process throughout. Data collection and review was an iterative process: firstly, the analysis of the initial scoping questionnaires informed the interview framework. The iterative process then continued with an in-depth review of data from the interviews and the policy analyses which led to more questions around the reciprocal relationship between public health nursing and policy. These questions in turn were addressed by seeking out and analysing particular extant documents. Each phase of data collection built on the previous phase.

Part 1 of the data collection process was primary data collection. This took place in two phases:

Phase 1: A scoping questionnaire was sent in an electronic format to public health nurses (specifically health visitors and school nurses) and team leaders/managers in five organizations. This questionnaire addressed current and emerging practice in public health nursing in relation to three themes identified in CAPLNHS (Department of Health 2005) (new service models, health promotion and support for people with long-term health problems) as well as key policies in the OHOCOS (Department of Health 2006 a or b) paper. During this phase, the emphasis was on obtaining a broad overview of key themes which were then investigated in more depth in Phase 2 of the data collection.

Phase 2: Follow-up one-to-one semi-structured telephone interviews were conducted with research participants who self-identified in Phase 1 that they were willing to be interviewed. The aim of these interviews was to generate more in-depth data on issues identified in Phase 1 (following coding and memo writing of Phase 1 data). The approach taken here was qualitative and inductive, attempting to elicit data which reflected actual practice development related to policy, as well as the associated opportunities and constraints. The focus was on the experience of participants in policy making and implementation. I wanted to elicit data which illuminated the policy implementation process (both its strengths and limitations) and impact on practice through respondents' eyes. I tried to ensure that the participants were given an opportunity for their own voices to come across in the data. One way in which I did this was to include many open-ended questions, with room for respondents to elaborate in their own words, in the initial questionnaire. From this original scoping exercise, I got an overview of how the two particular White Papers were being played out in practice. More importantly for my emerging research focus, however, I was also receiving

rich and in-depth data pertaining to the respondents' own perceptions of policy issues. For example:

Centralisation of admin has lead to staff in outlying parts of the county feeling forgotten, and that large parts of the organisation are ignorant of the who, where, what and how of people they make important decisions about. Following policies, and implementing new initiatives often appears to be about ticking boxes, and giving a good impression rather than really moving on with the intentions. (HV)

I further encouraged respondents to explore their perspectives on the policy-practice interface during the telephone interviews. I did this by attempting to put them at their ease from the outset. For example, at the beginning of the interview I explained the purpose of the interviews (to follow up on some key points raised in the on-line questionnaires) and I thanked them for agreeing to take part. Consistent with my research philosophy, I viewed the participant as a knowledgeable expert. I tried to be non-judgemental in my responses and to let the interview develop as a 'natural conversation' (as far as possible around certain pre-determined codes I had identified in analysing Phase 1 data).

Using a grounded theory approach, in the telephone interviews I followed up on themes and codes I had previously identified from the questionnaires. For example, an interesting code from the questionnaires was that of 'ticking boxes around policy' / 'superficial influence on practice' (see verbatim quote above). Here is an example of an excerpt from the transcript of one interview which illustrates how I followed up the theme of 'ticking boxes' in order to

find more. The excerpt also illustrates my interviewing style, which I hope encouraged participants to be open and to discuss their own experiences in the policy domain. It should be noted that all names have been changed and pseudonyms used throughout.

JG: Do you think policy affects practice in meaningful ways, or is it just about ticking boxes?

Suzanne: Do you mean government policy or PCT policy?

JG: I was thinking more government policy.

Suzanne: Yes. Do I really think they make a difference or is it just a tick box thing?

JG: Yes.

Suzanne: Umm, it would depend on what we were looking at because my mind is taken to a significant child protection incident in Haringey recently where, in the analysis, they were talking about the fact that the government want children to stay with their families and so they don't remove them as quickly. And so in a way that might affect care on the ground and I perhaps see a bit of that in practice as well, but it seems to be a lack of resources that seems to affect what we're doing, and so I would imagine that ultimately that's a government issue.....

JG: Yes, Thank you for that because the lack of resource thing is something I'm hearing from lots of people. Has that been a particular problem in [name of PCT], Suzanne?

Suzanne: Yes, it has. I can give you an example if that helps?

JG: Yes please.....

Following Charmaz' method (2006), a constructivist approach was taken to analyze the data within a grounded theory framework. I followed Charmaz' advice of writing memos from the wide ranging and detailed responses that I obtained from the original scoping questionnaire (see Appendix 2 for questions). Charmaz defines memo-writing as the 'pivotal intermediate step between data collection and writing drafts of papers...memo- writing constitutes a crucial method in grounded theory because it prompts you to analyze your data and codes early in the process.' (p.72). As Charmaz suggests, I wrote these memos at '...a range of levels of abstraction- from the concrete to the highly theoretical' (p.84).

Charmaz explains how the memo writing process is complex and protracted and has parallels with Glaser and Strauss' 'constant comparative analysis'. My memo writing became increasingly detailed as I started with some broad categories and then became more analytical, comparing emerging themes from memos to existing themes. Like constant comparative analysis, this method was an ongoing and iterative process throughout the entire research process and through all the forms of data collection and analysis (scoping questionnaire, telephone interviews, policy analyses and examination of extant documents). The theoretical component (i.e. building the theories which are an inherent and expected component of a grounded theory approach) was an integral part of this process. As Charmaz (2012) notes, the theory is not an 'add-on' which emerges at the end of the process, but rather an integral part of the whole research process:

As you develop categories, write further memos to detail comparisons between them. These memos help you to tease out distinctions that sharpen your treatment of the material. Such memos also aid you to weigh and locate your categories in relation to each other. Through

memo writing, you distinguish between major and minor categories and delineate how they are related. Thus, you begin to frame them into a theoretical statement. You direct the shape and form of your emergent analysis through your memos. (p.85).

The principles of Charmaz' constructivist grounded theory approach helped me to structure and digest my data and to scaffold emerging themes with emerging theory. In my research diary, I noted how this process had been helpful to me:

'...I think I delayed the analysis phase because I wasn't sure how to do it under a grounded theory approach. But I have this week got into the data using Charmaz' approach- codes followed by memos. I have actually found writing the memos easier than I thought and, once I have done these, it is easier to write up from this.'

Charmaz (2006) clarifies the process when she describes how the grounded theorist develops codes and then goes on to write memos from these codes. She says that memo writing is a process that continues throughout the research process, symbiotically with coding. For Charmaz, the researcher continues to work with the data and, through coding and memo-writing, '...become[s] progressively more analytic in how you treat them and thus how you raise certain codes to conceptual categories'.

I followed Charmaz' guidelines and found that the memo writing process helped me to work through the data systematically, yet organically. This is why Charmaz' method had appealed to me more than the more prescriptive

classical grounded theory of Glaser and Strauss for example. Coding the responses to the scoping questionnaire followed by memo writing enabled me to draw out the main themes and ideas for more in-depth consideration in the telephone interviews. In Appendix 4 is an example of how I interpreted verbatim raw data using Charmaz' constructivist grounded theory approach, through developing codes and memo writing.

All the major themes were brought forward into the next stage of data collection, using an iterative, grounded theory approach. It was interesting to see that there was a high degree of consistency amongst respondents. Although they explained it in different language, most of them alluded to the following questions:

- More centralized management- does this mean less opportunity for practitioners and line managers to make decisions. More detail/examples around this point.
- Do policies really affect practice in meaningful ways, or is it about 'ticking boxes'?
- Is there an issues re: staff cuts/shortages within your organisation? If so, how is this impacting on service delivery?
- To what extent are you engaging in multi-agency/ inter-professional working- e.g. using the Common Assessment Framework?
- Health promotion as collaborative process- examples.
- If you could name one government policy which has the greatest impact on your practice, what would it be? Why?
- More details on factors which enable/prevent them from changing practice or service delivery in relation to government policies.

- Do you think public health nurses could/should be more involved in policy development, implementation and evaluation? If so, in what ways?
- If you could name 1 or 2 priorities for health visiting/school nursing over the next 5 years, what would they be?
- Any other comments

I was able to take forward all of the main themes mentioned by the respondents in the scoping questionnaire and ask the telephone interviewees to tell me more about them. I also asked some supplementary questions in the telephone interviews which were not generated by the scoping questionnaire, but nonetheless were of interest to me in finding out more about the policy context. From the above list, all the questions/codes were from data emerging from the scoping questionnaire except:

- If you could name one government policy which has the greatest impact on your practice, what would it be? Why? And

If you could name 1 or 2 priorities for health visiting/school nursing over the next 5 years, what would they be?

Following the telephone interviews, coding and memo writing took place and revealed the codes discussed below.. This process followed Charmaz' (2006) system where the coding process, when done well, is a means of going beyond the surface to really try to understand issues and processes as they are experienced by participants. However, as Charmaz (2006) points out, there is a skill to eliciting these perspectives and then drawing them out of the data:

As we define our codes and perhaps later refine them, we try to understand participants' views and actions from their perspectives. These perspectives usually assume much more than what is immediately apparent. We must dig into our data to interpret participants' tacit meanings. Close attention to coding helps us to do that. (Charmaz, 2006: 47).

As seen in Appendix 4, the verbatim data from the telephone interviews were read and coded. This coding was followed by a process of memo writing and, from this memo writing, eight key concepts were devised. Each of these concepts was grounded in the codes and memos. The eight concepts which arose from the telephone interviews are discussed on the following page.

Appendix 4 shows how the verbatim telephone interview data were analysed using Charmaz' grounded theory through coding and memo writing to concepts. Theory was later inductively derived from these concepts, as well as those from other data sources, including other primary data sources (scoping questionnaires), policy analyses and the extant document analysis:

1. Code: Lack of Resources

Memo: A government issue because of cuts to service, but its impact is felt on the ground. Many problems arise from this theme of lack of resources- HV's having to fight for limited resources, returning to a core service (safeguarding), also personal cost – exhausted, demoralised. Identify needs, but unable to follow up. Inhibiting policy development by necessitating a

return to a core service, inhibiting development of practice in response to policy.

Concepts: Lack of resources are inhibiting policy implementation
Lack of resources is a government issue

2. Code: Importance of being heard in the policy agenda

Memo: Those working at the 'coal face' understand 'how it is' for clients. This understanding could be helpful in policy making and implementation.

Appreciates the times where their voices are heard (e.g. by senior management), but these are few and far between. Supports idea of HV's being seconded to government policy making departments and having a voice at the table. Believes PHN's have the skills and capacity to do this.

Concepts: Public health nurses experience a lack of input and control in the policy process.

Public health nurses see a role for themselves in policy and want to be more involved.

This process was repeated with the verbatim transcripts from the other seven telephone interviews and the following eight concepts were arrived at:

- policies are having some impact on practice
- public health nurses see a role for themselves in policy and want to be more involved
- lack of resources are inhibiting policy implementation
- lack of resources are a government issue
- public health nurses want more of 'a say' in policy
- public health nurses experience a lack of input and control in the policy process
- policy overload is a problem, and

- certain policies are identified by practitioners as having the greatest impact on their practice.

These eight concepts are further explored in the Findings chapter.

Data collection and analysis was an iterative process, and themes and concepts emerged from all the different data sources. The figure below shows how one concept (lack of resources) was explored in successive phases of data collection -on-line scoping questionnaire, follow up telephone interviews and extant document analysis. Appendix 4 shows how codes and memos were elicited from raw data.

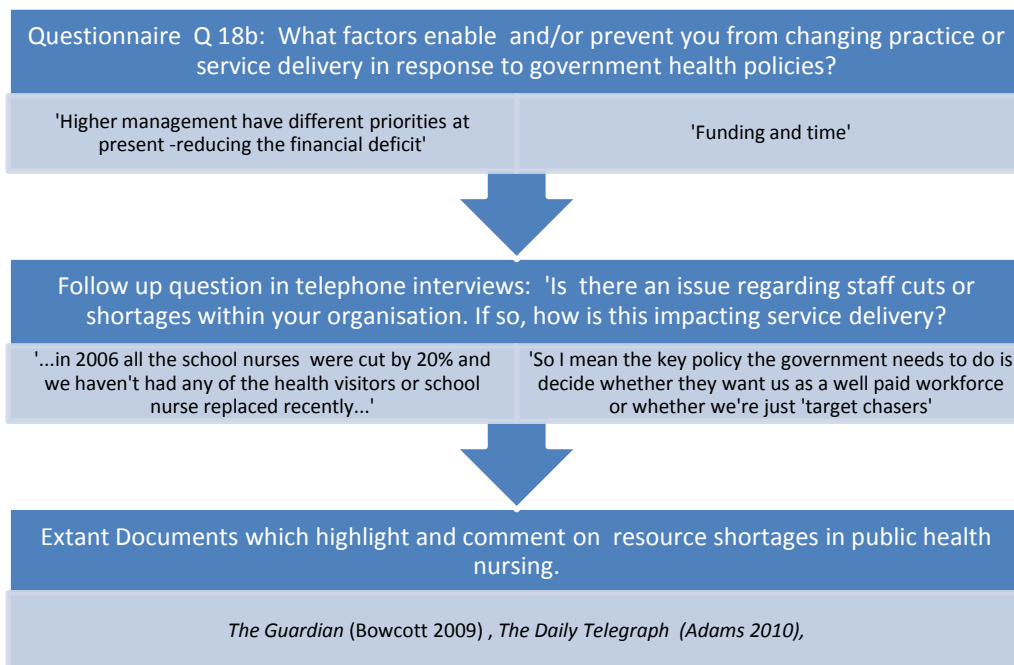


Figure 2: The Data Analysis Process

One of the reasons I chose to use a *constructivist*, as opposed to a classical, grounded theory approach was because constructivist grounded theory aligns more closely with the philosophical underpinnings of my work, which is critical social theory. As Mills *at al.* (2006 a) argue, constructivist grounded theory such as that espoused by Charmaz '...requires the adoption of a position of mutuality between researcher and participant in the research process, which necessitates a rethinking of the grounded

theorist's traditional role of objective observer.' (p.8). Mills talk about the importance of mutuality in the process, as opposed to the participant being somewhat more objectified in the classical grounded theory approach. This idea of mutuality is congruent with a critical social theory approach: in fact, I wanted to emphasise the voice of the participants in my study. From the extract of verbatim quotes from one of the telephone interviews reported in Appendix 4, I hope it is clear how i adopted a participatory approach. Charmaz' (2006) constructivist grounded theory, which emphasises the importance of participants' voice and experience, helped me to do this. This reciprocity in the researcher: participant relationship is in contrast to what Mills *et al.* (2006) term the 'hierarchical' relationship which is seen in an 'objectivist epistemology' (including classical grounded theory, which 'condones the separation of researcher and participant'. My hope that a more participatory approach will not only allow participants' voices to be heard, but will also, through such means as feeding back the findings, will allow them to be empowered move forward- for example, in becoming more involved in the policy arena.

Although I believe there is a strong case for making a link between constructivist grounded theory and critical social theory as discussed above, Mills *et al.* in a second paper (2006 b) present a convincing argument for using Adele Clarke's work in situational analysis to shift the methodology of grounded theory from a postpositivist to a postmodern paradigm. In this case, the importance of considering research participants in their social worlds is paramount. This is something which could have been

considered more fully in my approach, where more details of the participants' social worlds and own particular organisational contexts could have been included.

Following the primary data collection, further data was collected through the undertaking of detailed policy analyses of CAPLNHS (DOH 2005) and OHOCOS (Department of Health 2006). The results of these policy analyses can be found in Chapter 6. These were undertaken using frameworks by Popple and Leighninger (2008) and Walt and Gilson (1994). The Popple and Leighninger (2008) approach is comprehensive and encourages a critical appraisal of policy within its economic and social environment. Walt and Gilson (1994) emphasise the centrality of actors in the policy process, particularly when it comes to policy implementation. Both of the frameworks reflect a critical theory approach to policy analysis and are therefore congruent with my research philosophy. I used the Popple and Leighninger framework because of its comprehensiveness and scope. It allowed me to assess in detail all the facets of the two policies under consideration in terms of an initial overview, followed by detailed analyses of historical, social, economic and political aspects. Walt and Gilson's model was used because of the emphasis on the centrality of the actor in policy, which lent itself well to my research question. Although it was originally designed for policy analysis in low- and middle-income countries, it was also transferable to a high-income country such as the UK.

As well as generating new data in this distinct phase, the policy analyses also enabled me to re-interpret the primary data collected in Stage 1 through a different lens. Following the detailed policy analyses, secondary data was collected through searching for and analyzing extant documents. Each of the three stages of data collection (primary data, policy analyses and secondary

data -extant documents) fed into each other. The data collection and analysis was not in fact a linear process as might be implied here, but a circular, iterative process in line with a grounded theory approach.

The various sources of data: on-line questionnaires, telephone interviews, policy analyses and extant documents were collected in order to provide as complete a picture as possible of the reciprocal impact of health policy on public health nursing and public health nursing on policy. Specifically, the data were intended to address the four research questions:

1. What do they know about the policies?
2. How do they engage in the policy process?
3. What affects their implementation of policy?
4. Is there a policy-practice gap?

Once data had been received and analysed from the on -line questionnaires and follow-up interviews, further data were collected to address areas where I needed additional information to answer these research questions. This embodies the grounded theory approach. The rationale for including the policy analyses as data was that a detailed understanding of the actual policies themselves were needed in order to help explain the reciprocal impact of health policy on public health nursing and public health nursing on policy. The policy analyses served to put the documents and the public health nurses in context, as well as giving me a lens to theorise the central importance of the public health nurse as actor in the policy process. The policy analyses also helped with the dimension of context, as emphasised by Clarke and Proctor (1999).

The first stage of policy analysis (using Popple and Leighninger's framework 2008) helped me to gain a detailed understanding of what the documents were actually proposing. How did the government foresee practice as being changed or developed as a result of these White Papers and to what extent were the public health nurses aware of the proposed changes? This was informed by primary data collected in Stage 1. The second stage of the policy analyses of the two documents, using Walt and Gilson's 1994 model, focused primarily on the role of the public health nurse as Actor in the policy process. Walt and Gilson's framework led me, through a grounded theory approach, to return to my primary data and consider in more depth the perspectives of the public health nurses as actors in the policy process. This stage really enabled me to get to the core of exploring and then theorizing about the 'reciprocal impact' of health policy on public health nursing and public health nursing on policy.

The third strand of data used to answer the research questions included findings from a range of extant documents (secondary data), including mass media, organisational documents and websites and internet discussion. The four different data sources addressed specific research questions. This is outlined in the Table 1. Following this are two further diagrams which provide an overview of the data collection stages- Figure 3 and Figure 4.

Data Source	Method of Data Collection	Method of Analysis	Research Question Addressed
Public health nurses	On-line questionnaires (January-October 2008)	Analysis of quantitative and qualitative data.	1,3,4
Public health nurses	Telephone interviews (February-April 2009)	Analysis of transcripts (from MP3 files).	1,2,3,4
Policy documents	Review of documents (September 2009-November 2010)	Detailed policy analysis using two frameworks.	Popple and Leighninger framework 1,3 Walt and Gilson framework 2,4
Extant documents	Review of documents (January-April 2011)	Analysis, critical review	2, 3, 4

Table 1: Sources of Data

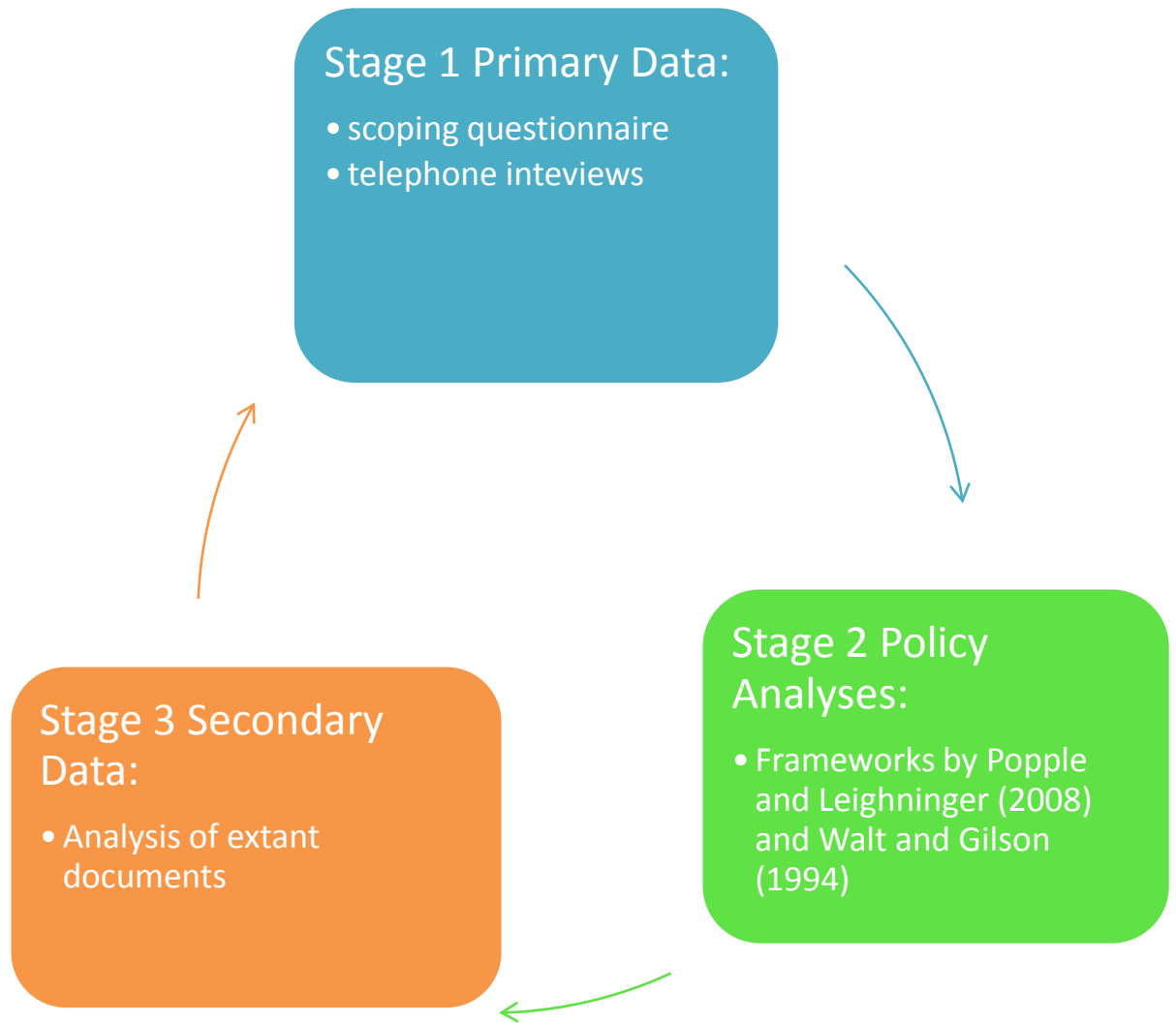


Figure 2: Data Collection Stages

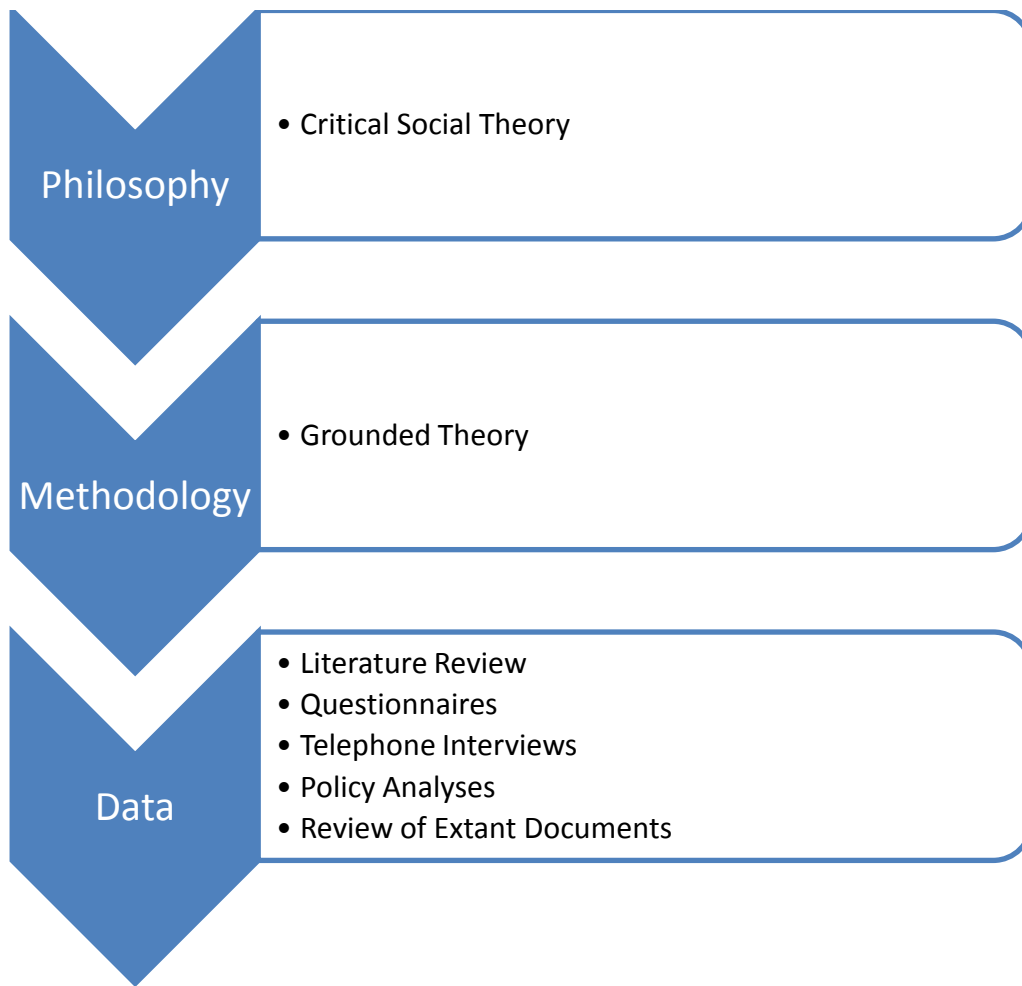


Figure 4: Research Design

In terms of the time line for the research, the on-line scoping questionnaires were collected and analysed between January 2008 and October 2008 (16 returns). The follow up telephone interviews were conducted between February and April 2009 (8 interviewees). Policy analyses were conducted during the period from September 2009- November 2010 and reviewing and analysing extant documents took place from January 2011- April 2011. At each stage of data collection and analysis, previous data were returned to and revisited. As the findings were written up, theory began to emerge and re-emerge in an iterative and organic manner.

In the next phase of the research process, I began to more clearly articulate how each process of data collection fed into the next, and to discover emerging theories and concepts from the data. In order to address the complexity of my goal (to explore the reciprocal influence of health policy on public health nursing and public health nursing on policy), I engaged in a prolonged period of data collection, reflection, articulation and theory formation. This is supported by the quote from Holter (2007) discussed earlier:

Thus, the researcher must pace herself, exercising patience and accepting nothing until this inevitable emergence [of theory from the data] has transpired. Surviving the apparent confusion is important, requiring the researcher to take whatever time is necessary for the discovery process and to take this time in a manner consistent with her own temporal nature as a researcher.....Rushing or forcing the process shuts down creativity and conceptual ability, exhausting energy and leaving the theory thin and incomplete. (Holton 2007: 286)

Using Charmaz' (2006) constructivist grounded theory approach, the four phases of data collection, as shown in Table 1, were iterative and interactive in nature. The original on-line scoping questionnaire was carried out to get a baseline understanding of public health nurses' knowledge of two specific policy White Papers and of the level of their engagement in the policy domain. The analysis of the initial data from the telephone interviews was carried out using Charmaz' method of initial coding followed by a process of 'constant comparative analysis'. Here, units of data were compared between different interviews in order to draw out major themes. These themes (see Figure 5) were then taken forward into the telephone interviews and used as a framework for the interview questions.

The telephone interviews resulted in rich and dense verbatim data which was again analysed using constant comparative analysis. The data were returned to and re-examined many times in order to elicit the main themes and ideas. In my analysis, I strove to put the participant at the centre, and included many verbatim quotes (see Chapter 5) in order to give them a prominent voice. I followed Charmaz' method of analyzing the data through a process of initial coding, followed by memo writing. In Appendix 4, I show how one of the eight telephone interviews was analyzed using Charmaz' method. The highlighted areas in blue are the parts that, through reading and re-reading of the transcript, I felt to be significant. Through a process of constant comparative analysis, both within and between transcripts, I was able to arrive at certain key themes. Those which arose from Suzanne's interview (seen in Appendix 4) included the themes: Lack of resources and Importance of Being Heard in the Policy Agenda. I wrote memos to elucidate the themes and worked through a lens of honouring the participants' experiences through creating *In vivo* codes

(Charmaz, 2006 p.55) and memos. The memo for the code 'Importance of being heard in the policy agenda' was:

Those working at the 'coal face' understand 'how it is' for clients. This understanding could be helpful in policy making and implementation. Appreciates the times where their voices are heard (e.g. by senior management), but these are few and far between. Supports idea of HV's being seconded to government policy making departments and having a voice at the table. Believes PHN's have the skills and capacity to do this.

This theme of 'Importance of being heard in the policy agenda' was followed up in the next phase of data collection: the policy analyses. A greater understanding of the centrality of the Actor in the policy process, brought about through examining Walt and Gilson's (1994) approach to policy analysis, was then applied to the idea of the importance of 'voice' in the policy process for public health nurses. The critical social theory lens, including issues of power, was also applied to elucidate an understanding of how and why this voice had historically been lacking.

Finally, the last phase of data analysis (of extant documents) also shed further light on these (and other) themes. Again, one can see how the whole process of data collection and analysis was highly iterative, with each phase building on and adding to the knowledge from the previous phase. The theme of 'The importance of being heard in the policy agenda' was further explored through examination of data from extant documents. (See Chapter 7).

The theme 'lack of resources' was further explored through the analysis of extant documents such as Bowcott's (2009) article in *The Guardian* 'Chronic shortage of NHS health visitors raises safety fears'. The second code from Suzanne's interview ('Lack of resources') was further explored through the analysis of extant documents such as the *Nursing Times* article (Woogara 2011) highlighting the campaign to stop the disenfranchisement of nurses from the new commissioning consortia (through 'A Seat on the Board' petition), and so give them a voice in this crucial policy implementation.

As well as using the four phases of data collection and analysis to give as comprehensive a view as possible, the use of the four phases show how data was collected iteratively and organically , with each phase informing the next. In line with Charmaz' grounded theory approach, the process was non-linear and not prescriptive. However, certain key tenets of constructivist grounded theory were present: such as constant comparative analysis and the construction of codes and memos when dealing with primary data.

As well as building on each other, distinct phases of the data collection process also addressed specific research questions. This is shown in Table 1 . The four research questions were:

1. What do they know about the policies?
2. How do they engage in the policy process?
3. What affects their implementation of policy?
4. Is there a policy-practice gap?

The initial online scoping questionnaires addressed questions 1, 3 and 4, the telephone interviews addressed questions 1, 2, 3 and 4, the analysis of policy documents using the Popple and Leihninger framework addressed questions

1 and 3 and the analysis of policy documents using Walt and Gilson's framework addressed questions 2 and 4. Finally, the analysis of a variety of extant documents addressed research questions 2, 3 and 4.

When first writing memos and eventually writing up my findings from all the sources of data, but particularly the primary data, I adhered to Charmaz' advice to strive for a deep and comprehensive 'rendering through writing':

Go beyond an analysis of acts and facts. Think about what is relevant but lurks in the background of your analysis. Cultural context? Historical antecedents? Organizational climate? Emotional ambience? See how rendering it explicitly in the text affects your writing- and moves your analysis beyond reporting.

In the analysis of my primary data, constant comparative analysis and paying careful attention to participants' voices (and including verbatim quotes in my report) helped me to do this. The policy analyses helped me to locate the two White Papers under consideration in their political and economic context (Popple and Leighninger's policy analysis framework) and to understand the current and potential role of public health nurses as Actors in policy making, implementation and evaluation (Walt and Gilson's policy analysis framework). Finally, the examination of extant documents helped with the deeper understanding that Charmaz encourages the researcher to develop: aspects such as the complex cultural and organizational context of policy. Extant documents were purposively chosen to fill any 'gaps' in my knowledge which persisted following the analysis of primary data and the conduction of the policy analyses. For example, I wanted to find out more about how nurses engaged in policy in order to answer research Question 2 ('how do they

engage in the policy process?'). In order to do this, I sought out extant documents in the form of website comments threads. Compared to some of the more rigid and quantitative approaches to grounded theory (such as that found in classical grounded theory), Charmaz' approach encouraged me to be creative and iterative in my data analyses, and to arrive at a deeper and more authentic understanding.

In this chapter, I have shown how the methodology of constructivist grounded theory as proposed by Charmaz (2006) was used to scaffold my approach to data collection and analysis. I have shown how an iterative approach was adopted throughout, and each consecutive stage of data collection and analysis (primary data, policy analyses and extant documents) built on the preceding one. In the following chapters, I both present and discuss those findings. Chapter 5 focuses on the findings from the primary data sources (questionnaire and telephone interviews), Chapter 6 on the findings from policy analyses of two specific White papers, and Chapter 7 on findings from extant documents.

Chapter 5

Findings from Primary Sources

In this chapter, I review the findings from the primary data sources: that is, the original on-line scoping questionnaires and the follow-up telephone interviews. One method which helped me to structure and analyse the patterns and themes in my data was to break down the process into four steps: concepts, theories, explanations and understanding. (Blaxter, Hughes and Tight 2001). In this chapter, I describe concepts which emerged from my primary data sources, and I go on to consider theories, explanations and understanding later in this report.

The findings chapter includes some discussion and analysis of the data as they are presented. There is further discussion of the findings in Chapter 8.

Concepts 1: Findings from the On-line Questionnaires

From the initial on-line questionnaire that I distributed, I was able to gather a range of information about how the respondents engaged with the two White Papers, CAPLNHS and OHOCOS. Important themes or concepts emerged

about, firstly, what they knew about the policies and then what some key issues were for them as policy interpreters and implementers. The questions which formed the questionnaire are in Appendix 2.

Using an iterative, constructivist grounded theory approach as proposed by Charmaz (2006), data from the questionnaires then informed the schedule for the semi structured telephone interviews that were carried out in Phase 2 of Stage 1 data collection.

The following 16 completed questionnaires were received between 23/1/2008 and 2/10/2008:

• S.E. England Social Enterprise community health organization	1
• Midlands PCT	6
• SW England PCT	6
• NE England PCT	1
• N England PCT	2

Table 2: Number of Completed Questionnaires

Of these respondents, 11 were health visitors and 4 were school nurses. One respondent described herself as a ‘health visitor/school nurse’ and worked in both capacities. Of the health visitors, 11 were employed as HV’s or public health nurses, whilst 3 were HV practitioners who also had a management component to their role. These included a public health team leader/health visitor, a health visitor/practice development facilitator and a health visitor/practice educator. Of the school nurses who responded, one was a

staff nurse working with the school nursing team, two were team leaders/school nurses and one was a senior sister in school nursing. The practitioner who had undertaken the dual role HV/SN post had a background in education and practice in health visiting, and had recently 'after 4 half days of training' taken on a school nurse role in addition to her health visitor role. This was brought about by restructuring in her organisation due to reduced budgets.

When asked how long they had been employed by their current organisation, there was a range from 5 months to 20 years.

In response to the question 'Have you heard of a government White Paper called 'Creating A Patient-Led NHS'?', 4 responded 'no ' and 12 'yes'. Those who responded 'yes' were asked to outline some of main policies put forward in the White Paper. On the whole, their understanding of the main policies proposed in this paper was comprehensive. They were able to put across many of the central tenets of this lengthy policy document in a succinct and concise manner. For example, a Team Leader in school nursing who had worked as a school nurse for 20 years wrote:

'PCTs to provide greater patient choice & control with patient/public consultation. Strengthened local strategic partnerships. Integrated networks with services across organizational boundaries. Health promotion, health protection & improvement across NHS- no longer just a sickness service.'

A health visitor said it was about:

‘Choice- meeting the needs of individuals and groups but aiming to switch the service so users lead as opposed to service directed. Leading to the new commissioning budget for PCTs.’

These statements indicate a good grasp of the overall ‘message’ of the policy, including the key message of greater patient choice and control. Although the drive towards an increased focus on health promotion is not a new one (WHO 1981; DOH 1999), the school nurse team leader identified the fact that CAPLNHS re-addresses health promotion, with an emphasis on the need for a health promotion focus ‘across the NHS’. The implication from CAPLNHS is that health promotion should include acute sectors. Perhaps because of the management component of the respondent’s role, she had a strategic focus, and talked about the importance of the freeing up of organizational boundaries to allow for ‘integrated networks’ which is promoted in CAPLNHS. Previously, many practitioners and commentators have identified the barriers to inter-agency working caused by a lack of co-terminosity- for example, between local authorities and PCTs. Policies prior to CAPLNHS (for example Valuing People DOH 2001) have also highlighted the importance of multidisciplinary approaches to public health programme delivery. However, the policy alone may not be enough. As Naidoo *et al.* (2003) argue, whilst policy directives support multi-agency working, there are many practical difficulties associated with working in this way including: developing effective communication strategies, teamwork, adopting evidence based public health practice and the provision of training and education, as well as ‘escaping the dominance of public health medicine’ (Naidoo *et al.* 2003: 83). Partnership working across different disciplines was mentioned as a key theme of the White Paper by two respondents. Another made the important point that the

patient is also a partner in the process. Other key themes which emerged in response to the question asking respondents to outline some of the main themes in CAPLNHS included the issue of greater patient/consumer choice, with increased 'flexibility towards patient need'. Themes of empowerment and improving accessibility were also mentioned.

The second White Paper, OHOCOS (DOH 2006), was included in the questionnaire because its themes are closely aligned to those proposed in CAPLNHS, particularly concerning changes to community services (including a key policy driver for the closer integration and increased partnership working between health and social care sectors). OHOCOS confirms the government vision set out in their Green Paper on the future of social care for adults in England 'Independence, Well-Being and Choice' (2005 a). However, OHOCOS (DOH 2006a) has a clear focus on community and primary health care, and many of the themes and policies proposed in this document echo or develop those put forward in CAPLNHS (DOH 2005).

OHOCOS (DOH 2000 (b)- Executive Summary) has four main goals:

1. Health and social care will provide better prevention services with earlier intervention. This is a core policy proposal in CAPLNHS (DOH 2005), but this document (OHOCOS) emphasises the fact that these prevention services should be delivered as a partnership between health services and local authorities.
2. Service users, of both social services and primary care, will be given 'more choice and a louder voice'. This echoes the emphasis on user involvement/consumer choice in 'Creating A Patient-Led NHS' (DOH 2005).

3. Tackling inequalities and improving access to community health services. The policy of addressing health inequalities has been a key one for New Labour since they were first elected in 1997 and shortly afterwards commissioned Sir Donald Acheson to investigate inequalities in health between rich and poor. His report included recommendations around the need to tackle the root causes, including homelessness, poverty, unemployment and social exclusion. (Acheson 1998). However, this is an ongoing issue and the health gap is not narrowing to any great extent. (CSDH 2008).

4. There will be more support for people with long-term needs. This echoes a key tenet of CAPLNHS, but the emphasis in OHOCOS is on joint working between health and social care with proposed integrated Personal Health and Social Care Plans and integrated social and health care records.

In order to ascertain to what extent the breadth of the policy was understood by respondents, a simple mapping exercise was carried out. The key policy drivers mentioned below were mentioned by the corresponding number of respondents. This was ascertained by content analysis.

• Better quality, and more capacity, stimulated by financial incentives	1
• People offered services to maintain health, not just to treat sickness	3
• Locally driven service, operating to a national framework and standards	4
• A choice for patients of when and where they are treated	11
• A joined-up service which enables integrated care for patients	5
• Applying learning from around the world in a new institute for skills and innovations	0
• More insight into local communities, to improve how effectively we help them	1

Table 3: Main Policy Drivers in Creating a Patient Led NHS

From the sixteen respondents to the questionnaire, eleven were familiar with the White Paper OHOCOS and could answer the question ‘Can you outline some of the main policies put forward in this White Paper?’ This is the same number who were familiar with the document CAPLNHS.

In relation to their knowledge of the four main goals of OHOCOS outlined above, the following were highlighted by respondents:

Prevention	3
More choice/greater voice for users	6
Improving Access To Services	4
Supporting People With Long-Term Health Needs	1

Table 4: Main Policy Drivers in Our Health, Our Care, Our Say

Six participants referred to the organisational changes which were or would be implemented in response to the policy. Their responses indicated a high level of knowledge about the proposed shift in roles for Primary Care Trusts from direct provision of services to a mainly commissioning role. It was recognised by respondents that the focus would change from being centrally led to a practice-based focus.

Other themes which were mentioned were the change in service delivery (specifically around the move towards practice based commissioning), the emphasis on integration of health and social care services, a greater diversity of providers and better value for money. One respondent noted that the White Paper provided a climate where there was ‘more freedom to innovate and improve services’. None of the respondents identified the theme of addressing health inequalities, although improved access to health care (which can help address this dimension) was mentioned by four respondents.

Among the respondents who were able to outline some of the policies in OHOCOS, as with CAPLNHS, there was a good understanding of its key goals

and themes. However, as will be discussed later, there were wide variations in practitioners' experiences of the way in which these policies were being implemented in practice.

Both of the White Papers lay the groundwork for a change in the way in which public health nursing services are managed in England. In the first paper, as part of a broader remit, public health nurses would be integrated into Primary Health Care Services and, in the second paper, much closer integration of the health and social care services would occur. In CAPLNHS, the emphasis is on a move away from PCTs negotiating and administering contracts and for commissioning of services to be at a practice level. The predominant theme in terms of management changes is the obligation of managers to listen to service users and provide real choice. The goal set out in CAPLNHS was that PCTs should be 'engaging all of their practices to take an active part in commissioning by 2008' (DOH 2005: 22). In OHOCOS, proposed management changes were largely centred on increased patient choice in terms of the GP they chose to register with and also a choice from a range of services commissioned by that GP. Practice Based Commissioning was a key policy shift recommended in the Paper.

In regard to these management changes outlined above, the respondents were asked: 'In the last two years, has there been a change in the way in which your service is managed?', fifteen said 'yes' and one said 'not obviously' (no). Of those who agreed that there had been changes, five respondents emphasised the extent of these changes: 'yes frequently', 'very much so', 'great changes', 'lots of changes', 'huge changes'.

One respondent (HV) in the questionnaire commented:

‘There have been huge changes in the restructuring of the PCT with reorganisation of the management, changes to boundaries, teams being merged. Decisions have been taken away from the HV teams and even the line managers. Now many decisions are made by management groups within the PCT with no front line staff involvement.’

In many cases PCTs had been merged to form much larger organisations , which were perceived by some as being remote and less involved with individual staff and issues at ‘grassroots’ level. One respondent (HV) said the changes in the way in which the service had been managed (in the last two years) included:

‘More ‘micro-management’. Talk of ‘bottom-up’ and ‘empowerment’ of staff, when exactly the opposite is happening. Managers are dictating to staff and morale is very low. Centralisation of admin has lead to staff in outlying parts of the county feeling forgotten, and that large parts of the organisation are ignorant of the who, where, what and how of people they make important decisions about. Following policies and implementing new initiatives often appears to be about ticking boxes, and giving a good impression rather than really moving on with the intentions.’

This last comment is interesting, in that it contains the idea of management paying ‘lip service’ to new policies, rather than intentionally following policy agendas with the full collaboration and input of their staff.

Other experiences of policy implementation were more positive, however. Although all the PCTs in the study (not the social enterprise) had amalgamated with other local organisations, in some areas this had been done alongside a shift towards the introduction of team leaders. This meant that there remained a management lead close to 'grass roots' services. One respondent noted that, under the new management arrangements, they were now more accountable to their team leader.

Another respondent (HV) said that there had been positive management changes associated with better working between different agencies. Changes as outlined in the White Papers were taking effect in her PCT: she described that much more working together between health, education and social services in multi-disciplinary teams was occurring, as well as joint ventures being set up in the new Children's Centres.

From analysis of the questionnaire data using a constructivist grounded theory approach, key themes were identified. . These themes then iteratively informed the telephone interview framework.. In all, eight telephone interviews were carried out; all eight of the respondents who self-identified in Part 1 as being willing to take part in a telephone interview went on to do so. The telephone interviews were carried out using Skype technology with a 'call burner' application, where an MP3 file recording of the conversation was made and stored as a computer file. They were then transcribed verbatim. An example of one of the transcribed telephone interviews can be found in Appendix 4. The interviews were conducted as semi-structured, 'free-flowing' conversations centred around the key themes identified in the scoping questionnaires. (These key themes used to create the telephone interview questions, as outlined in the following table.

- More centralized management- does this mean less opportunity for practitioners and line managers to make decisions? Please give examples.
- Do policies really affect practice in meaningful ways, or is it about 'ticking boxes'?
- Is there an issues re: staff cuts/shortages within your organisation? If so, how is this impacting on service delivery?
- To what extent are you engaging in multi-agency/ inter-professional work (e.g. using the Common Assessment Framework)?
- Do you see health promotion as a collaborative process? Please give examples.
- If you could name one government policy which has the greatest impact on your practice, what would it be? Why?
- Which factors enable/prevent you from changing practice or service delivery in relation to government policies? Please provide examples.
- Do you think public health nurses could/should be more involved in policy development, implementation and evaluation? If so, in what ways?
- If you could name 1 or 2 priorities for health visiting/school nursing over the next 5 years, what would they be?
- Any other comments?

Figure 5: Emergent Themes from Questionnaires Further Explored in Telephone Interviews

To summarise, the findings from the initial scoping questionnaire were key themes which then emerged as further questions as outlined in the table above. These questions were explored in the telephone interviews using a grounded theory approach. However, some distinct knowledge, in addition to the other themes which formed the basis of the telephone interview questions, was generated by the scoping questionnaires. So in contrast to a classical grounded theory approach, there was an iteration of the different *phases* of the study, rather than an iteration of the individual interviews. This is an approach that I was able to adopt under Charmaz' more flexible interpretation of the grounded theory process.

Findings gleaned from the original scoping questionnaire can be summarised as follows:

- PHN's (public health nurses) overall had a very good understanding of the main policy priorities outlined in CAPLNHS and a good understanding of the policy priorities outlined in OHOCOS.
- There was wide variation in how these policies were actually being implemented in practice (suggestions of a policy-practice gap in many instances).
- There were significant managerial and organisational changes in all five of the organisations in the two years preceding the administration of the questionnaires (which took place between January and October 2008).
- In some cases, PHN's reported that these changes had led to an increased role for them in the policy process. However, in the majority of cases, they reported that the changes had led to a diminished role for them as 'front line' workers in the policy process.

One of the key questions when analyzing and reporting on data using a constructivist grounded theory approach is: 'what do I keep in and what do I leave out?' The constructivist grounded theorist has an active role in this process, deciding what he or she deems significant and elevating this to the form of categories and ultimately concepts or theories. This process is well explained by Charmaz:

We choose to raise certain categories to concepts because of their theoretical reach, incisiveness, generic power, and relation to other categories. Raising categories to concepts includes subjecting them to further analytic refinement and involves showing their relationships to other concepts. For objectivists, these concepts serve as core variables and hold explanatory and predictive power. For constructivists, theoretical concepts serve as interpretive frames and offer an abstract understanding of relationships. (Charmaz 1990, cited in Charmaz 2006: 140).

Significant in this is Charmaz' opinion that we, as grounded theory researchers, 'choose' which chunks of data are significant. So this is both an active and a creative process, in contrast to the more rigid guidelines imposed on the data by a classical grounded theory methodology. Charmaz sums up this idea as:

Our actions shape the analytic process. Rather than discovering order *within* the data, we create an explication, organization, and presentation *of* the data. (Charmaz 1990, cited in Charmaz 2006: 140).

As well as being an active and creative process, the analysis of data and decision about what data is significant to bring forward to the 'findings' section is also somewhat subjective. The researcher decides which parts of the data resonate, but this is done through an iterative process, where, as Charmaz says, data is assigned significance because of its 'theoretical reach, incisiveness, generic power, and relation to other categories.'

So in carrying out my telephone interviews, I had distilled the data from the original scoping questionnaires down into key concepts (not yet at the level of theory), according to Charmaz' criteria. These concepts were:

- PHN's (public health nurses) overall had a very good understanding of the main policy priorities outlined in CAPLNHS and a good understanding of the policy priorities outlined in OHOCOS.
- There was wide variation in how these policies were actually being implemented in practice (suggestions of a policy-practice gap in many instances).
- There were significant managerial and organisational changes in all five of the organisations in the two years preceding the administration of the questionnaires (which took place between January and October 2008).
- In some cases, PHN's reported that these changes had led to an increased role for them in the policy process. However, in the majority of cases, they reported that the changes had led to a diminished role for them as 'front line' workers in the policy process.

These concepts formed the basis of the topics that I planned to cover further in the telephone interviews. They were not translated into a fixed schedule of

uniform questions that I asked each interviewee: rather, they were used to guide my conversations with them.

Concepts 2: Findings from the Telephone Interviews

Eight telephone interviews were carried out in all. The eight participants were drawn from across the range of the five organisations represented within the study. To protect respondents' anonymity, pseudonyms were used and I have not linked the respondents to their organisations. The telephone interviews were carried out between February and April 2009. The themes outlined above in Figure 5 (identified from the questionnaires) were explored with the eight participants. Whilst the two documents CAPLNHS and OHOCOS were central to these discussions, other policies were also considered. The aim of the telephone interviews was to answer the questions raised in the initial scoping questionnaires and to find out the extent to which public health nurses in the study, in their professional roles, engaged with policy.

Following the telephone interviews, coding took place, followed by the process of memo writing. Following Charmaz' advice, I aimed for interpretive understanding, contingent on contextual conditions. This is in contrast to the early grounded theory studies which stressed causal relationships (Charmaz 2006: 120). Data were read and re-read, themes and codes were elicited, and the task of identifying some of the codes as conceptual categories began. Attempting to treat focused codes as categories allowed me to 'develop and scrutinize them' (Charmaz 2006).

In the realm of strategic thinking and political skills, Toward (2008) believes it is important for practitioners 'to be aware not only of the content of policy but also of the macro level wider context, and the political and power dimensions of policy'. (Toward 2008: 137). Some participants in my study showed a great awareness of context and power in relation to policy issues and how these impacted on their work. Others saw policy as something that was imposed in a top-down manner, as something over which they had very little direct influence on. One of the areas I addressed in the telephone interviews was the question raised by Abbott *et al.* (2004) namely, how prepared are public health nurses to be flexible and innovative in their roles, whilst, at the same time, are they being given the necessary support from managers?

As discussed in above, through a grounded theory approach involving the iterative identification of codes and memo writing, broad initial categories from the telephone interviews were gradually distilled down to the following findings:

- policies are having some impact on practice
- public health nurses see a role for themselves in policy and want to be more involved
- lack of resources are inhibiting policy implementation
- lack of resources are a government issue
- public health nurses want more of 'a say' in policy
- public health nurses experience a lack of input and control in the policy process
- policy overload is a problem,
- and certain policies are identified by practitioners as having the greatest impact on their practice.

In Appendix 4, I show how one of these eight concepts ('lack of resources are inhibiting policy development') was derived from the data using a constructivist grounded theory approach. The parts of the transcript that I deemed to be significant in relation to Charmaz' criteria of their 'theoretical reach, incisiveness, generic power, and relation to other categories'.

Taking the example of 'lack of resources' as an area that I deemed to be significant (because it was clear and incisive, was powerfully articulated in this case by my respondent Suzanne, and was something that had been reported by several other telephone interviewees), I wrote a phrase (highlighted in blue on the transcript in Appendix 4) next to each of the cases relating to resources in the literature. The phrases were: 'lack of resources- no staff to follow up on identified needs', 'lack of resources- impact on clients', 'had to fight for resources- poor working conditions', 'stress/difficulties of trying to implement new policy with limited resources'(see Appendix 4).

These phrases were then distilled down into one code' Lack of Resources', with an accompanying memo (see below) and finally into two concepts:

- Lack of resources are inhibiting policy implementation
- Lack of resources is a government issue.

1. Code: Lack of Resources

Memo: A government issue because of cuts to service, but its impact is felt on the ground. Many problems arise from this theme of lack of resources- HV's having to fight for limited resources, returning to a core service (safeguarding), also personal cost – exhausted, demoralised. Identify needs, but unable to follow up. Inhibiting policy development by necessitating a return to a core service, inhibiting development of practice in response to policy.

Concepts: Lack of resources are inhibiting policy implementation
Lack of resources is a government issue

The concept of lack of resources was seen in both the initial scoping questionnaires and in several of the telephone interviews. Using the grounded theory iterative approach to data analysis, which as discussed above incorporated the idea of 'constant comparative analysis', the concept of 'lack of resources' was also followed up in the policy analyses (as part of the consideration of the public health nurse as actor in the policy process) and in the analysis of extant documents which spoke to a lack of resources in public health nursing (Bowcott 2009, Adams 2010). Figure 2 illustrates this process.

Wuest (2010) highlights the inductive and pragmatic nature of analysis in grounded theory:

From a pragmatist perspective, truth cannot be arrived at through deductive reasoning from *a priori* theory, but rather must be developed inductively with constant empirical verification. Truth is modified in light of new directives and is relative to time and place.'
Wuest 2010: 228.

The 'constant empirical verification' arose in my work when I constantly compared data between individual questionnaires and between questionnaires and telephone interviews. Findings from the original scoping questionnaires informed what I would ask in the telephone interviews. Subsequently, findings from these primary sources informed both the

collection and the analysis of secondary data (policy analyses and extant documents).

The concepts 'lack of resources are inhibiting policy implementation' and 'lack of resources is a government issue' were eventually raised to the level of theory, informing my third grounded theory. Theory 3 states that, because of the severe resource limitations at the time of my study, public health nurses are 'burned out', providing a reactive service and unable to be innovative in response to new policy directives.

The eight key concepts from the telephone interviews are explored further below:

Policies Are Having Some Impact on Practice

Inter Agency Collaborative Working

A key policy driver in both of the White Papers under consideration is that of collaborative working. In the questionnaires, respondents showed that they understood the importance of collaboration as a key element of the papers. In the telephone interviews, I was able to gain more knowledge about how the public health nurses saw collaboration played out in practice. An example of collaborative working which some respondents referred to was the Common Assessment Framework (CAF) (Department of Education and Skills 2006). Where collaboration is needed across professionals and across sectors (e.g. health, education and social services), a single Common Assessment Framework for assessing children and families is used in England (Cowley

2008). When reporting findings from telephone interviews, It should be noted that all names of respondents have been changed and pseudonyms used throughout.

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In response to the question 'To what extent are you engaging in multi-agency/ inter-professional work?', Suzanne mentioned that it is the professional who first identifies a family's needs under the Common Assessment Framework (CAF) who will then take a leadership role in its progression. She felt there were issues around sharing of information and effective communication:

'The problem is it's the personnel who actually start the CAF who is going to be the lead of the CAF- so who is going to hold the baton and pass the baton around? For example, if the CAF shows that there are many different needs like housing, benefits, drug work, parenting, then each of the professionals makes an assessment to add towards that CAF, but it's such a very slow process because you might be doing your work and thinking 'well, this isn't going to change actually until this person is able to move house', and then fighting for housing to do their bit, but there also seems to be a lot of red tape which prevents us from streamlining our work. For example, we can't access, or we've only just been able to access and we're still having problems with it- accessing a safe drive for us to write our case conference reports.'

In a dialogue with Sarah, she indicated that the CAF had helped with collaboration to some degree, but that the individuals within this collaborative process had a big impact on how successful the collaborative process was in the end:

JG: O.K. So what kind of agencies do you work with?

Sarah: That would be social services. And we're aiming to do it with the Children's Centres. That's beginning to get off the ground.

JG: Interesting....So do you think collaborative working is maybe something that is going to be improved as a result of things like the CAF framework?

Sarah: I think it helps each others' understanding because we're coming from the same place really and we're looking at the same things. That's where that helps. But in the end I think collaboration comes down to personalities most of the time.

JG: Yeah, can you say any more on that?

Sarah: I think it comes down to the willingness of individuals to accommodate each other and sort of listen to each other and incorporate each other in their planning.

Richard's perspective on inter-agency collaboration was that it was happening to a limited extent (so the policies were translating into changes at practice level), but these developments were embryonic. He could see that Children's Centres (one vehicle for inter- agency working) were in place, but he felt that more direction (from management) was needed to help health visitors work more effectively with them:

JG:Do you think that people who are working with clients at a grass roots level ...have to then change policy to suit your clients as it were? You have to sort of be flexible in that way?

Richard: Um, I think it's very difficult to do because I think, I mean certainly within ...[name of PCT], it's been such a strange time to be a health visitor. You know, completely unstable. And there's been real sort of instability in management structure. So it's very difficult to know actually what we're supposed to be doing as public health nurses or health visitors.

JG: Yes.

Richard: Yeah, the Children's Centres are actually launched, but again you don't seem to be sort of that involved with them. You're involved to a certain extent....sort of things are very didactic and you're told what your involvement should be...to another extent you're sort of left to your own devices. So you know, you're sort of 'devil and deep blue sea'. You know you should be in there, but you're not entirely sure what you should be doing!

Tackling Health Inequality

Addressing health inequality was a key part of New Labour's agenda throughout their time in office. This theme emerged in 1997, very soon after the Labour government took power (The New NHS: Modern, Dependable, DOH 1997). As discussed earlier, addressing health inequalities continues to be a cornerstone of OHOCOS (DOH 2006). Though respondents did not refer to 'tackling health inequality', four public health nurses identified 'improving access to health' as one of the key policies put forward in OHOCOS. Improving

access to health was identified in my study as one of the main means of addressing health inequality.

When this theme (improving access to health) was followed up in the telephone interviews, I saw some interesting examples of Lipsky's (1980) idea of Street Level Bureaucracy in play. Aware of the lack of resources, and yet still highly committed to the idea of addressing health inequality, practitioners on the ground were seeking to use scarce resources in the most effective way possible. More than ever before, there was a shift in practice from the universal to a targeted service as they focused on families with most need. Targeting services was mainly implemented in response to directives from policy and managers, but in some instances this targeting was of their own volition. Joanna talked about managers discouraging intensive post-natal home visits of the kind universally carried out by many health visitors in the past, saying that health visitors in their PCT should visit 'on the basis of need only'. However, a problem for Joanna was that she was working in a deprived area of the city, and felt that all her families were in need (or potentially in need without intensive support). So she maintained a high level of home visiting to many of her clients (as a street level bureaucrat, she was interpreting the 'Hall Report' (Hall and Elliman 2003) directives to a schedule that 'worked' for her clients). The 'Hall report' guidelines set out a schedule for a reduced, but targeted, level of contacts with infants and pre-school children. However, Joanna said that working 'against' policy in this way (i.e. offering more contacts than recommended by Hall, many of them in clients' own homes) was 'at the expense of other things', such as developing wider community public health initiatives.

The experience of implementing the Hall policy for Joanna also linked to policy development issues. She related how certain health visitors had been chosen by managers to sit on a committee looking at a new post -natal

visiting schedule. She felt that the sample chosen by managers was 'selective' and represented only health visitors with more middle-class case loads. These practitioners, according to Joanna, were more willing to give up intensive, universal post-natal visiting, because their clients were more affluent. This is an example of a potential 'policy practice gap' where, although practitioners were being consulted in policy implementation, the consultation process had been too narrow. From talking with Joanna, I got the impression that she was a very experienced practitioner who knew what worked for her particular families and clients. She agreed with the broad thrust of government policy (for example, narrowing the health gap between different spectrums of the socioeconomic continuum), but she felt that there were problems around how these policies were being implemented. For her caseload, targeting visits as proposed by Hall was not sufficient.

Sarah was also committed to the idea of focusing on vulnerable populations, but felt that her PCT sometimes placed less emphasis on this than she would have liked. For example, the PCT tended to focus on strategies which were easily measurable (such as breastfeeding rates), as opposed to support around prevention within the vulnerable population she served. For Sarah, breastfeeding was less of a priority than, for example, safeguarding children:

'Yes, one of the big things I would say is we've got big targets on breastfeeding, and that seems to supersede things that a lot of health visitors might think are more important. Breastfeeding gets a lot of attention because you can tick boxes on how long people are breastfed for...and some of us feel there's less support for safeguarding [child protection] than there is sometimes for

breastfeeding- which doesn't really target the hard to reach.'

Conversely, Suzanne, who worked in the same PCT as Sarah (also with a vulnerable population) felt that her role was primarily around safeguarding children, and that this was at the expense of a wider, proactive public health role:

'My role, although I started out as a 'searcher-out of health needs' and health promoter and ill- health preventer [here, Suzanne is referring to the Principles of Health Visiting, CETHV 1977], I'm now a Safeguarding Nurse- that's what I feel like.'

From the questionnaires and interviews overall, it emerged that public health nurses had a good awareness of many of the key policy directives in both CAPLNHS and OHOCOS, but there were differing experiences of how these were being implemented. Many experienced a policy-practice gap. Where stated policies were being directly played out in practice (i.e. the policy-practice gap was reduced), progress was slow and non-linear. Suzanne said:

'Yes, so when you say about government policy making changes [in practice], I think you know the money they've put into Sure Start and obviously in Children's Centres [pursuing the collaborative working agenda set out in OHOCOS], - it is going the right way. But obviously we need to keep...we all need to stay motivated to get people in to use the resources and to learn about child development and to feel confident in their parenting. So,

in answer to your question [‘is policy changing practice?’], yes it is changing and we are doing it, but it seems we are very much going uphill.’

Public Health Nurses See A Role For Themselves In Policy and Want To Be More Involved

Richard, as a practice educator, believed the policy agenda is something he had a responsibility to raise with his students.

JG: In your education role, Richard, as practice educator...is policy something that you would talk about with students? Would you encourage them to kind of be politically involved..?

Richard: Yeah, absolutely. You know, it’s the key to health visiting isn’t it- to be aware of the policies and how it impacts....Because everything, I don’t know if it’s more politicized, but it feels a lot more- there’s a political drive. You know, headline of the week. And certainly, when it comes to sort of child protection or safeguarding, you’ve got to know where the policies came from and why they developed.

In the area of safeguarding children, Richard believed that the recent Laming Inquiry (The Lord Laming, 2009), which was a review of child protection ordered by the government in the wake of the Baby P case published on 12 March 2009, would have a key influence on future practice. One impact was

that it had highlighted the negative impact of staff shortages on safeguarding and had called for this to be addressed:

‘Lord Laming and the last Laming Inquiry are very important. Although it’s not policy-forming, I think it’s going to have an effect on policy. Because there’s a reassertion- I think probably from a health visiting point of view it’s one of these key articles. ‘Cause at last somebody’s actually saying you know what we’re all saying, which is that we don’t have enough people to actually do the job that we’re expected to do.’

Elaine, a health visitor, believed that public health nurses should get involved in policy development. As she said, this reflects one of the four ‘principles of health visiting’ (CETHV 1977, CPHVA 2007). These principles include the search for health needs, the stimulation of an awareness of health needs, the influence on policies affecting health and the facilitation of health enhancing activities. Although these are fairly old principles, first proposed by the CETHV in 1977, they were found to be still relevant to health visiting practice by Twinn and Cowley (1992) and again by Cowley and Frost (2006). As well as being important principles for practice, they also underpin specialist community practice registration and so are ‘an inherent expectation of the HV role’ (Rees, 2012, personal communication). For Elaine and many other health visitors they are still a guiding principle of practice. The third strategy: ‘The influence on policies affecting health’, speaks directly to the need for health visitors to have an involvement in influencing policy.

JG: Do you think that health visitors could or should be more involved in policy development?

Elaine: Well I think our managers have quite a lot of involvement. I think that's where health visitors' managers need to influence policy and I mean it is part of our role really isn't it- policy development? You know, influencing policies is one of the four things that we should be doing.

JG: That's very true.

Elaine: I do think we should, yes. And you know, getting public opinion and really working in the community and fighting for what we think is good public health.

This last comment relates to the public health remit of health visitors to work across the community, not just with their caseloads or GP practice clients.

Suzanne agreed that public health nurses had a clear mandate to be involved in policy development and implementation. However, she felt that at present they were not working to their full scope of practice in this regard:

I think that health visitors could, definitely should, er... get more of a voice and get more involved in Government policy.

However, she also acknowledged that, because of stretched resources and staff cuts, many health visitors she knew were 'exhausted...burnt out...they've lost their fight'. For Suzanne, the only way public health nurses could really influence the policy agenda was to remove them from the hectic world of everyday practice and allow them to concentrate on the policy agenda:

'I don't think you would be able to get a health visitor who was carrying a caseload to do anything, but you could

second somebody to a Government department, and I think that that would be the way to go. But somebody who's working in an area that is representative of the people that we want to help. Because that way, that person would be able to inform the Government about what is actually happening, what they're finding, what the barriers are, what the drivers are for getting people to do things or not.....'

The scheme Suzanne describes here sounds similar to the Robert Wood Johnson Health Policy Fellowship scheme in the U.S. as described by Gebbie *et al.* (2000). This is discussed in this document's Literature Review. As far as I know, no such scheme exists currently in the U.K, but it is interesting that Suzanne had identified this as being a potentially useful model for increasing public health nurses' involvement in policy making in a meaningful way.

Lack of Resources Is Inhibiting Policy Implementation

In the telephone interviews, public health nurses recounted how cuts in funding and service reduction over recent years had had a negative impact on innovation in practice. Resource limitations negatively affected the extent to which they were able to implement new policies (CAPLNHS, OHOCOS and others) as well as limiting their input into the development and evaluation of policy. Suzanne referred to health visitors as being 'stressed' and 'burned out' due to reductions in numbers. She gave me an example of a policy-practice gap when she explained how new Safeguarding Children policy brought in 'post- Haringey' (Laming 2009) , which included a strong emphasis on the policy of supporting children where possible to remain in their own

home rather than automatically being removed from the home, had been implemented. Whilst she felt that this policy did have some impact on practice, she also believed that supporting children to remain at home did not always happen because of lack of resources. She felt that, in this instance, there was a conflict between government policy on the one hand and the lack of resources on the other, and that the lack of resources had a greater influence on practice.

Joanna said that they were currently one health visitor short in their locality and were in the process of undertaking a two week time and motion study to prove the need for an extra health visitor. She, along with other respondents, articulated a frustration with the 'numbers game', where workload was assessed in terms of quantity (case loads numbers and number of visits or contacts a day) rather than the quality of those interventions. This health visitor also said that the dependency levels of caseloads should be looked at, rather than working to the 'old caseload figures of approximately 300 clients to 1 health visitor across the board.

Suzanne agreed that her PCT should look at providing more resources in deprived areas in order to make the service more equitable. She suggested there might be one health visitor in a team largely consisting of middle class clients with generally lesser need (who she termed 'the worried well'), with greater resources in the teams with clients in greater need. Suzanne also strongly believed that adequate staffing levels and other resources were needed in order to provide a quality service. She identified increasing skill mix and increasing the number of HV's as priority areas for the service in the next five years.

JG: Surely it's more about quality [than quantity of client interactions] isn't it?

Suzanne: Yes, especially if they want us to start making a difference. We do have to work with people, and we have to engage with them and we have to let them know that we've got time to facilitate this change. Maybe it's that we can identify it, but somebody else can do it. But we need them [members of the skill mix team], where are they?

Suzanne also mentioned staff shortages as having a negative impact on her team's ability to be responsive to new policy directives and to new PCT initiatives. She explained how recently their health centre (which she described as 'a very busy practice with a 60% ethnic minority caseload') had lost a 3-day-a-week health visitor. She and the rest of the health visiting team had been proactive in putting together a 'special case' outlining why they believed the post should be re-established because of the demands of the caseload. Following much advocacy on their part, it was decided to re-establish that post. However, there was a three month period before that was done, because, as Suzanne put it, 'essentially there is no money'. For Suzanne, lack of resources was an issue because it restricted practitioners' abilities to respond to changing policy directives. However, more crucially, they also had a negative impact on clients:

'So ultimately that [lack of resources] does affect the people that we are working with or working for....'

There was also a problem at Suzanne's practice with overcrowded surgery premises and a lack of office space. There had been a promise to move the team to new premises, but Suzanne said 'it seems to be a lack of money that's holding that up as well'. Suzanne said that she thought skill mix may be the

solution to staff shortages. She saw the health visitor/public health nurse role as being primarily about assessment of need and planning of subsequent interventions, but she identified a current 'lack of people to hand over [the work] to'.

Lack Of Resources Is A Government Issue

Suzanne voiced her frustration that the Government was failing to provide adequate resources to support their new policies and that this could lead to a stagnation of practice or to a policy practice gap. In response to the question 'Do you think policy affects practice in meaningful ways, or is it just about ticking boxes?', she said she felt that at least part of the cause of policy not always impacting practice in meaningful ways was because government wasn't providing the necessary resources for this to happen. She felt therefore the lack of impact of policy on practice could be deemed a 'government issue', rather than being a result of a lack of implementation 'on the ground'.

The practitioner who was employed by the social enterprise explained how lack of resources impacted their work. Interestingly, she contrasted the social enterprise with the traditional model in PCTs. She believed that resources were more limited in the social enterprise because, working on a private enterprise model, they were not allowed to overspend:

'...we are the social enterprise that everyone thinks has lots of money and at the moment that's not the case

because in other areas of the NHS, if you go over budget, the Chief Executive gets pushed off and you know, you get your hand smacked and that's it. With [name of organisation] that's not what will happen because we are a company and so you cannot So at the moment, we aren't employing any staff at all.'

In an attempt to address the labour shortage brought about by the cuts in the service over the last five years or so of the Labour government's term of office, the Conservatives, as part of their election manifesto, pledged to employ an extra 4,200 health visitors by 2015 (Clover 2010 a). This led to a proposal to move towards a long-debated 'direct entry route' to health visiting. This proposal has been broadly welcomed by the Community Practitioners and Health Visitors Association, who see the skills and knowledge of health visitors as a distinct area from nursing, but others are concerned about a dilution of the role and believe that health visitors should have an initial nursing registration.

At the Community Practitioners and Health Visitors Association annual conference in October 2010, health minister Anne Milton re-affirmed the coalition government's commitment to educating more health visitors. She said that the government's pre-election promise to increase health visitor numbers still stood, despite the recent government spending review. She promised government funding to establish 4,200 new health visitor posts and to improve training. (Clover 2010). Whatever the outcome of these debates, staff shortages need to be addressed, and respondents indicated that their ability to engage in and be responsive to policy was one of the casualties of the shrinkage to the service over the past few years.

Importance of 'Having A Say' In Policy

One of the themes that I was interested in exploring in this project was the extent to which practitioners are engaged in the political context of nursing, both in policy development and implementation, and more broadly. This aligns with the critical social theory lens which I employed throughout the process- are public health nurses 'political'? As Gortner (2009) notes, critical social theory approaches require the researcher to consider the political and social consequences of their inquiry and to be explicit about the socio-political frameworks for their work. My assumption on beginning this study (based on the experience of myself and colleagues working in public health nursing , as well as some of the literature I had read) was that public health nurses would have little power or 'say' in the policy process. Through carrying out my research, I wanted to ascertain if this was also the experience of my study participants. If so, I wanted to also consider what might be done about this lack of power to influence the political process. In this way, I was '...upfront about the inherent assumptions governing a given investigation'. (Gortner 200:280).

Where I found that practitioners did perceive a lack of power to influence the policy process, I went on to consider some possible solutions or recommendations for action. This aligns with Gortner's view that:

Critical theorists and critically inclined scientists take seriously the charge for action; for them inquiry is incomplete without the consequential and liberating act. In this key feature critical social theory can become the basis for political and social action; for nursing situations involving group processes and societal organization, the

dialectic as rationality and method is appropriate and creative. (Gortner 2009: 280).

Melissa (staff nurse in a school nursing team) felt that involvement in policy by public health nurses, although important, had been one of the first casualties of resource cuts. It was not 'crucial work' in a climate where nurses were being forced to prioritise:

JG: Do you think that nurses working on the ground level- you know, for yourself, would you like to have more involvement in policy development and implementation- or do you think that's not really part of your role?

Melissa: If you had enough staff, I think it is something that would be very helpful because then you are using people who are actually there doing the work at the grass roots, but because you do not have enough staff- you know we've had to cut our service by 20%- so you are working very much doing the you know the most crucial work and policy making isn't in there.

Elizabeth said that there had been a lot of recent changes in the management structure of her PCT, but she did feel that public health nurses were given an opportunity to affect how policy was implemented at a local level. So, for example, she told me she had been at a meeting discussing how to implement government directives on safeguarding children. Elizabeth is a Team Leader, so I asked her if there had also been representation at the meeting from the grassroots staff:

‘Absolutely, I think there were eight or nine possibly of us. There were mostly health visitors, two team leaders, one safeguarding supervisor and our senior manager.’

When asked if she thought there were any factors which prevented grassroots health visitors being involved in the policy process, she said no, that she felt there was ‘an opportunity for everyone to voice their opinion and participate’.

Interestingly, Sarah, who is employed as a health visitor by the same PCT, saw things rather differently. She did not think that staff at a grassroots level had a say in policy development or implementation:

JG: Do you think public health nurses kind of working on the ground could or should be more involved in policy development and implementation- or not really?

Sarah: Yeah- they should be more involved. They aren’t.

JG: Why do you think they aren’t?

Sarah: Um, I think they’re not because in [name of PCT] there’s a few people that have got a specific agenda. There’re sort of in management and they just sort of carry that out really.

JG: So you think there’s not much consultation maybe with staff on the ground then Sarah?

Sarah: No, there isn’t. No.

Sarah felt that the Trust was very influenced by the commissioners’ agenda: to a large extent it had to provide the services that they wanted to purchase,

irrespective of the wider policy agenda coming from government through papers such as CAPLNHS.

Public Health Nurses Experience A Lack of Input and Control in the Policy Process

Some of the respondents articulated in the telephone interview that they did not feel that they were able to have a great deal of influence on the policy arena. Melissa, a staff nurse working in schools, felt that there was 'lip service' paid, but little actual commitment to nurses' involvement in the process.

'The impression I get is that in one breath we are asked to contribute towards policy-making, but then it is not followed through if that makes sense. I want to use the word 'lip service', but that sounds really derogatory, but that's how it seems to come across to me- that policy's there for policy's sake half the time isn't it?'

The last sentence illustrates her belief that policies are not particularly influential when it comes to changing practice. Even where she and a colleague had had an opportunity to be involved in writing a specific policy in their organisation, she had yet to see the implementation phase of that policy: '.....it's gone up to the higher levels and it's never come back down again if that makes sense?'. For Melissa, both government policy and more specific organisational policy and procedures were experienced in a 'top down' manner.

At the time I spoke to her, Melissa was not a specialist community practitioner, although she was studying for a Bachelor's degree at the time. Being currently employed as a staff nurse may have had an impact on her ambivalent stance towards whether nurses should have a stronger voice in policy. In contrast, those public health nurses and school nurses who were specialist practitioners believed that the policy mandate was definitely part of their role.

Despite her ambivalence around the policy process, Melissa was in fact involved in the implementation of 'health protection' strategies: this is a type of intervention mandated in both CAPLNHS and OHOCOS. As part of her current degree studies, she had established a smoking cessation clinic in two secondary schools which she planned to evaluate. However, she also said that she might not have initiated these clinics if a health promotion activity were not a mandated part of her degree studies. This is because, in her organisation as in all the others in my study, a lack of resources had resulted in a lack of innovation in practice. In her organisation there was a focus on 'child protection and you know the core work really'. I heard this expression 'core work' from many of the public health nurses I interviewed. Whilst this may have been an example of a response to directives issuing from reports such as 'Hall 4' (Hall and Elliman 2003), this focus on 'core work' did not allow for an expansion of health protection and health promotion initiatives as stipulated in CAPLNHS and OHOCOS. Public health nurses were unable to respond to this policy directive due to a lack of resources.

Policy Overload Is A Problem

Hunter's (2007) observation that '...in public health as in other policy domains the government has shown great restlessness with an endless

stream of strategies and reports' (Hunter 2007: 27) appeared to resonate with the respondents in this study. They were frustrated by and weary of the sheer volume of change in the public health nursing service: changes brought about to a large degree because of government policy. I call this 'policy overload'. Respondents referred to 'constant change' (Elizabeth), and Suzanne referred to health visitors she knew as being 'exhausted' and having 'lost their fight'.

When asked 'if you could come up with one or two priorities for health visiting and school nursing over the next five years, what would they be?', Maggie replied: 'Am I allowed to say 'leave it alone, go away?' '. For Richard, one of the key things he wanted to see over the next five years was 'stabilisation'. Richard strongly felt that public health nurses needed to be aware of policy and to be political but, at the same time, he expressed a feeling of policy overload:

'You know it's the key to health visiting isn't it- to be aware of the policies and how it impacts...it's become more difficult because actually there's been so much contradictory social policy. For example, alcohol. We want to ban it. We want to tax it...Because everything, I don't know if it's more politicised - but there's a political drive. You know- 'headline of the week'.

Policies Identified By Practitioners as Having the Greatest Impact on Their Practice

Respondents were asked if there were policies other than CAPLNHS and OHOCOS which impacted on their practice. Some of the policies and influential reports they mentioned were:

- Hall, D. and Elliman, (2003) *Health For All Children: 4th Report* ('The Hall Report')
- *Every Child Matters: Framework For The Assessment of Children in Need and Their Families* (DfES 2003), which led to the *Children Act* (2004) and the publication of the *Children's Plan* (Department for Children, School and Families, 2007)
- *The National Service Framework For Children, Young People and Maternity Services* (DOH, Department For Education and Skills, 2004)
- *Healthy Lives, Brighter Futures- The Strategy For Children and Young People's Health* (DOH, 2009).

Many of the respondents mentioned the influence of the Every Child Matters document on their practice in terms of using the Assessment Framework (CAF) for safeguarding children and in the drive towards increased collaboration with other professionals (e.g. social workers) in Family Centres.

Whilst there was an understanding of a range of policy and how it impacted practice, the process of integrating new policy directives into their practice was not straightforward for practitioners. For example, The Hall Report (Hall and Elliman 2003) greatly influenced practice through its recommendation of the 'Core Programme' which outlines a framework for the assessment and health promotion of children. This document, published in December 2002, set out proposals for preventive health care, health promotion and a

community-based response to the needs of children, young people and families. A specific schedule was set out for children and young people advising particular health assessments at prescribed age related intervals. Many PCTs adopted the recommendations of Hall in their own policies for child health assessment.

Although the Core Programme recommendations come from a robust evidence base, some research participants felt that its implementation had had a detrimental effect on the public health nursing service offered to clients. It was associated by one respondent as a call for a 'skeleton service': reduced universal contact, in favour of targeted contacts with 'children in need' (Safeguarding, children with disabilities etc). The respondents talked about a feeling of dissonance when policies they were directed to implement differed from what they believed to be best practice for their clients. In many cases, they mourned the loss of the universal service they had previously been able to offer. I did not explore these themes further with respondents, although in retrospect, it would have been interesting to do so: was part of this a 'revisioning' of the past through rose-coloured spectacles? For example, was the previous universal service actually as comprehensive and effective as they remembered it to be?

Data from the questionnaires and telephone interviews helped me to address all four of my research questions. From the telephone interviews I gained a lot of rich data about the public health nurses' understanding of and engagement with policy at a day to day level as part of their work. I was gratified by the participants' willingness to tell their stories, and by their eloquence and insights into this complex part of their role. I found that all of the public health nurses I spoke to felt that they should be involved in policy,

and that they had an important voice to bring to the table. This is borne out by other researchers in the area of policy and public health nursing:

Nurses have unique knowledge about the health and wellbeing of the communities in which they live and work and this knowledge and experience needs to be harnessed to inform effective policy and practice development.

(Aarts *et al.* 2010).

However, whilst all the public health nurses I interviewed deemed policy to be an important part of their role, many felt that they currently lacked a meaningful voice in the policy process. This was sometimes because policy decisions were taken at a 'higher level' within the organisation. Many public health nurses felt, even when they were consulted on policy issues, their voices were not heard.

However, the most significant barrier to their ability to engage in both policy making and implementation had been the severe cuts to the public health nursing service in all parts of England which had led to a pared down, crisis intervention service. Nurses told me that there was no time or space to develop innovative practice, even though government policy which appeared to mandate such innovation was continuing to be produced at a rapid rate. This was a source of dissatisfaction and conflict for most of the public health nurses I interviewed.

From responses to the on-line questionnaire, I found that most respondents had a good understanding of the two White Papers CAPLNHS and OHOCOS. Both of these documents were mentioned in professional journals at the time as well as scholarly journals and the general media, and this probably helped

disseminate knowledge about them to practitioners. Despite this fairly widespread dissemination, I was still somewhat surprised by the high level of awareness and knowledge of the detail of these policies amongst many survey and interview respondents, particularly given their difficult working conditions.

My respondents' political awareness and understanding of complex policy indicates some progress since Antrobus, in 1997, looked at nurses' involvement in and influence on the process of policy implementation around commissioning. At that time, Antrobus found that nurses' influence on, for example, the GP commissioning agenda was negligible. She noted a clash between humanistic and therapeutic nursing values and an aggressive managerialist policy agenda which 'refused to value caring'. A further explanation that Antrobus found for the lack of nursing representation and influence in both policy making and implementation was that nurses were not being educated to think politically:

...nurses [who] are educated to care but not to be political. Political skills do not form part of the nursing curricula at pre- or post-registration level, nor are they incorporated into the socialization process of nurses as part of a 'hidden agenda' that prepares nurses to work in a complex system, with its own particular gendered and hierarchical culture. (Antrobus 1997: 447)

From my own knowledge of current nurse education practice in the UK, I would argue that political awareness (through courses in sociology, health policy, social determinants of health) is now somewhat more firmly embedded into both pre- and post- registration nursing courses and is

particularly emphasised in specialist post-registration community nursing courses. The politicisation of nursing has been recognised as a global issue: the World Health Organisation's Munich Declaration called for at all levels of nurses to be actively involved in the decision process around policy-making and implementation. (WHO 2000).

In summary, the findings from the primary data sources were that public health nurses definitely saw a role for themselves in policy and wanted to be more involved. However, they were inhibited in this domain by lack of resources and cuts which had led to them having to adopt a 'core service' mainly based around safeguarding children. Many of the public health nurses I elicited data from through the questionnaires and telephone interviews were angry and/or disillusioned ; blaming government decisions to severely cut their service as preventing them from 'having a say' in policy development and implementation processes. In this already difficult context, 'policy overload' was seen as exacerbating the problem. In the next chapter I will present and discuss findings from the policy analyses.

Chapter 6

Findings from Policy Analyses

Having reviewed the data from primary sources, in this chapter I go on to present the data from the policy analyses. The secondary data (extant documents) are reviewed in Chapter 7. As outlined in Table 1 (Sources of Data), this project draws on data from a variety of data sources: on-line questionnaires, telephone interviews, policy documents (CAPLNHS and OHOCOS) and extant documents. In this chapter, I am presenting new data which arose from the process of conducting the policy analyses. A detailed analysis of the two policy documents provided data which afforded a detailed understanding of both the content and the context of these two documents. These documents were chosen as exemplars to illustrate the reciprocal relationship and interaction between policy and public health nurses. Knowledge gained from a detailed understanding of the policies was then taken forward into the final stage of data collection and analysis: that of extant documents.

Two models were used to guide me in undertaking the detailed analyses of the two policy documents: Popple and Leignhinger's Policy Analysis Outline (2008) and Walt and Gilson's Model for Health Policy Analysis (1994) (see Appendices 3 and 4).

In the first part of the process, the two policy documents were systematically analysed using the questions in the Popple and Leighninger framework. This framework consists of a series of questions grouped around a general overview of the policy, and then a detailed historical analysis, social analysis, economic analysis, political analysis, program evaluation and, finally, current proposals for policy reform. Whilst analysing the documents, I adhered fairly rigidly to the framework, although I chose not to include a detailed economic analysis as this was outside the scope of this study.

Following the first policy analysis using Popple and Leighninger's framework, I came to a good understanding of the two documents, both in terms of their content and their context. This depth of understanding was necessary to help me to develop further theory on the reciprocal relationship between policy and public health nursing practice in relation to two specific White Papers.

However, having undertaken this process, I felt that there was still a piece of the picture missing. Therefore, coming across Walt and Gilson's model for policy analysis was a 'light bulb moment' for me. Walt and Gilson (1994) argue that health policy analysis previously had a narrow focus on content as opposed to process. They argue for a more effective, qualitative approach which includes both 'the processes contingent on developing and implementing change and the context within which policy is developed' (Walt and Gilson 2004: 353). They present a clear analytical model for policy analysis which incorporates the concepts of context, process and actors as well as content. The authors argue that using this model would better enable policy makers and researchers to understand the process of health policy reform and to plan for more effective implementation. They say that the model can be used both retrospectively and prospectively. In this case, I used the model retrospectively. Returning to the primary data that I had from the

questionnaires and telephone interviews, I re-examined it through Walt and Gilson's model and this helped me to build new theory, particularly around the concept of the public health nurse as actor in the policy process.

I found that using the two theoretical frameworks (Poppo and Leighninger and Walt and Gilson) led to a more integrated and better analysis than I would have achieved had I used only one of the frameworks. Poppo and Leighninger (2008) encourage a critical appraisal of policy within its economic and social environment. Walt and Gilson (1994) emphasise the centrality of actors in the policy process, particularly when it comes to policy implementation. Both of the frameworks reflect a critical theory approach to policy analysis and are therefore congruent with my research philosophy.

Analysis of The Policies Using Poppo and Leighninger's Policy Analysis Outline(2008).

Creating A Patient-Led NHS

I. Delineation and Overview of the Policy

A. What is the specific policy or general policy area to be analysed?

The specific policy to be analysed is a UK government health policy. It is a White Paper published in March 2005 entitled *Creating a Patient-Led NHS* (DOH 2005).

CAPLNHS (DOH 2005) is the main vehicle through which the government intended to deliver the NHS Improvement Plan. This plan was published in June 2004, and its key driver was to set out the changes needed in order for

the NHS to become 'truly patient-led'. The patient-led emphasis was to be built on the following tenets:

- Building on best practice from the past.
- Building capacity and quality, stimulated by financial incentives.
- Services orientated to health, not just to treatment.
- A locally driven service, operating to a national framework and standards.
- A choice for patients of where and when they are treated.
- A joint-up service enabling integrated care.
- Working with local communities to better serve their needs.
- Applying learning from around the world in a new institute for skills and innovation.

The major themes were expanded on in the Summary of the CAPLNHS White Paper (DOH 2005). It was proposed that, in a patient-led NHS, people would have more choice and information to help them make choices, there would be stronger standards and safeguards for patients and patient needs and choices would become an integral part of service planning. It was proposed that new service models will be developed; services which gave patients more choice and control, offered integrated networks for emergency, urgent and specialist care and ensured that all parts of the NHS contributed to health promotion, protection and improvement.

Sweeping changes in the commissioning of services were proposed in this White Paper. From 2006, Primary Care Trusts would have to offer choice to patients. This choice could typically consist, for example, of four or five local NHS providers, together with all NHS Foundation Trusts and nationally procured Independent Sector Treatment Centres. Primary and community

services would be encouraged to develop new services and practices and there would be a concentration on health improvement and developing local patient pathways and services.

CAPLNHS acknowledged a need to change culture as well as systems in order to bring about a truly patient-led service. In order to achieve this, it was proposed that there was a need, among other things, for greater support of frontline staff and clinical leadership, as well as clearer leadership at all levels; integrated nationally through the new National Leadership Network for Health and Social Care. In order to bring about these changes, a variety of organisational changes were proposed, including a development programme to assist NHS Trusts to become NHS Foundation Trusts and a similar programme to support the development of PCTs. There would be greater integration of all financial and quality incentives and greater use of information technology.

From CAPLNHS, the key aspects of the policy to be examined in my study in relation to practice included new service models, health promotion and the role of public health nurses in supporting people with long-term health problems. CAPLNHS initiated the third major NHS reorganization since New Labour took office in 1997 (Hunter 2007). The sweeping changes identified in the document would take place across the whole of The NHS in England, would be delivered by the NHS in partnership with private enterprises, and would be financed through NHS funds (government revenue raised through taxation). In line with the traditional service delivery model of The National Health Service in England, most services would be free at the point of delivery. CAPLNHS cannot be seen as a 'stand alone' document, but instead should be looked at within its historical context in terms of other policy and social developments of the time.

One of the key features of the policy was that it sought to reintroduce market –style competition, which the Labour government had vociferously opposed when in opposition. In terms of the policy context, it is interesting that this emphasis on consumer choice and a market economy for health care was introduced at a time when the WHO Commission on Social Determinants of Health’s final report (2008 - chaired by Sir Michael Marmot) was published. There is a difference in the ideological basis of these two documents; and it could be argued that they are proposing opposing policy directions. The introduction to CAPLNHS identified that it was closely linked to the government’s recent health promotion framework set out in the Choosing Health document (DOH 2004) and closely allied to the soon to be published Green Paper on the future of social care for adults in England Independence, Wellbeing and Choice (DOH 2005). This social care strategy was combined with a policy for community health in a paper to be published the following year, OHOCOS (DOH 2006).

B. What is the nature of the problem being targeted by the policy?

The subtitle of the document is ‘Delivering the NHS Improvement Plan’. Essentially the problem that this White Paper addressed is how the NHS Improvement Plan would be implemented and delivered. The NHS Improvement Plan was published in June 2004. The key policy direction of this Plan was that it was to lead to a re-organisation of NHS services to allow it to become ‘truly patient-led’.

The scale of the proposed changes was ambitious and were planned to bring sweeping changes to the whole NHS system which would lead to 'more choice, more personalised care and real empowerment for people to improve their health'. (DOH 2005: 3)

CAPLNHS saw the problem or challenge of implementing the new NHS improvement plan as essentially a 'top down' process. In the introduction to the White Paper, it is stated that it was written primarily for the 'leaders' of the NHS: the clinicians and managers, the Boards and 'everyone who is helping to lead the transformation of the NHS' (p.3). In terms of Walt and Gilson's model (1994), the idea of the health care worker as an actor in this process is missing. In a phrase that could be interpreted as condescending, the DOH concedes that '...it is vital that these leaders communicate its [CAPLNHS] key messages - about the vision, the values and the major changes- in their own words for their patients and staff'. This seems to imply that 'their' patients and staff might not be capable of digesting the document in its original format and that, although they have a role in implementation, it is not a proactive one.

However, although in this policy patients and staff are largely excluded from actively participating in the initial implementation phase, it is recognised that they have a role in 'feeding back' during the process. There is an acknowledgement that policy implementation is not straightforward, and there appears to be a willingness to develop a staged approach to implementation which takes into account feedback from both patients and NHS staff:

We therefore need to develop even better systems for 'feeding back', learning lessons and adapting our approach whilst maintaining the overall direction'. (Sir Nigel Crisp, NHS Chief Executive, Introduction to CAPLNHS, DOH 2005: 4).

The nature of the problem being targeted by this policy is that, although the NHS had made 'huge steps' in providing faster, more convenient access to care through increases in capacity and changes in ways of working, still it was identified that much more needed to be done. There was a stated need to focus more strongly on quality issues. This policy set out an ambitious proposal for the next few years to change the health system so that there would be more choice, more personalised care, and real empowerment of patients and the public. The document summed this up as a 'move from a service that does things to and for its patients to one which is patient-led, where the service works with patients to support them with their health needs. (DOH 2005: 3).

Primarily, the need for patients to be actively involved in their own health care can be assumed to be a problem or an issue for government. However, in the policy it is implied that it is also an issue for patients and service users. One question that comes to mind here is- is it, in fact, an issue for patients? No evidence is presented in the policy document that supports the idea that patients seek or demand this type of increased control over their health care.

The specific 'problems' (Popple and Leighninger 2008) or foci of the White Paper that I will address in this policy analysis are new service models (specifically greater patient choice) , health promotion (or health

improvement) and the role of public health nurses in supporting people with long term health problems. These were the three aspects which I incorporated into the online questionnaire and to some extent I touched on them again in the telephone interviews.

In this next section of the policy analysis, where I use Walt and Gilson's (1994) analysis model, I will be focusing on what the public health nurses (or actors in the policy process) said about these three key themes (new service models, health promotion and long-term health problems), as well as their opinions on other aspects of the policy.

C. What is the context of the policy being analysed?

Patient Choice and User Involvement

As stated previously, this policy came about following a deluge of new policy papers introduced by New Labour from 1997 onwards. Thompson (2007) provides an interesting overview of the concept of patient involvement and participation in its political context. He writes that, since 1997, New Labour could be seen as 'in the vanguard' of promoting citizen involvement. This was being done through the various parts of its modernisation agenda: inclusiveness, stakeholder engagement and partnership working. Further putting this in context, Sir Michael Crisp, in his introduction to CAPLNHS, wrote:

The past five years have been about building capacity and capability. The next will be about improving quality, making sure that we give the very best value for money

and use the new capacity and capability to build a truly patient-led service. (DOH 2005: 4).

Although a lot of change and new policy was implemented by the Labour government in the five years before the publication of CAPLNHS, in this document they do not give any actual evidence or citations to support the fact that these previous policies had actually led to new capacity and capability within the service. Echoing the idea of 'policy overload' which many of my study participants had experienced, one could question to what extent capacity and capability had been built, despite Sir Crisp's claims that previous policies had been about doing just this.

However, there is recognition in CAPLNHS that changes should involve not just the health sector, but also joint working with local authorities, other parts of government, the voluntary sector and private agencies. In this respect, this policy document refutes Ritsatakis' claim that, in European health policy development, 'the health sector still appears to act largely alone and tends to be dominated by medical models'. (Ritsatakis 2000:353). In CAPLNHS, we see an acknowledgement of the importance of a multi-disciplinary approach, but this does not mean that the biomedical model is not still a powerful influence in UK health policy and practice.

The focus on a patient-led service is not a new one. It has been debated in the literature since the 1980's and gained currency as an important concept within health and social care provision in the early 1990's. The concept was found both in policy documents (most notably in the 1990 community care reforms) and in academic discourse by such writers as Leathard (1990) (as part of a wider discourse around inter-professional working) and Smith (1993). A patient-led service is a concept which continues to be debated

today. Whilst CAPLNHS (DOH 2005) presents the idea of user involvement as both desirable and unproblematic, this issue does not lack complexity. Leathard (1994) identified how, before we can talk about user involvement, we need to first address the issue of service users as encompassing potentially vulnerable groups such as disabled people, older people, black and ethnic minorities and women; groups which had traditionally been disempowered. For Leathard, as well as seeking to empower users through effective user involvement, as opposed to tokenism, there is a need to think about adopting measures which actively promote effective user involvement from all groups in society. Smith (1993), in an evaluation of what leads to effectiveness in community care projects, found that it was essential to develop mutual trust between all parties: users, professionals, informal carers and voluntary networks. If we are to talk about real 'user involvement' it will need to be built on such a concept of trust.

The idea of 'user involvement' and choice, key to CAPLNHS, (DOH 2005) has been presented as a 'good thing' by this current coalition government and the previous Conservative government who came into power in 1979. However, it is a complex area, which is still up for debate among social commentators: Daly (2008) asks 'is choice the right policy?'

Whilst still a contested concept, the theme of patient choice continues in current policy and is a key theme in the 2010 White Paper *Equity and Excellence: Liberating the NHS* (DOH 2010). This paper proposes that patients be given a choice of GP practice, consultant-led team and treatment. It is interesting that this 'choice' is presented in the 2010 document as a radical idea. I would argue that patients have been given such a choice for the past several years. For example, under the GP fund holding reorganisations, introduced by the Conservative government under Margaret Thatcher,

patients were given a choice of which GP they registered with. The 1999 Health Act led to a replacement of GP fund holding by a system focused on health improvement. All primary health services were reorganised into Primary Care Groups (PCGs), which later evolved into Primary Care Trusts (PCTs). The main functions of PCGs were to improve the health of their community, to develop and integrate primary and community care services in their area, and to take on a role in the commissioning of hospital services. (Toward 2008). However, under this new approach, a market type system was retained through the principal of primary care-led commissioning. Patients retained the right to choose their GP and to have an increased voice about the choice of hospital and consultant they were referred to and to some extent the treatment plan adopted.

The focus on choice as mentioned before is a key part of CAPLNHS (DOH 2005); one of its key proposals being 'a choice for patients of where and when they are treated'. As I began to study policy in depth, I was struck by the continuities between policies. Toward (2008) also recognises the continuity of health policy over successive UK governments. Certain concepts like 'patient choice' first appeared under Conservative policy formation (1979-1997), continued into the New Labour government (1997- 2010), and now some of the same themes are being proposed by the present Conservative/Liberal Democrat coalition (2010- present). It is not clear whether these are being reiterated in consecutive White Papers because they are seen as a 'good thing' (for example, patient choice and increased self- determination around health would be popular with most of the electorate), or they are being focused on again because there is a perception that they are not, in fact, happening and they are being introduced as a 'new thing'?

Whatever the reason, patient choice comes up again in the 2010 White Paper Equity and Excellence: Liberating the NHS (DOH 2010). This paper proposes that patients be given a choice of GP practice, consultant-led team and treatment. Reflecting neo-liberal values of the Conservative- Liberal Democrat coalition, there is an increasing emphasis on 'marketisation' of health and a shift from 'the NHS' as a social value. The document proposes a cut in management, and budgeting and commissioning of services to be taken from managers and given to GPs. In this, we see a possible shift from managerialism to professionalism. (LeGrand 1999).

Health Improvement

Another continuation of previous health policy which is seen in CAPLNHS is the whole area around health promotion or 'health improvement'. Under the Conservative government (1979-1997), population health improvement and health gain emerged as key principles to inform GP fund holder and District Health Authority purchasers in their priority setting. The emphasis on improving and maintaining health was continued in their 1992 White Paper The Health of the Nation (DOH 1992), the first ever health strategy in England. This focus on health improvement and target setting was then taken up by the Labour government in their subsequent health strategy Saving Lives: Our Healthier Nation (DOH 1997). Labour's strategy concentrated on four key areas- coronary heart disease and stroke, cancer, mental illness and accidents and set just 4 targets (in contrast to the 27 targets in the 1992 White Paper The Health of the Nation). Saving Lives (DOH 1997) was criticized because sexual health was not a key area (in contrast to the 1992 strategy), because of the focus on a disease-based approach (as opposed to a broader strategy which took into account wider social determinants of health) and because of the inclusion in the title of 'Saving Lives'; which again suggested a narrow

disease focus. (Toward 2008). Health improvement continued as an important theme in the reports on health inequalities written by Wanless (2002, 2004).

In CAPLNHS, it was proposed that primary and community providers would be encouraged to develop new services and practices and develop local patient pathways and services, with the overall aim of health improvement. In Part 2 of the document 'What Services Will Look Like', it states that 'all services [will be] provided within a health improvement environment' (DOH 2005: 13). In a brief section on Health Improvement and Self Care, CAPLNHS refers readers to the Choosing Health document (Department of Health 2004). CAPLNHS does not go into detail about health improvement strategies and targets, but it does say that patients will increasingly:

- Get advice on improving their health as part of routine care, e.g. advice on giving up smoking before an operation (to improve wound healing) or when receiving mental healthcare.
- Be able to develop their understanding and skills to improve their own health, e.g. through Health Direct, health trainer services and the Expert Patient Programme.
- Have access to high quality health improvement services for smoking cessation, healthy eating and physical activity, obesity and sexual health. (DOH, 2005 p.14).

Here, the focus appears to be on a multi-pronged approach to health improvement. Whereas before there had been a primary focus on health promotion strategies, here there is a suggestion that all health services, in both primary and secondary sectors, should be involved and also, true to the emphasis in CAPLNHS on 'patient power', a clear mandate for patients to be

empowered to improve their own and others' health through initiatives such as the Expert Patient Programme. However, caution should be exercised here in that we cannot assume that the health promotion priorities highlighted in CAPLNHS are all necessarily evidence-based. There is also a tension between its stated aim of offering health improvement for all, whilst at the same time addressing health inequality. This is a dilemma which is also a feature of OHOCOS, where there is a similar tension between the economic imperative and the need to address health inequality. As Exworthy (2008) notes, the use of and analysis of policy to address social determinants of health is highly complex;

...by its very nature, tackling SDH implies a multi-faceted approach. Whilst much public policy tends to focus on single strategies for particular population groups in specific circumstances, there is a need to examine the inter-connectedness of components of SDH. The breadth of such research is daunting and therefore requires large-scale, longitudinal research programmes (including policy research). Exworthy, 2008: 325.

A policy focus on health promotion has continued since CAPLNHS, with the publication in November 2004 of a follow-up public health White Paper- Choosing Health: Making healthy choices easier (DOH 2004). Underpinning principles of this policy such as 'Informed choice' and 'Personalisation' echoed CAPLNHS' focus on patient choice and the need to strengthen partnerships between health professionals and patients or clients. In terms of health promotion goals, this strategy stated a commitment to reducing the number of people who smoke, reducing obesity and improving diet and nutrition, increasing exercise, improving sexual health and improving mental health.

These goals are interesting because, unlike in previous public health White Papers, the original statements are written in positive terms and are behaviourally focused, as opposed to disease focused (although after each initial statement, a rationale is given for the particular goal and this is linked to disease among other things).

In *Choosing Health* (DOH 2004) we continue to see a Government commitment to health promotion. Perhaps partly due to the criticisms levelled at *The Health of the Nation* (DOH 1992) and *Saving Lives* (DOH 1999) discussed above, the approach adopted is multi- agency and multi-dimensional. One of the underpinning principles is 'Working Together', with an acknowledgement that Government and individuals alone cannot make progress on health. There is a commitment to working in partnership with local government, the NHS, business, advertisers, retailers, the voluntary sector, communities, the media, faith organisations and many others.

Supporting People with Long-Term Health Problems

The public health/ health promotion White Papers, *The Health of the Nation* (DOH 1992) and *Saving Lives: Our Healthier Nation* (DOH 1999) did include a focus on people with long term health problems. The former document set out a national framework around five priority areas: cardiovascular diseases, cancers, HIV, mental illness and accidents. All of these have potential for being 'long term', and some of the document's targets reflected this – for example, one of the targets around mental health was 'to improve significantly the health and social functioning of mentally ill people', so there was an emphasis on helping people to function well with their condition rather than just an emphasis on acute, curative interventions. However, there was still a lot of criticism at the time and subsequently that *The Health of the*

Nation was too disease-focused (Fulop and Hunter 1999). Saving Lives: Our Healthier Nation (DOH 1999) was different in that it '...unashamedly used the language of health inequalities and social equity'. (Hunter 2003). However, although an improvement in this respect, this later document was also criticised for being too disease-based and firmly grounded within the health care domain. The title alone seems to suggest this approach.

So although it was largely chronic or long-term diseases that were being focused on in these two policy documents, still the strategies proposed were primarily medically focused and target-led. We only really began to see a real government understanding of and commitment to a broader perspective on supporting people with long-term health problems with the publication and implementation of the National Service Frameworks. One of the early ones was the NSF for diabetes (DOH 2001 b). Here, we also began to see rhetoric around partnership and patient involvement in their own care, a theme later developed in CAPLNHS. So Standard 3 in the NSF for diabetes was around 'empowering people with diabetes':

All children, young people and adults with diabetes will receive a service which encourages partnership in decision-making, supports them in managing their diabetes and helps them to adopt and maintain a healthy lifestyle. This will be reflected in an agreed and shared care plan in an appropriate format and language. Where appropriate, parents and carers should be fully engaged in this process. (DOH 2001: 5).

In CAPLNHS, there was to be a continuation of a concern '...with health promotion and prevention- looking after the whole person- as with sickness

and injury (DOH 2005: 6). In terms of new service models, it was proposed that all services would be provided within a health improvement framework. Support for people with long term conditions was indentified in CAPLNHS as one of the key priorities for 2008. Aims were to improve the rate of early diagnosis, empower patients to manage their own condition as far as possible, support them with personalised care and ensure access to specialist advice when needed.

II. Social Analysis

A. Problem description

1. How complete is our knowledge of the problem?
2. Are our efforts to deal with the problem in accord with research findings?

The three 'problems' or issues addressed in CAPLNHS are patient choice, health promotion and supporting people with long-term health problems.

Patient Choice

As stated earlier, this document and others both before and after it have focused on the area of 'patient choice' as unequivocally a good thing without providing a clear rationale or evidence base for it. It may be that the government is attempting to pacify a public who believe that the old style NHS is too much about centralism and social control and aligned to a social medicine type model. It appears to be equating 'choice' with marketisation of health care. There may indeed be many benefits of patient choice, but we need to ask several analytical questions before we accept it non-critically as a concept. How much choice is there in reality for patients? For accessibility reasons alone, many may choose, for example, to register with a local GP and

have no desire to 'shop around'. Leathard (1990) raised the potential problem of tokenism in user involvement in healthcare, and, twenty years later, I would argue that this is still something we have to guard against. The idea of patient choice is taken even further in recent policy such as Equity and Excellence (DOH 2010), where patients are promised, for example, that they will be able to choose their treatment. However, the wording implies that the patient alone would decide. It is probable that many patients already have a say and ultimately make an informed decision about treatments (for cancer for example), but this would (and should) be done in conjunction or in partnership with the clinician. For me, the very ubiquity of this concept of user involvement and choice throughout healthcare policy under the Conservatives (1979- 1997), New Labour (1997-2010) and now the Conservative/Social Democratic alliance (2010- present) is a little suspicious. I think it is a 'selling point' for policy: politicians believe it will be near universal in its appeal. However, it does have marketisation undercurrents which not all voters would support: the patient as consumer. It also speaks to the past and present Government's preoccupation with league tables and performance indicators. This is an example of how political ideology affects policy. Conservative ideology under different Conservative governments has promoted the idea of the mixed market economy in health care. Whilst there may be advantages to this approach, it has been promoted by these governments as desirable for the public, whilst some of the potential problems associated with it (lack of real 'choice', tokenistic 'user involvement') have been glossed over or overlooked.

Propper et al. (2006) agree that extending choice in health care is popular amongst English politicians, and that those promoting such choice appeal to economic arguments: proposing that 'competitive pressure' helps make private firms more efficient and consumer choice acts as a major driver for

efficiency. The assumption from politicians is that 'giving service users the ability to choose applies competitive pressure to health care providers and, analogously with private markets, they will raise their game to attract business' (Propper *et al* 2006: 537). Propper *et al.*(2006) carried out a systematic review of the theoretical and empirical economic evidence on choice in health care and used this evidence to evaluate the likely impact of the then Labour government's 'choice' agenda. They ask whether either economic theory or empirical evidence suggest that greater choice will improve health outcomes and what is the impact of combining choice with centrally fixed prices. The article concludes that there is neither strong theoretical or empirical support for competition, but there are some instances where competition has improved outcomes. Interestingly, they say that other European countries including Denmark, Sweden, Norway and Holland are also pushing a 'choice' agenda in health care.

Health Promotion

More recently termed 'health improvement', there is a huge and wide-ranging literature concerning the area of health promotion. Here, I will discuss only a small part of this literature as it pertains to the policy analysis of CAPLNHS (DOH 2005)- the question in Popple and Leighninger's framework (2008) is : 'Are our efforts to deal with the problem in accord with research findings?'

The health promotion part of CAPLNHS is addressed in the section What Services Will Look Like, under sub-heading 'Health improvement and self care'. (DOH 2005: 13). It refers readers to the Choosing Health White Paper, which spells out the Government's commitment in this area. In summary, in CAPLNHS, we learn that patients will get advice on improving their health as

part of routine care. Secondly, there is again a commitment to patient empowerment and user involvement- patients will be able to develop their skills and understanding to improve their own health. Thirdly, patients will have access to high quality health improvement services -it is not stated here what services they mean-(i.e. no particular professional groups such as public health nurses are mentioned). The target areas are identified as smoking cessation, healthy eating and physical activity, obesity and sexual health. In the CAPLNHS document, there is no further discussion as to why these are priority areas and what the latest evidence is in addressing them. It is probably outside the scope of CAPLNHS to do this, as it is so wide-ranging, and health improvement is only one aspect covered by the policy. However, in the health improvement document referred to in CAPLNHS (Choosing Health DOH 2004), there is an attempt, in layman's terms, to provide a clear rationale for choosing each of the target areas. For example:

Reducing obesity and improving diet and nutrition, because the rapid increase in child and adult obesity over the past decade is storing up very serious health problems for the future if it is not addressed effectively now. Effective action on diet and exercise now will help to tackle heart disease, cancer, diabetes, stroke, high blood pressure, high cholesterol and a range of factors critical to our health.' (DOH 2004b: 5).

Going back to Popple and Leighninger's question, I would argue that the above statement and rationale is 'in line with research findings'. For example, there is a wealth of research evidence linking obesity and poor diet to the range of health problems identified in the above excerpt from Choosing Health (DOH 2004). In CAPLNHS as a whole, the target areas for health

improvement mentioned appear to have been highlighted because they are areas of high morbidity and mortality in the population, and they reflect the target areas identified in Choosing Health (DOH 2004). However, there is no specific mention within the document (CAPLNHS) of who will be responsible for implementing the health improvement agenda, and no examples are given. Instead, readers are referred to Choosing Health (DOH 2004). Choosing Health does not suggest the sort of defined targets seen in previous public health White Papers (DOH 1992, 1999), but instead talks broadly about policy change in the various focus health areas- for example, changes to policy on smoking in public places and food advertising to children. It states that The National Institute for Health Improvement will appoint an Executive Director for Health Improvement to provide professional leadership in delivering public health across the NHS and partner organisations. Choosing Health is presented as ‘...the start, not the end, of a journey’. (DOH 2004 (b): 19).

2. Are our efforts to deal with the problem in accord with research findings?

Limited research or evidence for the choice of health promotion targets or interventions is presented within the White Paper. We cannot therefore assume from the document itself that the strategies and priorities in it are evidence based. The policy analyst would only know this by carrying out a literature review on all the proposed strategies. For example, a key tenet of CAPLNHS is the concept of a patient-led service, where:

- people have a far greater range of choices and of information and help to make choices
- there are stronger standards and safeguards for patients

- NHS organisations are better at understanding patients and their needs (CAPLNHS 2006: 5)

However, previously discussed, researching beyond the 'choice' rhetoric exposes potential problems related to choice and user involvement.

. Although the CAPLNHS document does not provide evidence for its proposed interventions, it does give examples of good practice. In the section on offering support for people with long term conditions, an example of good practice is given around a project on diabetes self-care in Burnley, Pendle and Rossendale. Although this is only one project, it has been used in the White paper as 'evidence' of what works.

3. What population is affected by the policy?

CAPLNHS is directed at the whole population of England and Wales. At the time of publication in 2005, the population of England was 50,093,800 and the population of Wales was 2,952,500. (ONS 2008). Although some members of the population choose to access private provision for some aspects of health care, the National Health Service is a universal service. When planning health provision in CAPLNHS, it would have been assumed it was for the whole population. More details of the population distribution and defining characteristics at the time of CAPLNHS' publication can be found at www.statistics.gov.uk. Population characteristics and distribution are not referred to in CAPLNHS. However, there is mention of having to address vulnerable groups in the population: as part of the Choice and Information section 9), there is the comment that 'Some groups of people, including some from black and minority ethnic backgrounds, are difficult to reach, less well-served and less satisfied with services'. (DOH 2005: 9). Although the health improvement part of the CAPLNHS strategy is based around the priorities set out in Choosing Health (DOH 2004) and, as discussed

above, there is a very clear mandate in the Choosing Health strategy to address health inequalities, there is no mention of this in the health improvement section of CAPLNHS. The implication is that the health improvement strategies are aimed at the population in general. This shows a lack of continuity in policy terms between CAPLNHS and Choosing Health. However, whilst there is not an explicit commitment in CAPLNHS to narrowing the health gap, one could argue that a commitment to improve population health in general would result in improved health for everyone in the population. What CAPLNHS fails to address is the social determinants of health or societal or structural issues which perpetuate inequality. However, there is also a clear economic imperative in shifting to health promotion and prevention and minimizing costs for tertiary care.

- B. **What theory or theories of human behaviour are explicit or, more likely, implicit, in the policy?**
and
- C. **What are major social values related to the problem and what value conflicts exist?**

Popple and Leighninger (2008) suggest a range of possible theories of human behaviour which might underpin a specific social policy. These reflect a range of perspectives, but, as the authors of the framework are from the U.S., the theories they discuss are representative of what one might think of as 'American values': theories such as 'achievement and success', 'efficiency and practicality', 'progress', 'material comfort', 'nationalism-patriotism', 'freedom' and 'equality' are all mentioned. (Popple and Leighninger 2008: 101). Many of these do not translate directly to the UK context. It is interesting, however, to think about how influential an often unacknowledged ideology, or 'theory of human behaviour' can be on a policy.

When I considered CAPLNHS, I felt that there were indeed some implicit values or theories of human behaviour underlying it. It is important to consider these because, as Popple and Leighninger say, 'In order to understand our society's response to social welfare problems, you must inquire as to what values support a policy and what values a policy offends'. (Popple and Leighninger, 2008: 97).

In CAPLNHS, the policy strands reflect many of the values of the Labour government and the civil servants who wrote the policy. In a nutshell, it is a classic example of a 'Third Way' approach. The health improvement agenda espoused in CAPLNHS is actually set out in more detail in *Choosing Health* (DOH 2004), and readers of CAPLNHS are referred to *Choosing Health* for more detail on the health promotion plan. In *Choosing Health*, as mentioned earlier, there is a clear commitment to reducing health inequalities- this is a continuation from New Labour's earlier public Health White Paper *Saving Lives: Our Healthier Nation* (DOH 1998). However, the approach to reducing inequality in New Labour policy as a whole is, according to some critics, a departure from an 'Old Labour' socialist approach. Under New Labour, we see much less emphasis placed on structural causes of poverty and inequality. Lavalette and Mooney (1999) argue that New Labour's emphasis on social exclusion led to a 'pathologisation of the poor', with an abandonment of the wish to redistribute wealth and address 'increasing social polarisation'. For Lavalette and Mooney, New Labour was not about equality of outcome, but equality of opportunity. Their policy focus was on economic growth (the 'trickle down effect'), rather than redistribution.

Interestingly, Blair's Third Way approach was heavily influenced by the ideas of U.S. President Bill Clinton and the Democrats' policies being produced at the time in the U.S. The type of 'equality' pursued by Blair shows many

similarities with a U.S. emphasis on equality of opportunity rather than equality of outcome (addressing structural inequalities). For Popple and Leighninger (2008), 'Equality' is discussed as a social value that might underpin policy in the U.S., but the idea is not unproblematic for the population. So

Social welfare policies that help achieve equality of opportunity, such as Head Start, are warmly supported by most people in the United States. Policies that smack of equality of outcome, whether this is the intent or not, such as guaranteed annual income, racial and sexual hiring quotas, and the like, always face strong opposition. (Popple and Leighninger, 2008: 100).

For Thompson (2007), neo-liberal administrations in the UK from 1979 onwards have 'made citizen dependency on the State and the paternalism of health care practitioners a target for reforms to encourage a more active consumerist ethos within welfare services.' (Thompson 2007: 1298). This consumerist ethos is strongly promoted in CAPLNHS. Thompson does draw a distinction between two approaches to involvement of patients in health care: one 'espousing individual freedom to make choices and the other a more collective freedom to achieve inclusiveness and equity' (Thompson, 2007: 1298). For Thompson, these two approaches reflect 'contrasting political values'. I would argue that the rhetoric in CAPLNHS leans more towards the former approach. This is a consumerist model which sees service users as 'customers' in market style relationships. (Mullen and Spurgeon 2000).

D. What are the goals of the policy under analysis?

The overall goal of the policy is ambitious. Sir Nigel Crisp, then NHS Chief Executive, summarised in his Introduction to CAPLNHS in March 2005 the major changes the NHS had undergone since 2000 – building capacity, reducing waiting times, introducing clinical governance amongst others. He wrote that CAPLNHS was to herald even more changes- it was to be the blueprint for helping NHS leaders and managers to implement the NHS Improvement Plan (DOH 2004). These changes were to be ‘profound’ and would affect both individuals and organisations:

But the ambition for the next few years is to deliver a change which is even more profound- to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health- a fundamental change in our relationships with people and the public. In other words, to move from a service that does things to and for its patients to one which is patient- led, where the service works with patients to support them with their health needs. (Crisp, 2005, Introduction to CAPLNHS DOH 2005: 3).

This is the overall manifest (stated) goal of the policy, and is clear in the document’s title: Creating a Patient-Led NHS. As mentioned above, there is no doubt that this rhetoric would be popular with most NHS users, in that many could see ‘choice’ and partnership working with professionals as something they would sign up to in theory. However, Propper *et al.* (2006) found that, while consumers now have access to more information about health care providers, information in health care markets is often too complex for them to use. Furthermore, information on performance gives providers the

incentive to perform well on the established criteria. However, they may just concentrate on these criteria, whilst not improving actual outcomes. Propper *et al.* also found that patients in England have expressed willingness to travel to non-local hospitals and have done this when given assistance to exercise this choice (for example, help with travel costs). However, when such support is absent (or waiting times at the local hospital are shorter), the evidence from other European countries suggest that there is very little take up of services situated far from patients' homes. Patients who are better informed or who have more severe conditions may be more likely to travel with or without assistance. Propper . (2006) speculate that this could lead to differences across hospitals in patient acuity.

Performance indicators and benchmarking are now rife within the N.H.S. This is partly in response to the commodification of health care and the patient choice agenda. In the NHS context, Holloway *et al.* (1999: 352) look at the area of benchmarking and performance measurement and conclude that many current measurements are not effective because they do not take a holistic approach to measurement .This holistic approach would include 'softer' indicators.

In a philosophical critique of performance measurement in higher education, Adcroft and Willis (2002) argue that performance measurement approaches are 'unlikely to deliver any real improvements in performance'. They see problems with adapting a managerialist, private sector approach to a public sector organisation. In a critique which I believe could be equally applied to the health sector, Adcroft and Willis (2002: 45) argue that the most likely outcomes of the performance management agenda would be 'further increases in the de-professionalisation of academic staff and commodification of the work they carry out'. This conclusion is reached for three main reasons:

- The regimes of measurement reflect the triumph of a flawed post-modern philosophy which privileges and emphasises system deconstruction and economic functionality.
- The regimes reflect a further instalment in the two decade old story of New Public Management (NPM) and the transformation of the public sector through the importation of private sector practices and philosophies.
- The regimes will not deliver on their objectives because they are fundamentally flawed in terms of management process.
(Adcroft and Willis 2002: 45)

Despite these debates in the literature, Patient Choice (and the associated performance management indicators which supposedly help in this choice making) is presented in CAPLNHS as unambiguously a good thing. It is also presented as a new and somewhat 'revolutionary' strategy, whereas in fact it has been a recurring feature of government health policy from the time of the 1979 Conservative government under GP fund holding onwards.

A latent or unstated goal might be that of putting more responsibility onto individuals for their own health care. As Tony Blair said in his speech to the Labour Party conference in 1997:

A decent society is not based on rights. It is based on duty.
Our duty to each other. To all should be given opportunity;
from all responsibility demanded. (Blair, cited in Lavalette
and Mooney 1999).

CAPLNHS embodies many of the aspects of a Third Way approach and, within the government at the time, there was a fairly high degree of consensus

regarding this. However, there were dissenters within the Labour Party. For example, Lavalette and Mooney discuss Roy Hattersley's Guardian debates with Gordon Brown in the autumn of 1997; where 'Hattersley attacked Brown for New Labour's willingness to accept gross disparities in income and wealth, with Brown replying that equality of income simply imposed 'uniformity' and 'stifled human potential'. (Lavalette and Mooney 1999).

Political Analysis

A. Who are the major stakeholders regarding this particular policy?

The stakeholders are the government at the time -specifically the Department of Health and the National Health Service. The document CAPLNHS defines the 'target audience' as PCT Chief Execs, NHS Trust Chief Exec's, Strategic Health Authority Chief Exec's, Care Trust Chief Exec's, Foundation Trust Chief Exec's, Medical Directors, Directors of PH, Directors of Nursing, PCT PEC Chairs, NHS Trust Board Chairs, Special HA Chief Exec's, Directors of HR, Directors of Finance and GPs. These individuals can also be seen as major stakeholders. The presentation of this document is very much a 'top down', management led initiative. To a large extent, this makes sense, as it was senior managers who were largely responsible for driving these changes forward. However, in terms of health professionals 'owning' the process and having a stake in policy change, this top down approach may not be the most effective. This point will be discussed further below, when I consider the actors in the policy process.

At an earlier stage, there had been consultation with members of the public and patient organisations on this White Paper. Sir Nigel Crisp, NHS Chief Executive at the time, said in his introduction to CAPLNHS (written in March 2005):

Ministers and I have spent a great deal of time in the last few months [following the publication of the NHS Improvement Plan in June 2004] listening to patients and staff talking about the NHS, about its successes and shortcomings and about their hopes for the future. There is clearly a great deal of support for the direction of travel but some uncertainty about aspects of it and many suggestions about how to carry it forward most effectively. (DOH 2005).

Without actually stating it, the implication is that Government has listened to the suggestions of patients and staff following the publication of the NHS Improvement Plan and had incorporated some of these suggestions into the CAPLNHS strategies. However, it is not possible to know how influential these consultations actually were on subsequent policy development.

What was the power base of the policy's supporters?

The policy was supported by the Labour Government who proposed it. At that time, the government had a clear mandate and a secure power base. After 18 years in opposition, the Labour Party had won the 1997 General Election by a landslide, and again won a second landslide victory in the 2001 General Election. This enabled them to push through changes such as the launch of the first NHS Foundation Trusts (NHS hospitals with increased financial and managerial independence) in 2004. They also had a secure power base in government from which to implement the sweeping changes proposed in CAPLNHS.

What was the power base of the policy's opponents?

The Royal College of Nursing had major concerns about the reform plans for Strategic Health Authorities and Primary Care Trusts proposed in CAPLNHS. Under the new arrangements, it was proposed that PCTs and SHA's would be responsible for 'securing services for their population' (DOH 2005: 19). There would be an increase in their purchasing role, but a decrease in provision of direct services by both SHAs and PCTs.

In July 2005, Sir Nigel Crisp wrote to all NHS and local authority chief executives. He instructed Strategic Health Authorities (SHA's) to submit plans to the Department of Health by 15 October 2010 to reduce the number of SHA's and PCTs and to make savings of 250 million pounds. Following this, the RCN met with the Chief Nursing Officer, DH and SHA executive nurses. They also received feedback from a wide range of primary care staff (RCN 2005). This culminated in the RCN mounting a legal challenge against the Government 'to prevent the plan of reducing the PCT provider role to a minimum without prior consultation'. So although Sir Nigel Crisp said in his introduction to CAPLNHS that the Government had spent time 'listening to patients and staff', he did not mention that it had taken legal action by the largest nursing union in the UK to force that consultation process with nurses.

The RCN's opposition to the planned restructuring (what CAPLNHS refers to as 'new service models') was based on the following reservations:

...the RCN believes the implications of Sir Nigel Crisp's letter could fundamentally change the nature of the NHS. Commentators believe that the plans are designed to introduce market style incentives, and a divide between

purchaser and provider- greater patient choice underpinned by 'Payment by Results', foundation trusts and a range of other providers outside the NHS. While the RCN has always recognised the important role that the independent and voluntary sectors play in providing community care, we are concerned that plans to increase their involvement raise significant issues such as democratic accountability, transparency, governance, and commercial sensitivity around public and private funding. The RCN believes that patients, the public and key stakeholders must be fully consulted on these major plans to reform the NHS. (Royal College of Nursing 2005: 2).

Many of these points are valid. CAPLNHS did indeed propose changes that would 'fundamentally change the nature of the NHS'. Although the Government claimed they had consulted, in at least one case, the RCN, they had to be forced to consult more fully. Even then, they did not appear to change any of their major proposals following these consultations. The RCN were right to raise concerns about a range of providers outside the NHS being involved in service provision following CAPLNHS. An example is the new Social Enterprise organisations – one of which is included in this study. Whilst not necessarily a negative development *per se*, the development of a mixed economy of provision should have been more widely debated and consulted on. It is a policy which is being further introduced in the new Conservative-Liberal Democrat coalition Government's White Paper Equity and Excellence: Liberating the NHS (DOH 2010). For some commentators, liberating the NHS should actually read dismantling the NHS; as this is what they believe the new policy is really intending to do. In Equity and Excellence, all hospitals will become foundation trusts and are being encouraged to move outside the NHS

to become 'vibrant social enterprises'. From being reduced under CAPLNHS, strategic health authorities and primary care trusts now may be abolished.

The fact that nurses were not widely consulted on CAPLNHS (and they had to resort to legal action in order to be consulted), and, when they were consulted, their reservations were not taken into account, highlights the relative lack of influence of this professional group on the policy process.

How has the policy/program been legitimized? Is this basis for legitimization still current?

There is very little in the actual paper itself in the way of an evidence base to support or legitimize the policy. It is portrayed as a continuation of previous government health policy; a natural progression of their 'modernisation' agenda. Opponents such as the Royal College of Nursing rightly saw that CAPLNHS heralded a profound change to health service delivery. A significant part of the policy talks about 'What services will look like' (p.13) and 'Securing services' (p.20). (DOH 2005). In the section on what services will look like, patient choice is again highlighted. In the section on securing services, we see the concept of the purchaser provider split and the introduction of private provision being introduced. These radical changes are not signposted, but rather introduced on a 'Trojan horse' of other, more innocuous, changes- such as 'concentrating more on health improvement and developing local patient pathways and services'.

Although public consultation did take place on this document, it seems likely that CAPLNHS may have been 'sold' on some of the consumerist aspects such as 'choice', whilst some of the more controversial aspects such as a mixed economy of care may have been glossed over. Certainly, there was little

attempt to legitimize specific aspects of the policy or to provide an evidence base within the document itself.

B. To what extent is the policy an example of rational decision making, incremental change, or of change brought about by conflict?

I would argue that the policy is largely an example of incremental change. As discussed above, CAPLNHS presents itself in this way. The ‘threads’ which run through it build on previous ideas seen in previous New Labour health policy from *The New NHS: Modern, Dependable* (DOH 1997) onwards- idea they identify as building capacity, reducing waiting times, quality improvements, clinical governance and improving patient safety. The Introduction to CAPLNHS presents the policy as a continuation in this broad direction of travel, albeit ‘...a change which is even more profound- to change the whole system so that there is more choice, more personalised care, real empowerment of people to improve their health – a fundamental change in our relationships with patients and the public’. (DOH 2005: 3).

Watt *et al.* (2008) suggest that Alan Milburn, Labour’s ‘most radical health secretary, wanted all NHS hospitals in England to have the opportunity to become independent Foundation Trusts by 2008. However, by 2008, just over half of NHS trusts remained under government control because they failed to meet the criteria for independence. (Watt *et al.* 2008).

Following CAPLNHS, two acts of Parliament (the NHS Act 2006 and the Local Government and Public Involvement in Health Act 2007) spelt out in law the duties of NHS bodies to involve patients and the public. However, the policy is

clearly incremental in that the NHS has had mechanisms for engaging the public since 1974 when the government set up Community Health Councils (CHC's). These were statutory bodies charged with monitoring and reviewing local NHS services and recommending changes when deemed necessary.

In the early 2000s, CHCs became a 'thorn in the government's side with their annual Casualty Watch in which they collectively documented the often catastrophic state of the A&E departments, highlighting long trolley waits'. (Carlisle 2008). In 2003, CHCs were replaced by patient and public involvement forums and a Commission for Public Involvement in Health was formed (only to be abolished 6 months later, although the forums remained). (Carlisle 2008). In April 2008, the PPI forums were replaced by new public and patient involvement bodies covering both health and social services. These are known as local involvement networks, or Links. A report by the Commons Health Select Committee in 2007 (cited by Carlisle 2008) found that the Commission for Public Involvement in Health was disbanded because it was found to be bureaucratic, expensive, did not represent forums and did not respond to forums' needs. Echoing the concerns of Leathard (1990) discussed in the literature review, the report also found that the PPI forums themselves were not representative of the population. The majority of their members were white, middle-aged retirees. (Carlisle 2008). This was something that the new Links groups hoped to rectify.

If we go on to look at current health policy under the Conservative-Liberal Democrat alliance, many of the themes in CAPLNHS are still present. We could argue that incremental policy making has continued across party divides. In the White paper Equity and Excellence (DOH 2010), five years after CAPLNHS, we see familiar themes

such as patient choice and more overt references to restructuring and to some extent dismantling parts of the NHS to allow for more private provision.

C. What are the political aspects of the implementation of the policy?

In the May 2005 general election, the Labour Party under Tony Blair won its third consecutive victory, but failed to win any new seats and had a decreased majority of 66. Politically, it still had a fairly strong (albeit reduced) mandate to enact new policy such as that proposed in CAPLNHS, but its reduced majority meant that it was in a weaker position than previously.

Policy Evaluation

Popple and Leighninger's framework (2008) has a section on policy evaluation. In this section are the questions: 'what are the outcomes of the policy in relation to the stated goals?' and 'what are the unintended consequences of the policy?' I found that it was very difficult to answer such questions without actually talking to the people responsible for implementing the policies on the ground.

This is one of the key things that Walt and Gilson's (1994) model brings to the table. By emphasising the role of actors in the policy process, it provides a rationale for the policy analyst to consider the perspective of these actors (in this case, public health nurses) as a central strand. The question of policy evaluation, therefore, will be considered in the Part 2 which looks at the role of what Walt and Gilson (1994) refer to as actors (in this case, public health nurses) in the policy process.

Our Health, Our Care, Our Say

I. Delineation and Overview of the Policy

A. What is the specific policy or general policy area to be analysed?

The specific policy to be analysed is a UK government health policy. It is a White Paper published in January 2006 entitled *Our Health, Our Care, Our Say* (DOH 2006a). The paper differs from CAPLNHS in that it concerns itself with addressing both health and social services provision. A key theme in this policy, following on from one of the core policy thrusts in CAPLNHS, is the concept of 'patient choice'. The introduction to OHOCOS states that in the NHS, patients are beginning to see real choice in the hospital they go to and the treatment they have: choice brought about by new purchasing arrangements (resources following the choice) and greater autonomy for professionals. The policy states that the government now wants to extend this choice to primary care, so that, through practice based commissioning, patients would be given a choice of which GP surgery to register with. It also stated a wish to move services from secondary to primary care. For social services, OHOCOS confirms the vision for which was outlined in the social services Green Paper, *Independence, Wellbeing and Choice* (2005). A key policy area set out in this document, and confirmed in OHOCOS, was around the provision by social services of 'high quality support meeting people's aspirations for independence and greater control over their lives, making services flexible and responsive to individual needs'. (DOH 2005: 5).

The White Paper OHOCOS has four main themes:

- i) Health and social care services would provide better prevention services with earlier intervention.
- ii) People (service users) would be given more say and a greater choice in both health and social services provision.
- iii) There would be more done to tackle inequalities and improve access to community services- there was an undertaking in OHOCOS that local health and social care commissioners would work together to understand and address local inequalities.
- iv) There would be more support for people with long-term needs.

Three of the four themes were also key themes in CAPLNHS. As discussed in the analysis of that document, prevention, patient choice and support for people with long term health needs are all central policy areas promoted in CAPLNHS. This illustrates the way in which policy development and implementation is not a linear process: key themes and policy drivers reoccur over time and documents merge together and overlap in terms of trying to move towards the ultimate achievement of goals. However, a key area in previous government policy and strategy, that of addressing health inequalities (DOH 1997; Wanless 2002, 2004), was lost in CAPLNHS, only to re-emerge strongly in OHOCOS. Interestingly, the government was upfront in OHOCOS about the economic imperative to save money which underpins the policy. They stated that the goal to create 'safe health and social care in the community...is not only better for people's health and wellbeing, but provides better value for the public's money' (DOH 2006a: 10).

B. What is the nature of the problem being targeted by the policy?

Unlike CAPLNHS, which took a 'top down' approach to policy implementation (being aimed at leaders and senior managers within the NHS), OHOCOS's primary intended audience was the public and professionals. The nature of the 'problem' being targeted by the policy seems to be the lack of a voice and choice for the public in health and social care provision and the perceived concentration of services in the secondary care sector. The vehicles for addressing this problem were identified as a range of new policy initiatives including:

- Practice Based Commissioning
- Shifting resources into prevention
- More care undertaken outside hospitals and in the home
- Better joining up of services at the local level
- Encouraging innovation
- Allowing different providers to compete for services.

The secondary care sector is seen as problematic because it is more expensive and less 'personal' than primary care services. The government is upfront about economic factors being a strong motivation for a shift from secondary to primary care. In OHOCOS, it is stated that the goal to create 'safe health and social care in the community...is not only better for people's health and wellbeing, but provides better value for money'. (DOH 2006a:10).OHOCOS also promised to '...give people a stronger voice so that they are the major drivers of service improvement'. (DOH 2006a: 7).

Echoing CAPLNHS, in OHOCOS there continues to be an emphasis on developing a mixed economy of care in health (and in the case of OHOCOS, also in social) services. However, in OHOCOS, this promotion of a mixed

economy of care is presented as a way to address inequality. An example is given in the document where in some deprived areas there are fewer doctors per head of population than others. 'Allowing different providers to compete for services' (DOH 2006: 10) is seen as a possible solution to this. These 'different providers' will include the 'third sector'. Interestingly, the term 'third sector' is used, but not defined, in OHOCOS. Whilst I take it to refer to the private sector (the first sector being public provision and the second voluntary or non-profit sector), the target audience of this paper may not all be aware of what 'third sector' refers to. Because the term 'private sector' is not used, I wonder if the privatisation agenda is being introduced rather furtively here, by the 'back door'.

There is an implication that a further problem that is being addressed by OHOCOS is that health care has previously been somewhat inflexible regarding individual need and choice: 'we will move towards fitting services round people not people round services'. (DOH 2006b: 6).

C. What is the Context of the Policy Being Analysed?

In the Executive Summary of OHOCOS (2006: 6), there is a section entitled 'The context of the White Paper'. This contrasts with CAPLNHS, which does not explicitly refer to 'context'. In OHOCOS (DOH 2006b), Britain is described as a country of 'extraordinary opportunity'. (2006b: 6) Reference is made to the fact that Britain is at the forefront of technological advances in e-commerce and the biotech industry. In the future, ...'exponential advances in trade and technology hold the promise of a dramatically more productive economy and medical science offers us the prospect of living longer to enjoy it'. (DOH 2006b: 6). So OHOCOS is presented to the reader in a context of optimism (one could say 'propaganda') about Britain's economic and

technological security at the time. However, the economic downturn which began to manifest itself shortly after this in 2007 meant that the actual policy was being implemented in a very different economic context to the one portrayed in the document.

A second context area which the White Paper refers to is increased longevity. It states that people are living longer, and that the number of people aged over 65 with a long term condition is set to double each decade. It is in this context that the policy promises to provide more support for people with long term needs.

Technological change is a key contextual theme, and is presented optimistically. The document states that medical science, assistive technology and advances in pharmaceuticals 'will continue to rapidly change the society in which people's lives can be improved by health and social care'. (DOH 2006b: 6). There is a commitment to changing the organisation of care delivery to reflect these technological changes; for example, to use 'assistive technology' to support people safely in their own homes and shift care from hospital to the community. There is a passionate rallying cry for readers of the policy to 'get on board': 'It would be wrong to allow a traditional method of delivery to hold back progress'. (DOH 2006b: 6).

The technological advances and the promise of 'safe' care in people's homes is presented as unproblematic and as cheaper than secondary care. This shift is not new; for example, it was integral to the NHS (Primary Care) bill , published in February 2006 and rushed through Parliament to receive Royal Assent just before the May 1997 General Election. However, although the shift towards a more preventative, primary care approach is positive in many ways, there is some debate about whether it is in fact a cheaper option.

Leathard (2000: 151) said that it was not clear whether the shift towards a primary care lead NHS in the mid-1990's was '...real primary care or merely secondary care outside hospitals in the hope that [it] might be a cheaper option.' This is still a valid question today. In terms of OHOCOS's commitment to provide 'safe' care, this can only occur in a context of sufficient training, education and resources. A case where a community nurse accidentally switched off a patient's life support machine prompted a debate in the Nursing Times (Ford 2010) about the adequacy of the training this particular nurse had received by the Nursing Agency who employed her, but also a more general debate about increased level of patient acuity and complex health care needs in the community. Ensuring adequate numbers of highly trained staff to carry out this work autonomously in the community is not a cheap option.

There is a brief mention in the context section of the fact that health inequalities are still 'much too stark' (DOH 2006b: 6) and a commitment to developing targeted, innovative and culturally sensitive services.

Social Analysis

Problem description

In OHOCOS, the problems which the policy is trying to address can be linked to the four main themes of the document. The first is health and social services working more closely together to improve prevention services. The second problem is a perceived lack of choice for service users in both health and social care provision. Next, the problem of health inequalities, identified by New Labour as an important policy issue very soon after they came into power, remains a priority in OHOCOS. Finally, there remains a commitment

to support people with long term needs (both health and social care needs). Of these 'problems' or policy themes, the second (increase user choice) and fourth (support people with long term health needs) are also seen in CAPLNHS. This indicates a clear continuity between the two documents.

How complete is our knowledge of the problem?

If we look at one of the issues promoted in OHOCOS (the issue of health and social services working more closely together to support people with long term health problems), our knowledge of this problem/issue is good. A policy push towards closer inter-agency working between health and social services has long been on the agenda in the UK- for example, from The New NHS, Modern, Dependable (DOH 1997) onwards, New Labour promoted the idea of joint working in health and social care in early policy documents. (Cabinet Office 1999; DOH 2001). As Johnson *et al.* (2003) say, policy documents reflected a dominant discourse around integrated collaboration, coordinated partnership and , in respect of health and social care, 'integrated ('seamless') service planning, management and delivery.' (Johnson *et al.* 2003: 71).

Researching the theme of interprofessional working across health and social care, Johnson *et al.* (2003) interviewed 22 senior health and social services managers in two rural and two urban areas in England. They asked them what helped or hindered their efforts to work together in general, and also specifically in relation to three client groups needing collaborative community care- individuals with developmental disabilities, those with serious mental illness, and frail older people. The research highlighted a number of barriers to interprofessional collaborative working across health and social care. These barriers were organisational, professional and internal (including marked 'cultural differences' between health and social care).

Johnson *et al.* (2003) made recommendations for changes which they believed would lead to enhanced interprofessional working across the two sectors. This included:

- The development of multidisciplinary teams with decision making authority over their local budgets devolved to the local level.
- A single source of funds for these teams; preferably a unified budget.
- Joint training for team members and assistance in learning to appreciate the role that each performs.
- A single management entity to direct them.
- Clearly articulated goals and commitment to meeting them
- Accurate assessments of local community needs and circumstances matched with accurate inventories of local supply. (Johnson *et al.* 2003: 81).

Whilst OHOCOS does reflect some of the more macro recommendations proposed by Johnson *et al.* above, such as creating joint health and social care teams with a shared manager (in Children's Centres for example), it does not address the more micro, but equally important elements- such as joint training around such areas as enhancing practitioners 'appreciation and understanding of each others' professional cultures and language. It is at this level that the actors in the policy process become crucial- for example, social work and community health care practitioners and managers could commit to and develop a joint training programme, thereby greatly enhancing the likelihood of effective interprofessional working. It is at this level of detail (rather than the government mandated 'big picture' policy recommendations) that policy can succeed or fail at the implementation stage.

Although OHOCOS went some way towards achieving it, it is clear that the move towards more effective interagency working (just one part of the policy recommendations in OHOCOS) is not yet complete. This illustrates the lengthy and complex nature of much policy implementation in health and social care. The push towards enhanced interprofessional collaboration between health and social care is a cornerstone of the new Conservative- Liberal Democrat alliance government's policy, where a recent White Paper (DOH 2010) has at last proposed the linking of health and social care budgets(advocated by Johnson *et al.* in 2003).

From a service user perspective, closer integration would seem to be desirable. Abbott *et al.*(2005) report that more than 20 years of research with disabled children, young people and their families has highlighted the need for the various professionals and services that support them to work more closely together, and this has been assumed to be a 'good thing' for families. However, in their three year research project that looked at the processes and impact of multi-agency working on families, Abbott *et al.* found that multi-agency working appeared to make some positive, but not significant, differences to the lives of families. Sloper (2004), in a review of the literature on multi-agency working, found that , although there was a lot of research around the facilitators and barriers to multi-agency working, little research had been carried out on the effectiveness of multi-agency working itself or different models of such working.

Whilst intuitively it does seem to make sense to move towards closer integration of health and social care services, it is interesting that the government appears to have had little empirical evidence on which to base this policy.

Are our efforts to deal with the problem in accord with research findings?

As discussed above, there are aspects of the policy that are not evidence informed. An example is the promotion of closer integration of health and social care. Whilst closer interagency working would seem to make sense, particularly in the care of people with long term health problems (and indeed it is a policy which I support) the evidence base around whether it actually makes a significant difference to the client experience is limited.

As with CAPLNHS, I found that in OHOCOS research evidence is not integrated into the policy report itself. Some policy strands within the document appear to have been put forward because they reflect government policy or dogma and are presented unequivocally as a 'good thing' for service users without supporting research evidence being provided or referred to.

What population is affected by the policy?

Like CAPLNHS, OHOCOS is directed at the whole population of England and Wales. At the time of publication in 2005, the population of England was 50,093,800 and the population of Wales was 2,952,500. (ONS 2008).

Although some members of the population choose to access private provision for some aspects of health care, the National Health Service is a universal service. When planning health provision in OHOCOS, it would have been assumed it was for the whole population. More details of the population distribution and defining characteristics can be found at www.statistics.gov.uk.

A. **What theory or theories of human behaviour are explicit or, more likely, implicit, in the policy?**

If we look at one of the four major themes here, that of giving service users more say and a greater choice in both health and social service provision, this theme is steeped in consumerist discourse (Thompson 2007). Newman and Kuhlmann (2007) argue that the idea of patients as ‘discriminating consumers’ is at the heart of current European health policy. They see this consumerism, together with tighter regulation of provider services, as bringing about new forms of welfare consumption whilst challenging the ‘scientific-bureaucratic power of welfare professionals’ (p.2). In breaking down the various elements behind the promotion of consumerism in health care, Newman and Kuhlman provide some valuable insights into its complexity. They argue that ‘modernisation strategies collapse a number of different aspirations’ (p.3):

- Increasing consumer participation in decision-making which promotes the idea of citizens’ self determination and social inclusion
- Overcoming the ‘producer dominance’ of health care systems by challenging professional power
- Encouraging patients to take more responsibility for their own health and wellbeing, thereby reducing their reliance on state services and promoting better health outcomes.

One can see how there may be tensions between these different aspirations. Adding to the complexity, Newman and Kuhlman ask , in the case of the two countries they focus on in their paper Britain and Germany, ‘how do health systems that are not based on market laws respond to the demands on citizenship rights and ‘choice’ of the service users?’ (Newman and Kuhlman 2007: 4). They conclude that consumers may not act in ways intended by

government, and consumerism in health care not only challenges medical power and knowledge, but also challenges and changes the concepts of state and public. Through the consumerist model, the state, the professions and the public are connected in complex ways, and change in one domain has an impact on the others.

So in just one aspect of OHOCOS, the promotion of the patient as consumer, one can see the potential complexities and the 'ripple effects' this policy could cause within a particular health care system. For Newman and Kuhlman, some of these effects may be positive; for example, they argue that the idea of 'patient choice' could enable health care providers to 'translate a discourse of consumerism into a professional discourse of patient-centred care and empowerment' (p.18). There is some evidence that this idea of true patient empowerment, alongside a more aggressive idea of the patient as 'consumer' in a market model, is what the government were trying to achieve in OHOCOS. This is a classic example of Third Way thinking.

B. What are major social values related to the problem and what value conflicts exist?

A major social value espoused in OHOCOS is that of tackling health inequality. This reflects a continued commitment to this under New Labour, but, as discussed in the analysis of CAPLNHS above, is very much a Third Way approach to this problem. There is a focus on individual, as opposed to structural, causes and solutions.

One could also argue that there is a potential value conflict, as discussed by Newman and Kuhlman (2007), between social values around addressing inequality and the pursuit of a consumerist model of health care.

C. What are the goals of the policy under analysis?

The main goals relate closely to the four main themes of OHOCOS as discussed above: these include an increased focus on prevention (in both health and social care), greater patient choice and participation, reducing health inequalities and supporting people with long term health needs.

Political Analysis

A. Who are the major stakeholders regarding this particular policy?

What was the power base of the policy's supporters?

Like CAPLNHS, the policies outlined in OHOCOS were largely supported by the Labour Government consensus at the time. The government had a clear mandate and a secure power base. After 18 years in opposition, the Labour Party had won the 1997 General Election by a landslide, and again won a second landslide victory in the 2001 General Election.

What was the power base of the policy's opponents?

There was opposition to OHOCOS from some powerful organisations, including some Trades Unions. The TUC passed a number of resolutions at its 2006 Annual Conference stating its opposition to the New Labour government's public sector 'reform' agenda. Chief concerns were around privatisation and marketisation of health care, as well as cuts to services:

Congress also notes that proposals to invest in health promotion set out in the Government's White Paper , Our Health, Our Care, Our Say are undermined by the rush to tackle historic deficits resulting in 'slash and burn' cuts to services such as health visiting, mental and sexual health. It is no coincidence that against a backdrop of rapid reform and wider market-based initiatives, such as Payment by Results, job losses are being announced on a daily basis with many PCTs and hospitals facing financial deficits. These are stymying the efforts of members who support many aspects of the modernisation agenda and want to see the NHS thrive. (Tucker *etal.*2006).

In many ways the TUC was prescient in stating such concerns at this time of relative economic stability. They saw and drew their members' attention to the implicit policy shift towards marketisation and less government investment in health care. In the recent health White Paper Equity and Excellence: Liberating the NHS (DOH 2010), we see these policies being pursued more explicitly and aggressively.

B. How has the policy/program been legitimized? Is this basis for legitimization still current?

Like CAPLNHS, there is very little in the actual paper itself in the way of an evidence base to support or legitimize the policy. On researching the key policy areas proposed, I found that some, but by no means all, were evidence informed or research based.

C. To what extent is the policy an example of rational decision making, incremental change, or of change brought about by conflict?

The policy is very much an example of incremental change. Two of its main themes or goals (those around consumerism and support of people with long term health problems) are direct continuations of policies set out in CAPLNHS. The focus on prevention also reflects government policy from the early days of New Labour onward: specifically, its public health White Papers, *Saving Lives; Our Healthier Nation* (DOH 1999) and *Choosing Health* (DOH 2004) provided clear targets and goals for health promotion and health protection.

The fourth key policy area of addressing health inequalities also reflects an incremental approach to health policy under New Labour. On its election in 1997, the Labour Government presented a nine-point strategy aimed at reducing health inequalities. This strategy was a cross cutting, whole government approach to the problem (not just focused on health). The suggested areas of action included raising living standards and tackling low income, focus on education and early years, employment, transport and mobility, issues for the NHS (around equitable service provision, access etc), building healthy communities (regeneration initiatives), housing (tackling homelessness), reducing crime and appointment of the first ever Minister for Public Health (Benzeval 2002). Despite their continuous commitment to this issue, in OHOCOS the government recognises that the problem is not solved and re-commits itself to addressing it.

One could argue that this incremental approach to policy, with the reoccurrence of key policy themes throughout the life of the Labour government (and some, such as tackling health inequalities) continuing into the current Conservative- Liberal Democrat government, is a positive thing. Many of these policies need to be approached as very long term strategies, so it makes sense that an incremental approach is adopted. Although Hunter

(2007) talks about the plethora of new health policy and initiatives under New Labour as being overwhelming for practitioners, still the incremental approach adopted by the government may have ameliorated some of the frustrations brought about by the 'endless stream of strategies and reports'. (Hunter 2007: 27).

Policy Evaluation

Popple and Leighninger's framework (2008) includes a section on policy evaluation. This includes questions such as 'What are the outcomes of the policy in relation to the stated goals?' and 'What are the unintended consequences of the policy'? When I came to address these questions, I found I could not do so without taking into account the role and perspectives of the actors in the policy process as defined by Walt and Gilson (1994). In this case, I believed that the actors- public health nurses involved in actually implementing CAPLNS and OHOCOS on the ground- would be able to significantly enhance the policy analysis. With this aim in mind, I gathered data from online questionnaires and follow-up telephone interviews with the public health nurses and the responses, as discussed Part 2, were illuminating.

Current Proposals for Policy Reform

In order fully to evaluate a specific policy, Popple and Leighninger suggest that the policy analyst looks at the specific policy in relation to more recent policy developments. This puts the original policy in context and also allows the analyst to determine if the policy momentum has continued in the same broad direction or deviated from the original policy. As mentioned previously, one of the challenges of research on social and health policy is that the terrain is constantly shifting. In some respects, policy analysis has to be done retrospectively, especially if one is looking at impacts. However, a challenge is

that new policy supersedes the old and this will affect the context in which the previous policy is analysed. Therefore, I include here a brief overview of a major policy developed post- CAPLNHS and OHOCOS.

A recent health White Paper proposed by the current Conservative-Liberal Democrat Coalition government (formed in May 2010) is Equity and Excellence: Liberating the NHS (DOH 2010). This paper puts an increased emphasis on 'marketisation' of health and a move away from the ideology of 'the NHS' as a social value. It proposes a shift from budgeting and commissioning of services from managers to GPs. Despite these changes, however, there is also a marked degree of continuity. Equity and Excellence continues the shift in New Labour policy that led to the emphasis on choice and the consumerist agenda in CAPLNHS and OHOCOS. Equity and Excellence focuses on introducing structural and organisational changes within the NHS. A key objective is to save money- the document talks about seeking 20 billion pounds in efficiency savings. This in turn aligns to a broader current government policy of efficiency savings across the public sector.

Although there are continuities in current coalition government policy with New Labour health policy, there are differences too. Equity and Excellence (DOH 2010) emphasises the empowerment of health professionals as well as the public in a new 'bottom up' approach to NHS management. There is much less emphasis on primary care and health promotion in comparison with CAPLNHS and OHOCOS, and on inter agency working in comparison with OHOCOS. However, there is reference to addressing health inequalities, although this reference is oblique and talks about a service for 'everyone', rather than mentioning health inequalities directly: 'We will seek to ensure that everyone, whatever their need or background, benefits from these arrangements.' (DOH 2010: 3).

Current proposals for policy reform take the themes of consumerism and individualism seen in CAPLNHS and OHOCOS to a new level, a level which many see as essentially a call (through the mechanism of general practitioner commissioning amongst others) to privatise the National Health Service. Many Liberal Democrat coalition MPs, together with some Conservative MPs, were critical of the proposed changes to the NHS. Wintour (2011) described how four Conservative MPs (Sarah Wollaston, Charles Walker, Douglas Carswell and Ann Main) signed a motion 'urging ministers to listen to the concerns of patients groups, professional bodies and independent experts'. Toyne (2011) reported that 'for the first time the entire NHS has been put under competition law'.

To summarise my findings, conducting a policy analysis using Popple and Leighninger's policy analysis framework (2008) helped me to arrive at a clear understanding of the two policies in terms of their content and context. This helped me to answer questions 1 and 3 of my 4 research questions, namely:

- What do they know about the policies? (The development of my understanding of policy content through the analysis process helped me to evaluate the extent of the research participants' own understanding).
- Is there a policy-practice gap? (Understanding the policies' intents helped me to review my data from primary and secondary sources in terms of whether public health nurses were enacting and implementing the policies in practice).

Analysis of The Policies Using Walt and Gilson's Model for Health Policy Analysis (1994)

The Actors in the Policy Process: Public Health Nurses' Perceptions

As discussed above, Popple and Leighninger's framework (2008) does not explicitly address the actor, or the person responsible for interpreting and implementing a given policy. In the work of Walt and Gilson (1994), Context, Content and Process are all identified as key elements in the process, with actors playing a central role.

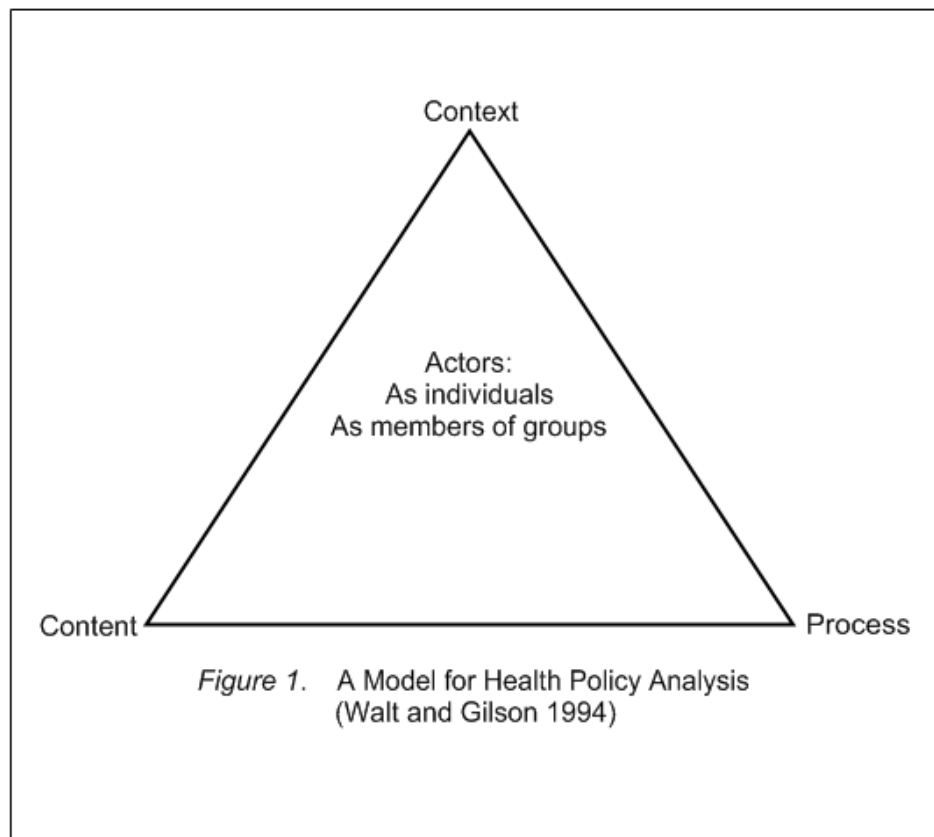


Figure 6: A Model for Health Policy Analysis (Walt & Gilson 1994)

The theoretical standpoint for my analysis of the role of public health nurses as actors in implementing CAPLNHS and OHOCOS (DOH 2006) was a critical social theory lens as discussed earlier. How the policy was mediated through the participants' social experience was, for me, one of the most interesting aspects of the research. Ingram (2002) discusses the work of a major critical theorist, Hannah Arendt (1906-1975). In her work *The Human Condition* (1958- cited and discussed in Ingram 2002), Arendt identifies three ways of being in the world: labour (instrumental activity aimed at consumption), work (instrumental and expressive activity aimed at cultural fabrication) and action (expressive and communicative activity aimed at deliberation). For Arendt, '...modern administrative states (including liberal democracies) end up privileging labour above political action'. (Ingram 2002: 16).

A key point in Arendt's work according to Ingram (2002) is that bureaucratic socialist regimes eliminate political life- replacing it with top down, 'scientific' economic management. In liberal welfare democracies (such as the UK), politics is a '...passive act of voting for pre-selected slates of administrative elites....which allow powerful economic interests to dictate political choices'. (Ingram 2002: 16). Ingram goes on to say that 'in both cases, [socialist and liberal democratic regimes] the public space necessary for sustaining free, equal political deliberation and elevated cultural life is subordinated to an all-encompassing economy of mass production and mass consumption' (Ingram 2002: 16).

I found the work of Arendt as discussed by Ingram helpful when applying a critical theory lens to my work. The Popple and Leighninger (2008) framework I used for policy analysis was useful in that it encouraged me to pull apart and

analyse the policies (CAPLNHS and OHOCOS) critically within their social and political contexts. However, the framework did not consider those who actually interpret and implement policy. This concept of Actor is seen as crucial in the policy analysis process by Walt and Gilson (1994). For Arendt, the individual as a political being or actor has a weak position, often subsumed by the economic sphere. Following this argument, one could perceive the actors in the policy process as relatively powerless, largely dictated to by top down policies which are aligned to an economic, market driven approach to policy (for example, the consumerist notion of 'patient choice' and the move towards a mixed economy of welfare provision). Arendt's work was influential on my thinking in terms of how the actor in policy might be constructed and situated within their social world.

I had a further opportunity to reflect on what critical theory can bring to policy analysis when I attended a conference ('Philosophy in The Nurse's World- The politics of nursing practice') in Banff, Canada in May 2010. This conference was convened by the Institute for Philosophical Nursing Research, based at The University of Alberta in Edmonton. In a key note address at the conference, Dave Holmes (Professor and Vice-Dean, University of Ottawa), delivered a lively and spirited critique of evidence based practice in medicine and nursing, where scientific, empirical research (e.g. RCTs) was still held to be the gold standard. For Holmes, scientific, rational methods continued (wrongly, in his opinion), to be valued above more qualitative, interpretive methods. (Holmes 2010). He discussed Foucault's critique of the scientific method: namely that 'scientific discourse conceals power relations through the appropriation of a supposedly absolute and objective truth that not only exists, but is also knowable'. For Holmes, Foucault saw scientific discourse as problematic because it, on the one hand, maintains the effects of domination whilst, on the other, strengthens the institutionalized structures that shape

them. For me, then, Holmes' arguments reinforced my opinion that policy analysis had to be more than a scientific, objective endeavour and a successful analysis would have to include the subjective experiences of policy implementers (public health nurses).

Interestingly, for Holmes (again drawing on Foucault), social policies themselves can be problematic in that social policies govern behaviour and discourse in the name of a particular ideology. Initial analysis of CAPLNHS and OHOCOS using Popple and Leighninger's framework had encouraged me to look at how powerful government ideology had shaped the direction of future health services- often with only minimum or tokenistic public consultation. Hearing the voices of the public health nurses as actors in the process further helped me, through a qualitative and normative approach, to apply a critical theory perspective to policy analysis. My approach to policy analysis then most closely aligns with a perspective which is very clearly articulated in the work of Midgley and Livermore (2009).

Midgley and Livermore (2009) discuss the development of social policy as an academic field, including the shift from a scientific, rational and positivist approach to policy analysis (the belief that scientific methods should be used to study social phenomena), to a greater acceptance of the potential value of normative approaches (the idea that social science scholarship should aim to improve social conditions). They argue that, where once these two positions were seen as 'antithetical', now there is greater acceptance that both scientific, rational and descriptive approaches can be used together to shed light on the policy process. Advocating for the empowerment of the powerless in advanced capitalist societies is central to the critical social policy approach. (Iatridis 2008). The public health nurses in my study were given an

opportunity to tell their stories about feeling relatively powerless in the policy process.

Whilst Popple and Leighninger (2008) offer a structured framework which initially could be interpreted as a 'scientific' method, and therefore antithetical to the approach proposed by Midgley and Livermore (2009) and others, once I started working with Popple and Leighninger's framework, I found that it contains elements of normative approach to policy analysis. It encourages the analyst to not take policy at 'face value', but rather to ask questions about how policy is influenced by its political and social context. This aligns with a critical social theory perspective.

The second stage of my policy analysis process, where I analyse data gleaned from the actors about their interpretations of influencing, interpreting and implementing policy is firmly within a critical theory paradigm. Through a grounded theory approach, I re-reflected on my primary data through the lens of Walt and Gilson's model (1994). This encouraged me to look again at the policies in terms of content, context and process, but, crucially, to do this the voices and experiences of public health nurses (actors) at the centre.

Essentially the part of the policy analysis using Walt and Gilson's model consisted of me returning to some of the findings from the questionnaires and telephone interviews which were concerned with the public health nurses' perceptions of their engagement in the policy domain. I reflected on this data further and attempted to explore it through a critical social theory lens: such a lens was appropriate to utilise because it reflected both the perspective of Walt and Gilson and indeed my own perspective and chosen foundation for my research.

In considering the themes which emerged from the telephone interviews which were specifically concerned with the public health nurses as actors in policy ('importance of having a say', 'public health nurses experience a lack of control in the policy process' and 'policy overload') I analysed these again and attempted to explain them through a critical social theory perspective. This stage of data collection (that is, the analysis of the policies using Walt and Gilson's (1994) framework) was instrumental in allowing me to address my core research questions which I had posed at the outset of the research process. Here, I addressed them specifically within a critical social theory paradigm. Although Walt and Gilson do not explicitly state that they are working within a critical social theory paradigm, their model is congruent with this in that it emphasises the importance of both health workers and context in the policy process.

Re-examining the data through Walt and Gilson's (1994) model and through a critical social theory lens helped me to develop new understanding around two specific questions addressed in the telephone interviews: as actors, how do public health nurses engage in the policy process and what affects their ability to implement policy? Essentially, the policy analysis using Walt and Gilson's model allowed me to attain a deeper level of understanding in relation to my research questions. This analysis was not concerned with content, but with process. In exploring my findings from a reanalysis of data using Walt and Gilson's framework (1994), I bring in some new supporting references from academics writing from a critical social theory perspective, such as Gortner (2009) and Gordon and Nelson (2006). These are references which have not been previously discussed in the literature review section of this document.

The rationale for this is that, in line with a grounded theory approach, the initial literature review was not all-encompassing. Rather, its aim was to give me baseline knowledge around the issues of approaches to policy analysis, the role of nurses in policy making and implementation and exploring the policy-practice gap before I went on to collect my initial primary data. Through an iterative and scaffolding approach, I developed new knowledge and understanding through each consecutive phase of data collection (primary data- questionnaires and telephone interviews, policy analyses and secondary data-extant documents). In order to show how literature and theory aided my understanding and development of my own theory in the policy analyses and extant documents analysis phases of data collection, some new references, which are not in my original literature review, will appear in both the findings and the discussion sections which follow. The aim is to help the reader to see how my thinking and theorising developed through building an understanding of my emerging themes in relation to critical social theory. These findings are mostly reflected in this section, as I believe that Walt and Gilson's model is closely aligned to a critical social theory approach and using Walt and Gilson's model as part of the policy analysis really helped me to begin to interpret what I was finding through a critical social theory lens.

So having applied Walt and Gilson's model to my primary data, supplemented by existing literature, I was able to answer the following two research questions: 'How do they engage in the policy process?' (see below) and 'What affects the ability of actors to implement policy?' .

How Do They Engage In the Policy Process?

Although there has been an increase in political and policy education within nursing curricula over the last ten years or so, that is not to say that we cannot improve on the situation and include more. Whitehead (2003: 590) believes that, although there was emerging evidence that nurses are 'becoming more politically aware, this rarely manifests itself as political action'. In 2009, Carnegie and Kiger argued that nurse educators must prepare nurses for political participation, and nurse managers should focus on national and local contexts to encourage policy analysis in nursing practice. In the U.S. and Canada, recent and current literature supports the need to politicise nurses, with nurse education seen as a key opportunity to do this (Reutter and Williamson 2000; Rains and Barton-Kreise 2001; Stevens and Hall 2007; Wold *et al.* 2008; CNA 2009).

The political awareness of my research participants was evident in their interview responses. They firmly believed that they had a role to play in the policy process, but many felt that they were unable to fully pursue this because of competing priorities (clients' needs came first) or because they were not enabled to do so. This returns me to the critical social theory stance of this work: as Gortner (2009) notes, critical social theory requires me as a researcher to consider the political and social consequences of my enquiry. For me, there is a continuing need to emphasise political education in both pre- and post-registration nursing education and professional development. My research could add to the growing literature cited above aimed at nurse educators which continues to argue for this. As Rains and Barton-Kreise (2001) argue, it is imperative that we continue to 'build political competence' in public health nurses. This is important 'not as an end, but as a means' (219), the means being to promote health through enacting supportive public policy. Thus, the 'charge for action', which Gortner (2009) believes is an

essential component of critical theory, is for nurses to be empowered to be effective and questioning actors within the policy process.

In my interviews, public health nurses talked about their desire to 'have a say' in the process, but many felt that only lip service was paid to their role in policy development and interpretation. This sense of 'invisibility' was challenged when the RCN made the decision to sue the government in order to demand a say in the drawing up of CAPLNHS; a policy about which they had real concerns (RCN 2005).

In terms of engaging in the policy process itself, the public health nurses in my study definitely saw this as part of their role and they wanted to be involved. However, they were not always empowered to do so. An example is when a school nurse mentioned she had been part of a working group looking at a specific organisational procedures based on the government policy Every Child Matters (DFES 2003). She felt that, whilst the input of practitioners on the ground had been sought, their opinions did not appear to have had an effect on subsequent practice. This made her quite cynical ('policy's there for policy's sake half the time isn't it?'). She did not feel any ownership of the policy process.

A health visitor in my study mentioned how she thought the representation of staff on committees looking at policy implementation was not reflective of staff from across the Trust in terms of socio-economic characteristics of their caseloads. Although there was consultation, it was selective and it meant that practice decisions may not have reflected the needs of more vulnerable groups. These findings are supported by the literature, particularly where researchers have adopted a critical paradigm. This encourages the researcher

not just to report why a phenomenon occurs, but to question why it occurs and to ask what might be done about it. In their critically informed study of nursing leadership, Antrobus and Kitson (1999) explore how critical theory can help in this type of research:

Critical theory is concerned with more than negative judgement. It refers to a much more positive act of exposing existing beliefs and values that restrict or limit human freedom. In effect, critical theory sets out to explain the social order in such a way as to serve as a catalyst for the transformation of that order. (747).

In the recommendations section, I look at how the social order might be transformed, so allowing more meaningful and influential interactions between public health nurses and policy.

When I reflected on the question 'how do they [public health nurses] engage in the policy process?' through a critical social theory lens, I considered some of the literature which analyses nursing roles and status. Here, I found material which helped me explain their limited power and influence within the policy domain. As I found in my conversations with public health nurses, so in all nursing areas of practice '...under-staffing, resources shortages, and abuse undermine nursing practice daily' (Summers and Jacobs Summers 2010). These limitations inhibit their ability to carry out their core work to their full scope of practice, let alone develop influence in spheres such as policy. A BBC news item (9 June 2010, Summers and Jacobs Summers 2010) reported how the nursing role has expanded beyond that of 'devoted angels, physician helpers and bedpan engineers', but the public perception does not always appreciate the extent of the new enhanced scope of practice, which

includes use of technology, advocating for patients and health promotion. The report blamed this public perception partly on nurses' invisibility in popular TV medical dramas such as *House* and *Grey's Anatomy*, where nurses are either invisible or 'appear as meek subordinates who rarely speak'.

Adams and Nelson (2009) discuss how, in diminishing health care economies, nurses are being increasingly challenged to articulate what they do and to defend their work against being undervalued. If their true scope of practice goes unrecognised, there is a constant threat that fewer registered nurses will be employed and the work shifted to health care aids. Adams and Nelson (2009) believe that the devaluing of nursing work can be partly explained by:

The dualistic elevation of 'mind' above 'body' and the sentimentalizing split between 'knowledge' and 'virtue' work to hide and/or devalue important aspects of nursing work. These habits of thought are historically and socially intertwined with notions of appropriate gender roles and appropriate gender-differentiated access to power and resources. (6)

Adams and Nelson (2009) argue that descriptions of nursing frequently emphasize service, altruism, emotional connection and relationship- what Gordon and Nelson (2006) term the 'virtue script'. This also entails nurses being encouraged 'to do their work quietly and out of the limelight- to aspire to be invisible'. (Adams and Nelson 2009: 6).

I would argue that this invisibility, together with the 'virtue script' constrains nurses and dis-empowers them from being vocal and involved contributors to

policy debate, policy development and implementation. As Melissa (staff nurse in the school nursing team) told me:

‘I’m only a staff nurse so I’m like the lowly of the low. The impression that I get is that in one breath we are asked to contribute towards policy making, but then it is not always followed through if that makes sense.’

The above discussion concurs with the work of Antrobus and Kitson (1999), who argue that the populist view of nursing, reinforced by media portrayals, is that nurses are only concerned with operational issues related to direct care delivery. Through a critical theory lens, they go on to critique the restricted view of nursing in terms of its influence that this engenders:

Confined to care delivery, the nurse is viewed, in scientific management terms, as analogous to a factory worker on the shop floor. The factory does not need input from the shop floor worker at the level of strategy. Rather, the factory worker is informed of strategic decisions related to factory business and is managed accordingly. If however, the contribution nurses make is publicly acknowledged within public health in addition to care, then it becomes easier to demonstrate the contribution nursing makes to the public health business of the NHS at the macro level of policy, in addition to the micro level of practice. (Antrobus and Kitson 1999: 751)

I believe that this contribution should be publicly acknowledged, but also acknowledged and promoted within the nursing profession itself. It is interesting to note that the idea of health professionals (including nurses) being involved in policy is enshrined within key primary health care literature and policy statements. For example, in interpreting and defining the Strategies from the Ottawa Charter for Health Promotion (WHO 1986) in a North American context, 'Intersectoral Collaboration' (one of the five strategies) was seen as encompassing a crucial policy role for health professionals:

It [intersectoral collaboration] also means that health professionals will participate in government policy formulation and evaluation, as well as in the design and delivery of healthcare systems. (ACPH 1994).

What Affects The Ability of Actors to Implement Policy?

On reflection, the fact that one of the managers was initially resistant to the research taking place in her organisation could have been because she was aware that staff, for a variety of reasons, were not in a position to effect change in relation to policy directives. One of the key tenets of Comstock's proposed strategy as discussed earlier is the importance of 'context'. The need to be aware of context when interpreting findings is also firmly embedded in the grounded theory literature (Gibson 2007). In terms of this study, the context, including what was happening in the five organisations regarding staffing levels and morale, competing priorities and organisational restructuring, all affected a particular PCT/ social enterprise's ability to implement change in response to policy directives. This may also have affected their willingness or ability to engage with my research study.

The key finding here was that the public health nurses were primarily restricted in their ability to implement policy because of lack of staff and resources. They talked about having to deliver a targeted, core service with a focus on priority interventions such as safeguarding children. Although this was in response to policy directives following major government commissioned reports and inquiries (The Hall Report, Hall and Elliman 2003; The Laming Inquiry, Laming, 2009), lack of resources prevented them from fully implementing policy from documents such as CAPLNHS and OHOCOS, with their focus on health promotion and support for people with long term health problems, as well as tackling health inequality.

That is not to say that the policies were not implemented at all. Some aspects, such as the drive towards inter-agency working promoted in OHOCOS, were seen in practice and were cited as examples by the research participants: in this case, the growth of their role with social services through children's centres. However, low morale was evident. The nurses talked of not having enough public health nurses and other members of the skill mix team (such as nursery nurses). This shortage of staff and other resources seriously impeded development and innovation in practice. In terms of implementation, it seems that the government had caused a policy-practice gap by being unwilling or unable to support policy promises with the resources necessary to implement them.

Another factor which affected policy implementation in some cases was a lack of clear direction and priority setting by managers. However, this was probably partly because they too were struggling to maintain a service in a context of severe resource limitations and were in 'fire-fighting' mode,

managing crises and unable to develop new services and initiatives in response to policies such as CAPLNHS and OHOCOS.

There is no doubt that this context had a massive impact on my findings: I was researching policy implementation and public health nurses' engagement with the policy process at a time where the whole service was in severe crisis. This contextual fact emerged as a central piece of my critical social theory perspective and issues around service cutbacks and their detrimental effect on innovation in practice also emerged in the next phase of the study, where I analysed extant documents.

Following the detailed policy analyses, which included primary data collected from the study's participants, I felt there were still gaps in my knowledge. After reflection and discussion with my research supervisors, I turned to a range of published evidence (secondary data) to enhance the analyses. Much of this was 'new' literature and publications, not included in the Literature Review section of this document. In this way I am following an established method in grounded theory, where literature and other documents including public records, government reports, mass media and internet discussions, are viewed as data. This is what Charmaz (2006) and other grounded theorists term 'extant texts'. Extant texts differ from elicited texts because the researcher does not construct them- they already exist. Charmaz (2006) says that extant texts can complement ethnographic and interview methods and Reinharz (1992) believes that they can be helpful in grounded theory studies by providing an independent source of data from the researcher's collected first-hand material.

This data was searched for using EBSCO databases including CINAHL and Medline, as well as social science indexes. Search terms and key words

included 'public health nursing', 'policy', 'politics' and policy-practice gap. 'Grey literature', such as technical reports, government documents, professional association publications and so on were accessed from Google Scholar, Google and Scirus. Findings from the secondary data was applied to the two documents CAPLNHS and OHOCOS and helped enhance my analytical understanding of them.

Having reviewed in-depth the findings from my first secondary data source (policy analyses), in the following chapter I go on to review and analyse the data from my subsequent secondary data source (extant documents)

Chapter 7

Findings from Extant Documents.

Following the detailed policy analyses, which included a re-analysis of primary data collected from the study's participants, I felt that there will still gaps in my knowledge. After reflection and discussion with my research supervisors, I turned to a range of published evidence (secondary data) to enhance the analyses. Much of this was 'new' literature and publications, not included in the Literature Review section of this document. In this way I am following an established method in grounded theory, where literature and other documents including public records, government reports, mass media and internet discussions, are viewed as data. This is what Charmaz (2006) and other grounded theorists term 'extant texts'. Extant texts differ from elicited texts because the researcher does not construct them- they already exist. Charmaz (2006) says that extant texts can complement ethnographic and interview methods and Reinharz (1992) believes that they can be helpful in grounded theory studies by providing an independent source of data from the researcher's collected first-hand material.

This data was searched for using EBSCO databases including CINAHL and Medline, as well as social science indexes. Search terms and key words included 'public health nursing', 'policy', 'politics' and policy-practice gap. Grey literature, such as technical reports, government documents, professional association publications and so on were accessed from Google Scholar, Google and Scirus. Findings from the secondary data was applied to the two documents CAPLNHS and OHOCOS and helped enhance my analytical understanding of them. These findings are discussed in Part 3 of the policy analysis section which follows.

Following Parts 1 (using the Popple and Leighninger framework) and 2 (further consideration of the public health nurse as Actor in the policy process) of the policy analyses, I concluded that some concepts needed to be explored further in order to give a more complete answer to my research questions. The focus was to find out more about the reciprocal relationship between policy and public health nursing. Having gleaned all the meaning I could from my primary data, supported by the policy analyses, I turned to secondary data (or extant texts) which I hoped would increase my understanding of the concepts. This method is in line with that proposed by Charmaz (2006), whose approach to grounded theory I followed in my work. For her, extant texts are a legitimate form of data in the grounded theory method:

Extant texts contrast with elicited texts in that the researcher does not affect their construction. Among those we might use are public records, government reports, organizational documents, mass media, literature, autobiographies, personal correspondence, Internet

discussions, and earlier qualitative materials from data banks. (Charmaz 2006: 37)

I followed Charmaz' advice on how to deal with these texts as data: she suggests that 'rather than assuming such texts are objective sources... uncontaminated by the researcher, you can treat them analytically as another source of data' (38). In essence, she views grounded theory methods as founded on facilitating emergence, and theory can emerge from all types of data, both primary and secondary sources.

One of the predominant themes which emerged from my primary data (telephone interview transcripts) was that of lack of resources severely limiting policy implementation. This was a source of great frustration for my study participants: they knew what the government policy proposals were, they supported many of them, but they were unable to incorporate them fully into their practice because of severe resource constraints. This had led them to adopt a 'crisis' service, focused around child protection and supporting the most vulnerable families and children on their caseloads. As well as being stressful work, they were unhappy about the lack of opportunity for them to be innovative in practice.

Mass Media.

A source of extant texts which dealt quite widely with this issue of cutbacks (latterly referred to by the coalition government from 2010 onward as 'efficiency savings') in both the NHS in general and public health nursing services in particular, was the mass media. The shortage of public health nurses, particularly health visitors, during the time period I carried out data collection for this study (January 2008 to April 2009), and indeed

subsequently, was severe. From 2005 onwards, the issue of cuts to community nursing services and the potential impact on clients was widely debated in the professional press (*Community Practitioner, Nursing Times*).

However, it was some years later that the problem had reached such critical mass that it began to be reported in the mass media, including national newspapers such as *The Daily Telegraph* (Adams 2010), *The Guardian* (Bowcott 2009), *The Independent* (Linden and Tapsfield 2010), *BBC News Online* (2010). The extent of this reportage in the mass media is unprecedented. I decided to include some of these reports as data in my study, and to analyse them to see if this could offer any contribution to my grounded theories. Guided by Charmaz once again, I analysed these extant texts (newspaper reports) in terms of 'form as well as content, audience as well as author and production of the text as well as presentation of it'. (Charmaz 2006: 40).

Services under Threat

Bowcott reported in *The Guardian* (2009) that 'Chronic shortage of NHS health visitors raises safety fears'. He explored how the 'chronic shortage of health visitors', particularly in London, has led to a reduced service, with a concentration on '...socially targeted visits'...neglecting those not deemed most at risk'. He quotes quite extensively from Norma Dudley, chair of the *Community Practitioners' and Health Visitors' Association* in London. For example, he reports her comment that the recommended HV: children on caseload ratio is 1: 350, but in the London borough of Hounslow, more than 2,000 children are being looked after by the equivalent of only 1.5 health visitor posts.

Having set the scene in terms of the risk this poses to children and families (particularly in the light of recommendations following the Baby P incident), Bowcott refers to the link between lack of resources and limited policy implementation. Again, he quotes Norma Dudley:

There are some wonderful [health] policies out there but they are not being carried out on the ground. Two experienced health visitor managers have resigned because they felt [their NHS] Trust was moving away from safe-practice guidelines.

This link is interesting as it is a form of secondary data which reinforces the finding from my primary data that lack of resources in public health nursing has stymied innovation in response to policy recommendations. In terms of the extent to which public health nurses 'have a say' in policy agendas (another key theme arising from my primary data) this article does include a public health nurse's 'voice'. Although the majority of the quotes are from the CPHVA Chair, Bowcott also quotes an anonymous 'CPHVA member' (presumably a practising health visitor) in Hounslow, who also mentions that two managers had resigned because they felt the service was dangerous and were opposed to staff nurses doing home visits previously carried out by health visitors. The article appears to acknowledge the skills of health visitors as specialist community practitioners, contrasting them with 'ordinary staff nurses' being used in a pilot project to carry out home visits in response to the shortfall in of health visitor numbers.

The tone of the article is largely supportive of the CPHVA's case and implicitly critical of the government cuts, as one might expect from The Guardian, the self-described 'world's leading liberal voice'. However, it still maintains a

journalistic impartiality, appearing unwilling to take the CPHVA's arguments at face value. For example, it reports that the CPHVA alleges that visits are now socially targeted and claims that more than 2000 children are being looked after in Hounslow by the equivalent of only 1.5 health visitor posts.

Victims/Partners/Specialists

At the opposite end of the political spectrum, The Daily Telegraph (Adams 2010) was also concerned about the implications of the severe health visitor shortage, this time around the possible negative effect on post natal depression statistics. The newspaper reported on a research study conducted by Professor Terry Brugha, a psychiatrist at Leicester University. This research found that, where there were sufficient numbers of health visitors, they could have a significant impact in preventing (as well as detecting) post natal depression. However, the article goes on to say that this potential health benefit is not being met due to the lack of health visitors- stating that '...in many areas the service is being cut, with health visitors unable to make just one visit to every new mother's home'. The implication in the article is that Professor Brugha and his team had hoped to train health visitors to develop their important role around post-natal depression prevention and detection, but they were unable to develop their project due to the shortages of front line staff. The article quotes Professor Brugha:

When the research team set out to repeat and develop further this research they were unable to make sufficient progress because in most parts of England there has been a substantial reduction in the number of health visitors funded by the NHS. Mothers were fortunate if they receive just one home visit from a health visitor. Health visitors were unable to take time off to undergo the extra training

in assessment of depression and psychological support approaches. Therefore the research team at the University of Leicester are now considering undertaking further research on prevention of depression in other parts of the world.

I find this quote interesting on many levels - related both to my research findings, but also in the light of my own experience in public health nursing practice. When I worked as a practising health visitor in the UK (1991- 1997), we were often grappling with the issue of how to measure our effectiveness and so to 'prove our worth' (at that time, to GP fundholders and other stakeholders who were deciding whether to 'purchase' our services) We also wanted 'evidence' of our effectiveness or otherwise in order to be accountable to ourselves as a profession. However, it was very difficult to 'measure' much of what we did, as it was focused around prevention, and effects were usually only seen over a long period of time (often years). It was commonly stated, often somewhat defensively, by health visitors that 'they will only notice our value once we are taken away'. We knew that our service did make a difference in clients' lives, and that if the service was reduced or discontinued, there could be a myriad of adverse health consequences (including increases in child abuse, (postnatal) depression, child behavioural problems and potentially a range of issues related to a decrease in health promotion interventions, such as obesity and hypertension).

It is interesting to see in the Telegraph article that Professor Brugha is lamenting just such a reduction in services. In the past, health visitors were active in the area of preventing and screening for postnatal depression, but now they were no longer able to do this crucial work because of lack of health visitors on the ground.

In terms of how it relates to the findings from my primary data,, health visitors themselves are also not given a 'voice' in this article, but they are given an advocate in a representative of a powerful professional group (psychiatry). This is something that has been lacking in the past, where community nurses have rarely received this powerful endorsement from fellow health professionals.

Like the Guardian article discussed above, the Telegraph article also clearly links to my research finding that lack of resources in public health nursing directly inhibit the implementation of government health policy. In this case, promotion of mental health is a key policy driver for both the former and current government, but the Adams (2010) article highlights how lack of public health nursing resources is directly impeding the implementation of government policy is mental health promotion.

There is no doubt that this key context issue around lack of resources had an enormous impact on my findings: I was researching policy implementation and public health nurses' engagement in the policy process at a time when the whole service was in severe crisis. This contextual fact emerged as a central piece of my critical social theory perspective. By going back to media reports and treating them as data, I was able to further support one of my key findings: that is, that lack of resources is severely impeding innovation in practice. It was also interesting to note how public health nurses themselves were portrayed in the press and how much 'power' they were afforded as actors in policy. I would argue that, in the media articles I looked at, they were not afforded much power. They were portrayed largely as impotent victims of the resource cuts who were not able to affect the negative picture in any meaningful way- apart from arguably in the case of the two health

visitor managers in Hounslow who had resigned over what they felt to be the unsafe practice of home visits being carried out by staff nurses rather than health visitors.

Organisational Documents.

In addition to the mass media, another enlightening source of extant documents as data was organisational documents. In terms of my finding that, for a variety of reasons, a policy- practice gap exists, I was interested to see how the organisations included in my study interpreted and presented their role as implementers of government policy. This quest took me to the websites of the four Primary Care Trusts and one Social Enterprise in my study. In the Strategic Plan from one of the PCTs (available on their website), a range of health priority areas and targets for the period 2010-2015 was outlined. These priorities reflected the broad direction of central government health policy as highlighted in CAPLNHS, OHOCOS and subsequent policy documents. In terms of triangulating my findings from the questionnaires and the telephone interviews, this strategic plan was interesting in that it alluded to the issue of having to implement new health strategies in a wider context of NHS cuts: 'The NHS is facing one of the toughest financial periods in its history. Our aspirations are set within that context and will require full-scale transformational change to the health services of the county. This ambitious plan outlines how we will lead the local NHS through the changing economic outlook'. I would say that this PCT is putting a positive spin on a very challenging situation: the struggle to meet its population's health needs at a time of severe resource cuts.

This PCTs Strategic Plan also recognises and acknowledges the importance of working with other agencies including local authorities, health and social care providers and the voluntary sector in order to achieve health gain. This echoes the strong message in OHOCOS that the health sector cannot achieve these gains working alone. The document also reflects key tenets of both CAPLNHS and OHOCOS (patient and public participation) when it acknowledges the role of the public who contributed to the planning through a series of public consultation exercises. Furthermore, the strategic plan emphasises the importance of a greater emphasis on health promotion and disease prevention (continuing the policy directives set out in CAPLNHS and OHOCOS).

Interestingly, the strategic plan includes a paragraph thanking the PCT staff for their role in the planning process. This indicates that this organisation sees its staff as having a role to play in policy development at a Trust level, and presumably they were consulted in drawing up health targets for the PCT. However, we do not learn from the Strategic Plan how staff were consulted and what their ongoing involvement in policy implementation and evaluation might be. (This would be outside the scope of a Strategic Plan).

Working Together with Others.

I wanted to find out if other extant documents were available which gave an idea of how the Trusts saw the role of health professionals (specifically public health nurses) in policy development, implementation, and evaluation. Looking on the website of one of the other PCTs in my study, I found a recruitment bulletin which gave me some interesting insights in this regard. Although I was not able to access full job descriptions, the vacancy postings gave some insight into what employers were looking for in prospective

specialist community public health nurses. The section 'You will develop and deliver plans to improve health outcomes for individuals and families and communities which contribute to the wider public health agenda...You will need to be adaptable and demonstrate the ability to innovate and improve services' for me spoke to an expectation that community nurses would (at least at some level) be involved in policy planning and strategic decision making.

From this brief job posting, I was also able to triangulate and validate another section of my findings from my primary data: that of specialist community practitioners becoming team leaders within a skill mix team. This was mentioned by respondents in the telephone interviews as both a positive development and negative development, as well as in other extant documents such as the Guardian article by Bowcott (2009) discussed above, where skill mix was portrayed as a largely negative development in response to cuts in numbers of specialist community practitioners.

In the job posting, skill mix was presented neither positively nor negatively, but rather as a reality in the new organisation of community nursing: 'Public health nursing is undergoing a significant change programme which is seeing the introduction of skill mix to teams who deliver services as part of a multi-disciplinary workforce. ...You should have excellent communication skills, be very organised and have the ability to lead a skill mixed team'.

Internet Discussions.

In addition to the media and the PCT websites, the third type of extant documents that augmented my data was that of internet discussions. Internet discussions are seen by Charmaz (2006) as a legitimate form of data

in grounded theory work. I was interested in determining the level of political engagement of nurses in general and public health nurses in particular and so I turned to the online professional journals and reviewed the 'comments threads' following opinion pieces and editorials on policy issues (as opposed to research or scholarly articles in the area of policy). I reviewed these articles and the subsequent online comments from nurses from the time of CAPLNHS and OHOCOS (in order to assess the amount of political dialogue engaged in by nurses in response to those two particular documents), and also more recent postings that had occurred in response to the current Conservative-Liberal Democrat alliance government's plans for sweeping changes throughout the NHS.

In the online version of the widely-read nurses' weekly professional journal Nursing Times (NursingTimes.net), I found a November 2007 article entitled 'Tool kit helps nurses understand primary care changes' (Nursing Times Online Editorial 2007). The piece outlined how The London Network for Nurses and Midwives decided to produce the toolkit after 'a series of discussion groups around government documents, including Creating a Patient Led NHS, revealed confusion surrounding the development of primary care'. The toolkit offered information on the commissioning process, particularly the importance of commissioning in relation to long term conditions. Crucially, the tool kit gave 'practical advice to community based nurses wanting to get involved in commissioning'. This is evidence of nurses engaging in the policy process: the London Network for Nurses and Midwives had clearly undertaken extended discussions around politics and policy and had gone on to produce a toolkit to help other nurses both understand policy and engage in the commissioning process. The toolkit was made available on the Royal College of Nursing website (www.rcn.org.uk), so a large number of

nurses (not just members of the London Network for Nurses and Midwives) would have had access to it.

Service Advocacy and Political Engagement.

A short article in Nursing Times from a journalist on the editorial team (Woogara 2011) included a call for nurses to be given a stronger voice in policy through the new commissioning consortia recently introduced by the alliance government. Woogara asks, 'Why haven't you automatically been granted a seat on the new commissioning consortia? Why do you have to fight for it? Who else can give such a unique view of the NHS? It seems like common sense to me....we need to encourage an ingrained cultural respect for nurses and what they do'. This article links to the *care2petitionsite* (www.thepetitionsite.com) and to a petition spearheaded by Nursing Times entitled 'Ensure nurses have real influence in shaping new NHS' (subtitled 'A Seat on The Board') and addressed to Andrew Lansley, MP, The Minister of Health. The petition's preamble presents an articulate and coherent argument for nurses' involvement in both commissioning and more generally in policy decisions:

Nursing Times believes that nurses must be actively involved in the new commissioning consortia being set up from now until April 2013, and that their involvement must be at the highest level. These consortia will determine the procurement and provision of services to patients in both primary and acute care situations. They will directly affect patient outcomes, safety and satisfaction with the decisions that they make in terms of buying and providing services, as well as the efficiency and

effectiveness of the NHS.

Nurses have previously been disenfranchised from commissioning services, but this new emphasis on local provision and procurement will present a real opportunity for nurses to share their knowledge, insight and expertise, and improve the NHS for all patients. Their focus on quality of care and their unique holistic view of the patient experience can ensure that these important concerns are raised from the very beginning of the commissioning process and care pathway.

While we recognise that GPs and other healthcare professionals - such as pharmacists and dentists - also have a part to play in commissioning, as the largest group of healthcare professionals, nurses must be represented on all boards. This is not just because of their impressive number, but because, unlike other healthcare professionals, nurses see patients in all situations - in the community, in patients' own homes and in hospitals. They also have the greatest amount of direct patient contact, which gives them a unique insight into the complex interplay of social, financial and environmental factors and their effects on their patients' health and responses to treatments. They are also in a position to understand the impact that patients' health and the care they receive has on families and carers.

Our campaign target is to ensure those bodies responsible

for issuing guidelines to commissioning consortia - that is namely the British Medical Association, the Royal College of General Practitioners, the NHS Alliance and the National Association of Primary Care - strongly advocate the statutory inclusion of at least one nurse on every consortium board.

Please sign our petition today to ensure that the new NHS will put patients - and those who know best how to look after them - at the heart of healthcare provision.

Thank you (A Seat on the Board, January 2011,
www.thepetitionsite.com)

The petition commenced on 1st December 2010, and by 27th January 2011 had 366 signatures: still somewhat short of the target of 10,000 signatures. However, comments from nurses and others who had signed the petition showed their deep commitment to the idea of nurses being involved in both the commissioning agenda in particular and to the policy agenda more generally:

My experience having worked within primary care for over 25 years is that local people have little say in their NHS service and the belief that GPs know what the local population health needs are will be based on the sick people who walk through their surgery door. Health and wellbeing is far wider than with families and people of all ages both the well and unwell and have the knowledge at local level that most GPs do not gain from the majority of their work within the confines of a practice surgery. Nurses are often overlooked in planning processes when their local knowledge is invaluable. It would appear

short sighted to place the onus of commissioning in the hands of GPs without drawing on the expertise of community nurses. (Comment no. 285
www.thepetitionsite.com 2011

Further evidence of nurses' engagement in the debate around the NHS changes proposed by the current Health Secretary, Andrew Lansley, was found on the nursingtimes.net website. In response to an article about a January 2011 NHS Confederation Report on the proposed new Health Bill (NHS Confederation 2011), the Nursing Times article (The Press Association 2011) states that the NHS Confederation Report accepts the need for NHS reform, but criticises the Health Secretary for 'failing to persuade patients or health professionals that his radical proposals will improve the NHS'. The article itself does not refer specifically to nurses' response to the new NHS agenda; dealing more with the response of GPs. However, the comments threads following it does reveal a level of political engagement from nurses, although the postings are not large in number (just 9 readers' comments appear).

The government seems so ideologically committed to its reorganisation of the NHS that it will not listen to the two groups who matter the most: the staff and the patients! Privatisation is the long-term agenda. The LibDems have yet again caved-in to Tory dogma.

This Government seems Hell bent on finishing what Maggie Thatcher started, that is finishing off the National Health Service. Not only by cutting essential services, but also dividing the workforce. We did not vote them in; they

did not win the election, is it not time to have a vote of no confidence?

I may well be out of step with previous comments, but I would like to make the following points. Privatisation of the NHS was started in 1980 by Maggie Thatcher, but those who think that New Labour have not continued with the process are being naive because they have. The NHS has always been a political football and always will be.....

Interestingly, all but one of the nine posts was posted anonymously. This may indicate a degree of discomfort amongst nurses about openly engaging in political debate and owning one's comments. It could reflect any number of concerns, from wanting to protect one's privacy to possibly a fear of reprisals in the workplace, or reluctance to see overt political engagement as something that 'nurses do'.

When searching Community Practitioner (the journal for health visitors, school nurses, nursery nurses and other community nurses working in primary care) using the terms 'Creating A Patient Led NHS' and 'Our Health, Our Care, Our Say', I found no returns in article titles, keywords or Abstracts. This suggests that the professional journal does not concern itself with detailed analysis of specific policy documents per se, although they might be mentioned in passing in editorials. However, I noticed that there were several scholarly articles in Community Practitioner which dealt more broadly with government policy as it pertained to the future role of community nurses (Brocklehurst 2004; Greenway 2008).

More recently, following the radical cuts and changes to the NHS suggested in the new Health and Social Care Bill 2010-11 (Lansley 2011)- (the Bill proposes the establishment of an independent NHS Board to allocate resources and provide commissioning guidance, increase GPs' powers to commission services on behalf of their patients, strengthen the role of the Care Quality Commission, develop Monitor, the body that currently regulates NHS foundation trusts, into an economic regulator to oversee aspects of access and competition in the NHS and, finally, to cut the number of health bodies including abolishing Primary Care Trusts and Strategic Health Authorities) - one sees in the professional journals more overt policy content, such as the editorial in the January 2011 edition of *Community Practitioner* by Communications Officer Shaun Noble:

As the battle to save the NHS from privatisation hots up, the most crucial date in that campaign could be 5 May 2011. This will be the electorate's biggest opportunity to date to pass on its verdict on the coalition's performance. Not only will voters cast their ballot papers in the English local elections and for devolved institutions in Scotland, Wales and Northern Ireland, but they will decide the fate of the Liberal Democrats' most cherished policy and *raison d'être*- whether to adopt the alternative vote (AV) system in general elections.

An upset in the local and devolved elections will cause the consummate PR man David Cameron to rethink the austere right-wing path that the coalition is treading. And a defeat of the AV proposal will cause even deeper fissures in the chaotic intellectual edifice that masquerades as modern Liberal Democrat ideology.

Government policy could be up for a dramatic U-turn following such an electoral kicking- and that includes the NHS, where changes may have started but won't have become irreversible.

.....It is unsurprising that the White Paper, cobbled together in just six weeks from the general election, is running into flak from many organisations including the British Medical Association, whose GP members will have to implement the proposals. Surely a classic case of hasty policy formulation making for poor legislation.

As the proverb goes: 'May you live in interesting times'. All times are interesting, but in 2011 they will be especially so. (Noble 2011: 3)

I read this as a thinly-veiled 'call to arms' for readers to engage both in the policy debate and, more directly, to vote against the Government at the upcoming local elections if they want to see a change in the proposed changes to the NHS. This indicates recognition by one of community nurses' major professional associations of the fact that nurses can make a difference when mobilised in this manner. The editorial takes a clear and unambiguous political stance here; being critical of the coalition's current 'austere right wing path'.

My impression when considering professional journals such as Nursing Times and Community Practitioner as extant documents is that these journals do not widely engage with and discuss individual policy documents such as CAPLNHS and OHOCOS (and subsequent White Papers). However, in times of proposed radical changes affecting service delivery such as the current Health

and Social Care Bill (Lansley 2011), political engagement by these journals is heightened considerably. This includes the recognition of their members as political citizens who potentially have a powerful individual and collective political voice, and can make their opinions known through the electoral process.

More recent documents have demonstrated the influence of and engagement in policy documents by public health nurses. An example of key players in public health nursing education, practice and leadership who came together to promote health visiting and suggest a new direction for health visiting into the 21st century was The United Kingdom Public Health Associations document *Health Visiting Matters* (UKPHA 2009). (Rees, 2012, personal communication). This report was a result of extensive collaboration with public health nurses through working groups and workshops and involved public health nurses in practice as well those from education and leadership. This extant document is a clear example of public health nurses directly becoming involved in policy – both clearly articulating the difficulties within the profession at that time (lack of funding and leadership), and giving succinct and achievable solutions in the form of recommendations for practice. These recommendations were:

- There is a need to establish secure funding for the health visiting service.
- There is a need to establish best practice criteria and leadership to support health
- Future employment options for health visitors need exploring

- There is a need to improve recruitment, education and regulation
- There is a need to strengthen the health visiting evidence base.

Another series of extant documents which highlight how health visitors seek to influence policy at the highest levels of government is Cowley and Bidmead's series of 'controversial questions' which were published in consecutive issues of *Community Practitioner* in June, July and August of 2009. (Cowley and Bidmead, 2009 a, 2009 b, 2009 c). The articles draw on Cowley and Bidmead's experience of providing evidence to the Health Select Committee's *Inquiry Into Health Inequalities 2008-2009* (House of Commons Health Committee, 2009) and address three pertinent and timely questions pertinent to health visiting and public health nursing. These questions were:

- What is the right size for a health visiting caseload?
- Should there be a direct-entry level route to health visitor education?
- Is there randomized controlled trial evidence for health visiting?

In addressing these areas of concern which they presented to the Health Select Committee, Cowley and Bidmead drew on the research evidence, but also their own considerable professional experience in public health education and practice and those of their peers. In this way, there was an opportunity for public health nurses to become actors in policy, either directly or indirectly.

In terms of whether the input by Cowley and Bidmead into the Select Committee proceedings actually did have an impact on practice, one needs to go to the subsequent policy document itself: *Inquiry Into Health Inequalities 2008-2009* (House of Commons Health Committee, 2009). In this

document, there is a paragraph relating to the role of health visitors and midwives in tackling inequality through early years interventions:

‘372: We have been told repeatedly that the early years offer a crucial opportunity to 'nip in the bud' health inequalities that will otherwise become entrenched and last a lifetime. While there is little evidence about the cost-effectiveness of current early years services, it seems odd that numbers of health visitors and midwives are falling, and members of both those professions report finding themselves increasingly unable to provide the health promotion services needed by the poorest families, at the same time as the Government reiterates its commitments to early-years' services. The Department must undertake research to find out the consequences of the decline in numbers of health visitors and midwives and to consider whether some aspects of the health promotion role played by midwives and health visitors could be effectively done by other types of staff.’
(House of Commons Health Committee 2009).

Whilst the Select Committee does not include the range of issues addressed by Cowley and Bidmead (2009) in their *controversial questions* series, still they did include in their report the importance evidence that Cowley and Bidmead had presented regarding the effectiveness of early interventions in families to combat inequality and the need to re-invest in health visiting and midwifery services.

A final recent government report *Health Visitor Implementation Plan 2011-15: A Call to Action* (DOH 2011) also recognises the importance and value of the health visiting service and proposes strategies to revitalize and reorientate it.

This policy, like the select committee report on health inequalities mentioned above, also gave public health nurses an opportunity to participate:

‘Health visitors in practice and in leadership roles have worked with the Department of Health to develop the key roles for health visitors, the new service vision and the family offer, and the profession has been welcoming and enthusiastic of the proposed approaches.’ (DOH 2011: 8).

The document also indicated an intention to continue the dialogue with bodies representing the opinions of nurses, including the Queens Nursing Institute, Royal College of Nursing and the Community Practitioners and Health Visitors Association (CPHVA).

The value of researching extant documents as a secondary source of data is that they served to present a different picture than that found in my primary data sources. Whilst the grass roots public health nurses in my study mostly spoke of being disengaged or disempowered from the policy process, some of the more recent government documents and policy papers charged with relaunching a beleaguered health visiting service (House of Commons Health Committee, 2009; Department of Health 2011) suggest that at least some of their colleagues are having a chance to engage in policy and are having some influence on the policy process.

Consideration of the more recent policy documents discussed above added to my understanding of how public health nurses can and do engage in policy: in this case, there was a rallying following a crisis in public health nursing funding and calls to address this.

Findings from extant documents helped me to address more fully research questions 2, 3 and 4: namely, how do they engage in the policy process, what affects their implementation of policy and is there a policy-practice gap? The next chapter consists of a summary of my findings from the all the data sources, together with a discussion of key points. I then go on to discuss what emerged from these findings in terms of new theory. Finding new theory which is grounded in the data is an essential outcome of the grounded theory process.

Chapter 8.

Discussion

In the previous chapters, the findings from the three data sources: primary data sources, policy analyses and extant documents, were considered. Findings were integrated with discussion of the findings in earlier chapters in order to highlight the iterative analysis and the building of new theory through a grounded theory approach.

In this chapter, I will briefly revisit and discuss the main findings from the data, before going on to the main focus of the Discussion chapter, which is to present and discuss *new theory* generated from the findings.

Review and Discussion of Findings from the Data.Primary Data Sources.

The original online scoping questionnaire revealed what the participants knew about the two policy papers: CAPLNHS and OHOCOS. It also highlighted the way they viewed their role within the policy making process; particularly around policy implementation. Twelve of the sixteen had heard of CAPLNHS and eleven had heard of OHOCOS. Of those who were aware of the policies,

there was a good broad understanding of the key policy drivers in both documents.

In CAPLNHS, respondents were able to articulate the main policy thrusts as: greater patient choice and control, a greater emphasis on (multidisciplinary) health promotion, the establishment of 'integrated networks' to provide care, and a greater voice for the patient/user. The majority were able to name the main policy drivers in OHOCOS as: organisational changes and shift of role for PCT's, changes in commissioning, greater integration of health and social services, a greater variety of service providers, and improved access to health care. The important theme of addressing health inequalities was not mentioned.

As well as articulating a good overall understanding of the policies and their contents, the original scoping questionnaire was an important phase within the grounded theory data collection process. Themes which emerged from the original scoping questionnaires which could then be explored further in the telephone interviews are highlighted in Figure 5.

The themes were further explored in the telephone interviews, using open-ended, unstructured questions. Rich data were elicited from the eight participants in the telephone interviews, and this data, along with verbatim quotes, is presented and discussed in Chapter 5 (Findings from Primary Sources). The major themes derived from the telephone interviews, using a grounded theory approach of constant comparative analysis, were: policies are having some impact on practice (for example, around inter-agency working and tackling health inequality), public health nurses see a role for themselves in policy and want to be more involved, lack of resources is inhibiting policy implementation, lack of resources is a government issue, the importance for public health nurses of 'having a say' in the policy agenda, public health nurses currently lack input and influence in the policy process,

and policy overload is a problem. These individual themes are discussed in more detail in Chapter 5. The overall findings for me were a powerful sense that public health nurses were disillusioned and under resourced. They had to focus on delivering a core service, and this caused them distress when they felt this core service was not meeting their clients' needs. They were aware of policy and believed they had a significant role to play in all phases of the policy process: development, implementation and evaluation. However, they felt that they had at best a tokenistic role in policy and wanted to have more of a voice.

In Chapter 6, I explore how I went on to carry out detailed analyses of the two policy documents under consideration: CAPLNHS and OHOCOS. The policy analyses used a combination of the frameworks proposed by Popple and Leighninger (2008) and by Walt and Gilson (1994). The findings from these analyses were treated as data in the grounded theory process. Popple and Leighninger's framework helped me develop a detailed understanding of the two White papers within their social, political and economic context. Walt and Gilson's emphasis on the centrality of Actors in the policy process enabled me to conceptualise the role of public health nurses as actual and potential Actors in the process. This was elicited through a critical social theory lens and helped me to answer two of my research questions:

- How do they engage in the policy process?
- What affects their implementation of policy?

The sense public health nurses had of being 'invisible' within the policy process that had emerged from my primary data, was further elucidated in extant documents which showed organisations such as the RCN campaigning for nurses having a greater voice in policy (RCN 2005). New scholarly sources

(not included in my original Literature Review) were also included as extant documents and again helped to shed light on the research questions. For example, Adams and Nelson's (2009) work helped to explain the constraints on nurses who desired to be political and engaged in policy, when historically they had been encouraged 'to do their work quietly and out of the limelight-to aspire to be invisible'. (Adams and Nelson 2009: 6).

Having collected and analysed a range of data from primary sources (original scoping questionnaire and telephone interviews) and the policy analyses, I realised that I still had some 'gaps' in terms of addressing my four main research questions:

- What do public health nurses know about policy?
- How do they engage in the policy process?
- What affects their implementation of policy?
- Is there a policy-practice gap?

Turning to a range of secondary data sources (extant documents) helped me to address these knowledge gaps. Table 1 shows how the various data sources helped to address the four research questions.

The findings from the data has been comprehensively presented and discussed in previous chapters (Chapter 5 'Findings from the Primary Sources', Chapter 6 'Findings from Policy Analyses'. Chapter 7 'Findings from Extant Documents') and the main findings are summarised above. I will now go on to discuss the new theory that was generated from this data.

New Theory Generated From The Research Findings

As well as answering the four initial research questions that I posed at the beginning of the study, I was able to use my data to develop new theory. The generation of new theory is an expected outcome of grounded theory. The three theories were developed around the following areas:

- A proposal for a new approach to policy analysis which leads to a comprehensive and analytical account of policy content and context, but also encompasses a detailed consideration of the importance of public health nurses as actors in the policy process.
- Explanations of why and how public health nurses currently lack influence in the policy process.
- Analysis of the effect of lack of resources on preventing practice innovation in response to policy agendas.

Theory 1

Through my analyses of two particular White Papers, I developed a new 3 stage approach to policy analysis which resulted in an integrated and comprehensive framework which may be replicated in the future. A combination of Popple and Leighninger's (2004) and Walt and Gilson's (1994) frameworks for policy analysis enabled me to produce a synergetic response to my research questions and to develop detailed and enlightening analyses which had public health nurses as actors at the centre of the analysis. The frameworks were used to guide and order my triangulated sources of data from questionnaires, interviews and extant documents. This enabled me to draw some interesting conclusions about a highly complex area: the

reciprocal impact of health policy on public health nursing and public health nursing on policy.

To summarise, my first grounded theory is the proposal of new and unique iterative, grounded theory research process for evaluating the reciprocal impact of health policy on public health nursing and public health nursing on policy. This is an approach which could be adopted by other researchers in the future.

Theory 2

Applying a critical social theory lens to my data analysis, I was able to develop a number of theories as to why public health nurses currently lack influence in the policy process. These have been discussed in the findings section. Barriers to full participation include lack of time and resources, issues around lack of status and decision making power afforded to nurses in comparison with some other professional groups and a lack of 'politicisation' of nurses, both in their educational programmes and subsequently as part of their professional identity.

Theory 2 encompasses the barriers to full participation in policy by public health nurses, as outlined above. These barriers need to be overcome in order to enhance their participation.

Theory 3

The most significant barrier to participation by public health nurses in the policy process is lack of resources. Although many research participants

identified policy development, implementation and evaluation as potentially a key and valuable part of their role, they were unable to be innovative in their practice in response to policy directives as a result of resource limitations over the past ten years or so forcing them to return to a core or crisis service. There was clearly a pronounced policy-practice gap, largely brought about not by lack of knowledge of policy, but lack of resources to implement it.

This, coupled with a feeling of 'policy overload' was a source of stress and frustration for public health nurses. Current proposals for radical reform to the NHS continue to find nurses alienated from the policy process and frustrated by their lack of influence (Watt 2011). Whilst they are able to voice their dissent in political terms (99% of nurses at the 2011 RCN Congress in Liverpool voted in favour of a motion of no confidence in Health Secretary Andrew Lansley, Watt 2011), still there is a continued lack of consultation and meaningful involvement of nurses at the policy development stage.

Theory 3 states that, because of the severe resource limitations at the time of my study, public health nurses were 'burned out', providing a reactive service and unable to be innovative in response to new policy directives.

In Chapter 10 (Implications of Research Findings and Recommendations for Practice) I revisit these theories and discuss possible ways in which the issues can be addressed.

As the research design was somewhat complex and involved several stages of data collection, in order to maximise transparency, I will summarise the process again here, with rationale. This will help the reader to see how the new theory was grounded in, and arose from, the research process. The

whole project was undertaken under the broad umbrella of critical social theory. This enabled me to critically evaluate the public health nurses' experiences of how context and processes either helped or hindered their engagement in the policy process, and also to consider concepts such as power and agency. The methodology was a grounded theory approach as proposed by Charmaz (2006). This approach is not prescriptive, and allows the researcher to adopt an iterative and fluid approach to theorising from data. Charmaz' approach also aligns well with critical social theory in that it espouses a grounded theory approach which is specifically designed for social research and encourages a move away from a positivist approach to undertaking grounded theory to a more constructivist approach.

The data were as comprehensive as possible and included the literature review findings, questionnaires, telephone interviews, policy analyses and review of extant documents. An initial review of the literature helped me to locate my research in context and to understand some of the theoretical issues around health policy and public health nursing practice. This review was added to throughout the research process. I was aware of the need to keep up to date with emerging work, particularly that around government policy in relation to public health nurse education and provision. The original on-line questionnaire allowed me to find out from public health nurses themselves both what they knew about specific government policies, and also what some of the issues were for them in terms of attempting to meet their mandate of having an 'influence on policies affecting health' (CETHV 1977). Because the online questionnaire included several open-ended questions, I was able to obtain some rich data from this phase. However, I found that this data generated as many questions as answers. These questions (as outlined in Figure 5)) could then be put to participants in the eight follow up telephone interviews. Again, rich and interesting data were obtained- the main themes

of which are explored in the Findings chapter. In the Findings chapter, there is extensive use of verbatim quotations. This was an attempt to bring the data 'alive' and also allows the research participants to speak and be heard in their own voices.

Although the findings from the literature review, online questionnaire and telephone interviews gave me a lot of data which I felt went a long way towards helping me to understand the reciprocal relationship between public health nursing policy and practice, still the picture was incomplete. It was at this stage that I decided to undertake detailed policy analyses of the two specific White Papers CAPLNHS and OHOCOS. The policy analyses were important in that they helped me to understand the content and the context of the policies in greater depth than would have been achieved by merely reading the White Papers. This greater understanding was necessary in order for me to gauge and evaluate the participants' own understandings: having carried out the policy analysis I returned to the questionnaire and telephone interview data and was able to interpret it in new ways. However, the policy analyses did more than just provide data about content and context. The act of carrying out the policy analyses using two specific frameworks helped me to bring a critical social theory lens to my interpretations of data. So, for example, Popple and Leighninger's (2008) framework encouraged me to consider under Social Analysis questions such as 'what are the major social values related to the problem addressed in the policy?' and 'who are the stakeholders?' Going on then to consider my data using Walt and Gilson's (1994) framework allowed me to reframe the public health nurses as key actors (or potential actors) within the policy process. Again, I asked questions of the data using a critical social theory lens. If they were not enabled to carry out their role as actors in the policy process, why might that be?

Going on to consider the policy analysis framework proposed by Walt and Gilson (1994- see Figure 1), I did not carry out another detailed policy analysis of CAPLNHS and OHOCOS using this framework. Instead, I re-evaluated existing data from the literature review, questionnaires and telephone interviews with the focus of the public health nurse as actor. This helped me to consider and address two of my four research questions, namely:

- How do public health nurses (actors) engage in the policy process?
- What affects the ability of these actors to implement policy?

This phase of data collection and analysis (using Walt and Gilson's model) enabled me to make links with critical social theorists such as Arendt (as discussed by Ingram, 2002), Holmes (2010) and Midgeley and Livermore (2009). This is discussed further on pages 190-195 of this document.

The final data collection stage was to collect and consider extant documents. These greatly enhanced my understanding of the processes involved in how, for example, health cuts had led to a return to a crisis service which had created low morale and stifled engagement and innovation amongst public health nurses. The rationale for including extant documents as data has been clearly outlined by Charmaz (2006).

Using three distinct data gathering processes (primary data, policy analyses and analysis of extant documents) allowed for the iterative emergence of themes which enabled the eventual building of new theory characteristic of a grounded theory approach. Integral to this was the policy analyses. The grounded theory approach adopted for this research enabled me to begin the process without preconceived ideas about the model or approach I would use for policy analysis.

The first part of the policy analysis process was to analyse the two particular White Papers (CAPLNHS and OHOCOS) using the Popple and Leighninger framework. This framework was useful in that encourages the analyst to go beyond mere description of the policy to a more analytical approach which views the policies critically in their broader social and political context. Using this framework enabled me to see the papers not as 'stand alone documents', but rather to view them as part of a policy continuum of prior and subsequent policy documents from the 1980's onwards (encompassing three different governments – Conservative, New Labour and, most recently, the Conservative-Social Democrat Coalition). I found this stage yielded some interesting and relevant data about the policies themselves; data which went on to inform subsequent stages of the policy analysis process.

In the second stage of the policy analysis, I was influenced by Walt and Gilson's model (1994) which sees the Actor as absolutely central not only to policy development, implementation and evaluation, but also to policy analysis. Although critical social theory was a thread throughout the whole of my work, and throughout the three stages of the policy analysis process, it particularly informed stage two of the policy analysis (the consideration of the Actor). As a critical social theorist, it was absolutely essential for me to include the perspectives of the public health nurses as actors in the policy process. By returning to their stories and perspectives in the open ended questionnaires and telephone interviews, I was able to build new theory about the relationship between practitioners and policy and to begin to explain the cause of the policy-practice gap.

There is some research which argues for the centrality of the actor within the policy process, but I did not find any research studies in the Literature which

provided a qualitative analysis of these actors' perspectives and experiences of engaging with policy. I did however find a quantitative study which looked at the extent to which national child health policy was reflected in health visitors' practice across the UK. This is the study by Condon (2008) which is discussed in the Literature Review of this document. As mentioned in the literature review, this was a large cross sectional survey involving the analysis of 1034 questionnaires in an attempt to see where health visitors' practice differed from child health strategies mandated in policy. Whilst I commend the author for the comprehensiveness of her work, it seems that this approach was only able to confirm the existence of a policy-practice gap, rather than explain why it existed. There was a general statement from the author that the practitioners did not appear to be 'on board' with the policy, but the broad brush, quantitative approach did not allow her to extrapolate participants' own lived experiences of engaging (or not) in the policy process.

Understanding the public health nurses' perspectives on the policy process is an area where I believe I have been able to contribute new knowledge to the study of the interface between policy and public health nursing practice in England. Jansson (2008) argues that, in effective policy analysis, criteria that rely on quantitative data are often enhanced by qualitative information. An example might be the political feasibility of implementing certain actions. In addition, what Jansson terms 'value-based criteria' such as social justice, confidentiality and self-determination, can also be included in a qualitative analysis.

Walters et al. (2000) were early advocates for 'putting more public in policy analysis'. They argued that effective policy analysis should involve public participation, since 'a persistent criticism of policy analysis is that it undermines basic democratic institutions and processes by replacing public

participation with expert analysis' (349). This interesting paper essentially takes a pragmatic view concerning what public participation can bring to policy analysis. Walters *et al.* (2000) argue that involving the public in policy formation and analysis can be advantageous in terms of educating and persuading them to embrace it and so to legitimize policy. This is somewhat in contrast to my own view, informed by a critical social theory paradigm, that public health nurses should be central to whole process of policy formation, implementation, evaluation and analysis because the policies concern them and their clients in a very real way. To exclude them and impose policy in a top down and bureaucratic manner leads to disengagement and often widens the policy-practice gap. Having said this, whilst I saw the public health nurses as important actors in the policy process and hope I enabled their voices to be heard through my research, I did not actually involve them fully in the process as policy analysts alongside myself. This is something I would consider in the future as part of a participatory action research study.

In the third stage of policy analysis, I reviewed a number of extant documents including national newspapers, professional journals, Trust websites and some supplementary literature. These documents helped to enhance the policy analyses by analysing how the profession and the Trust employers view the role of public health nurses in policy and political engagement. I also reviewed the media and electronic journals' discourse around government health policy and the politicisation of nurses.

Using the three stages of data analysis led to a comprehensive picture of the two specific White Papers, how these papers (and subsequently policies) were impacting public health nursing practice, and also, most interestingly for me, how nurses were engaging with the policy process and what factors inhibited or helped practice change in relation to policy directives (and consequently

widened or narrowed the policy-practice gap). Returning to my original research questions:

What do they know about the policies?

How do they engage in the policy process?

What affects their implementation of policy?

Is there a policy-practice gap?

I believe I was able to answer these critically and analytically. This was helped by both the critical social theory stance that I took and also the grounded theory methodology, through which the three stage policy analysis process was allowed to emerge organically. Grounded theory, using Charmaz' (2006) approach also helped me to adopt an iterative and open minded approach to primary data collection in Stage 2 of the analysis; where the public health nurses' voices became central to the policy analysis.

Although I have great interest in the engagement of public health nurses in the policy process, this was not something I knew much about prior to engaging in this research. In conducting the initial literature review, I was interested to note that the topic is not widely considered in the UK literature, although it is more commonly addressed in the North American context. From a critical social theory perspective, I found other research areas which are broadly aligned to my area of research, however. This included published research on topics such as how nurses educators can be more effective in 'politicising' nursing students: for example, through increasing the emphasis on social justice and global health issues in the nursing curriculum (Cohen and Reutter, 2007; Carnegie and Kiger 2009; Mill *et al.* 2010). Although it is beyond the scope of my research to discuss these findings in depth, I believe it is important to note that my work does sit within this broader critical social

theory discourse around how nursing education and practice (particularly community nursing) is influenced by and influences a wider political and social agenda.

As Walt and Gilson (1994: 353) note, 'focus on policy content diverts attention from understanding the processes which explain why desired policy outcomes fail to emerge'. Had I only used Popple and Leighninger's policy analysis framework to carry out a straightforward policy analysis of the two documents, I believe I would have gained knowledge about these two particular White Papers: however, I could have not claimed that this was 'new knowledge' in terms of new theory which is an anticipated result of using the grounded theory method. Walt and Gilson's model, with its emphasis on the centrality of the consideration of the Actor, calls for data which comes from these actors' perspectives. I believe that when such data is analysed and is combined with the more traditional discussions around policy content as context (which emerges primarily from the use of Popple and Leighninger's framework), together with the use of extant documents to create a deeper understanding, then a claim can be made for genuinely 'new knowledge', perhaps even new theory.

Through the questionnaires and interviews, I brought an interpretive approach to the policy analyses. I listened to the participants' stories, their understandings, values and beliefs about what Collins and Raymond (2006) term the 'messy' terrain of policy, with its attendant high degrees of interdependency, complexity and uncertainty. Such an approach to comprehensive, 360 degree policy analysis where the actors' perspectives augment and enhance knowledge gained through more traditional objective and 'analytical' methods has not been widely carried out before (or at least it has not been reported in the literature).

As well as answering the four initial research questions that I posed at the beginning of the study, I was able to use my data to develop new theory. The generation of new theory is an expected outcome of grounded theory. The three theories I developed can be summarised as follows:

- A proposal for a new approach to policy analysis which leads to a comprehensive and analytical account of policy content and context, but also encompasses a detailed consideration of the importance of public health nurses as actors in the policy process.
- Explanations of why and how public health nurses currently lack influence in the policy process.
- Analysis of the effect of lack of resources on preventing practice innovation in response to policy agendas.

Theory 1

Through my analyses of two particular White Papers, I developed a new 3 stage approach to policy analysis which resulted in an integrated and comprehensive framework which may be replicated in the future. A combination of Popple and Leighninger's (2004) and Walt and Gilson's (1994) frameworks for policy analysis enabled me to produce a synergetic response to my research questions and to develop detailed and enlightening analyses which had public health nurses as actors at the centre of the analysis. The frameworks were used to guide and order my triangulated sources of data from questionnaires, interviews and extant documents. This enabled me to draw some interesting conclusions about a highly complex area: the

reciprocal impact of health policy on public health nursing and public health nursing on policy.

Theory 2

Applying a critical social theory lens to my data analysis, I was able to develop a number of theories as to why public health nurses currently lack influence in the policy process. These have been discussed in the results section. Barriers to full participation include lack of time and resources, issues around lack of status and decision making power afforded to nurses in comparison with some other professional groups and a lack of 'politicisation' of nurses, both in their educational programmes and subsequently as part of their professional identity.

Theory 3

The most significant barrier to participation by public health nurses in the policy process is lack of resources. Although many research participants identified policy development, implementation and evaluation as potentially a key and valuable part of their role, they were unable to be innovative in their practice in response to policy directives as a result of resource limitations over the past ten years or so forcing them to return to a core or crisis service. There was clearly a pronounced policy-practice gap, largely brought about not by lack of knowledge of policy, but lack of resources to implement it.

This, coupled with a feeling of 'policy overload' was a source of stress and frustration for public health nurses. Current proposals for radical reform to the NHS continue to find nurses alienated from the policy process and

frustrated by their lack of influence (Watt 2011). Whilst they are able to voice their dissent in political terms (99% of nurses at the 2011 RCN Congress in Liverpool voted in favour of a motion of no confidence in Health Secretary Andrew Lansley, Watt 2011), still there is a continued lack of consultation and meaningful involvement of nurses at the policy development stage.

Strengths and Limitations of the Research

I will now review the strengths and limitations of my study. This not only helps my own learning in terms of reflection on the research process, but also helps the reader to evaluate the robustness of the findings and recommendations which are outlined in the following sections. In order to assess the extent of validity and reliability in my work, I have used the criteria for evaluating qualitative research proposed by Guba and Lincoln (1994). These criteria encompass the concepts of validity and reliability, but in a way that is less based in a realist, positivist model. For Guba and Lincoln, in much qualitative research there is an acknowledgement that there is more than one explanation or interpretation of social realities and they have proposed criteria for evaluation which reflect this interpretivist paradigm.

For Guba and Lincoln (1994) a qualitative study can be assessed using two main criteria: trustworthiness and authenticity. Trustworthiness is made up of four criteria, each of which has an equivalent concept in quantitative research:

- Credibility (internal validity)
- Transferability (external validity)
- Dependability (reliability)
- Confirmability (objectivity)

I will discuss the 'trustworthiness' of my research in terms of the four criteria before going on to assess its 'authenticity'.

Trustworthiness

Credibility

Establishing credibility of research according to Guba and Lincoln (1994) can be done by ensuring that research is carried out in line with good practice and also by preferably seeking respondent validation. I believe that my research was carried out ethically and in line with good research practice recommendations. An example is the informed consent process that I adhered to (see letter to potential participants in Appendix 1). However, a shortcoming of my study was that I did not seek respondent validation. The credibility of my findings could have been enhanced had I returned to the respondents having written up my findings from the telephone interviews to ensure that my findings were congruent with their views. In terms of whether the actual transcripts were credible, I am confident that the actual quotes used are indeed what the respondents said- this is because the interviews were recorded as MP3 files.

However, where I did not seek respondent validation was in returning to ask whether my analysis of their words was correct. If I were doing this type of research again, I would consider doing this. However, it is not without its difficulties, as suggested by Bryman (2004). He says that researchers have to analyze and interpret findings through a social science frame, and this may make their findings inaccessible or problematic for respondents to comment on in terms of how the researcher goes on to interpret and theorize from

their words. For some types of research, for example participatory action research, the researcher would have to involve his participants as co-analysers and theory builders and so would need to return to them for respondent validation of the findings. However, in a grounded theory approach such as I took, the researcher is primarily responsible for building theory, and so respondent validation of theory may not be necessary. What I did undertake to do, however, was to share my eventual research report with all participants.

A third way of enhancing credibility according to Guba and Lincoln (1994) is through the use of triangulation. Triangulation entails using more than one method or source of data in the study of social phenomena. I used triangulation in my work: a summary of my different methods and sources of data are summarised in the Table 1. . I believe this enhanced my study and gave it increased credibility than had I only used one method or source of data.

Transferability

In contrast to quantitative studies which emphasise breadth of data collection, qualitative approaches tend to emphasise depth. The difference can be seen when comparing my in-depth study of five primary care organisations with research conducted by Condon (2008), an account of which is included in this document's literature review. In her study, Condon aimed to assess the extent to which national child health promotion policy was reflected in health visitors' practice across the United Kingdom. She carried out a survey in 2005 of health visitors' Child Health Promotion Programme (CHPP) practice, taking a quantitative approach which resulted in 1043 returned surveys. Condon was able to claim generalisability or transferability across the context of England

from these findings (although as I argued in the literature review, these results may not be transferable to a UK context as the vast majority of respondent were from England). Nonetheless, one can definitely argue for transferability from Condon's findings which one could not claim for my own.

One way in which Guba and Lincoln (1994) say that transferability from qualitative studies can be enhanced is through the use of 'thick description': here, the researcher is encouraged to give a rich account of the setting(s) in which the research takes place. This enables the reader to understand the findings in context and to assess the extent to which the findings might be applicable to other contexts. In my work, I do not go into great detail about the five organisations included in the study, other than to say where they are situated geographically (in general terms- e.g. 'north east England') and what type of organisation they are (PCT or social enterprise). I also give some further detail when referring to the websites of certain organisations as a type of data from extant documents.

Although I believe that giving more contextual information would have afforded greater transferability of my results, I made a deliberate choice to limit this contextual information. The reason for this was that I wanted, as far as possible, to maintain anonymity of the organisations. This was something I had promised at the outset that organisations would not be identified in my final report, and, indeed, the anonymity of participants would also be protected. This was achieved through the use of pseudonyms, but also by not linking the participants with their organisations. This was mainly to protect the participants; where they may have made negative statements, they could not be traced back to a particular organisation either by their managers or by other readers of the final report.

I accept that this anonymity and lack of deep description of the different organisations may have limited transferability of my findings. However, I am comfortable with this, both because anonymity was an important guiding principle of my research (and aligns with the vital principal of credibility as discussed above) and also because I do not claim transferability of my findings. They are specific to these particular organisations at this particular time and are not necessarily transferable to other organisations. This is generally accepted as a feature of qualitative work: that is, it may not be possible to generalise from the findings.

However, I believe there are aspects of my findings which are generalisable. An example is the finding that lack of resources is severely hampering practice development and responses to new policy initiatives. This was a predominant theme in all five of the organisations in my study and, as cuts to services are occurring throughout England, I would hypothesise that this would be a generalisable finding to many or all primary care organisations in England. In this respect, there is an important contextual constant (resource limitations) throughout all organisations.

Dependability

This is an important criterion which is an equivalent concept to reliability in quantitative research. Reliability is concerned with the degree to which a measure of a concept is stable. In order to assess how dependable a piece of research is, Guba and Lincoln (1994) suggest that researchers adopt an 'auditing' approach. They recommend that the researcher keeps a complete record of the research process- including research question formulation, selection of research participants, fieldwork notes, interview transcripts, data analysis processes and so on. They suggest that peers then act as auditors,

either during the research process or at the end of it. Their role would be to establish how far proper procedures were followed, and would also include assessing the degree to which the theoretical inferences from the data can be justified.

To a large extent, my research supervisors Dr. Ann Hemingway and Dr. Jerry Warr acted as auditors. They were kept fully informed of the process of my research and offered guidance in terms of ensuring that proper procedures were followed. Concerning the second part of the dependability measure however- assessing the degree to which theoretical findings were sound- I did not ask my supervisors or a peer to review my raw data and comment on my findings. In retrospect, this is maybe something I could have done as a measure of the dependability of my findings. In practice however, this would be difficult in a grounded theory approach due to the ongoing and iterative nature of themes and theory development throughout the entire research process.

Confirmability

This fourth criterion of trustworthiness is concerned with ensuring that the researcher can be 'shown to have acted in good faith'. (Bryman 2004). This means that the work has not been overtly influenced by personal values or theoretical standpoints which have swayed the conduct of the research or the findings. At the same time, there is recognition that, in social research, complete objectivity is neither achievable nor necessarily desirable. Both my research philosophy (critical social theory) and methodology (grounded theory) accept a role for the researcher as an active voice in the research,

interpreting findings through their own particular lens. Having said this, I strove not to allow this lens to overwhelm the participants' perspectives and voices.

Guba and Lincoln (1994) propose that establishing confirmability should be one of the objectives of auditors. Again, as informal auditors, I believe my research supervisors helped to ensure a lack of overt bias within my work.

Authenticity

As well as the four criteria for evaluating the trustworthiness of a piece of research, Guba and Lincoln (1994) also suggest that research is evaluated in terms of its authenticity. These criteria raise a broader set of issues about the wider impact of the research. The five criteria concerned with establishing authenticity, as explained by Bryman (2004) are:

- Fairness: Does the research fairly represent different viewpoints among members of the social setting?
- Ontological authenticity: Does the research help members to arrive at a better understanding of their social milieu?
- Educative authenticity: Does the research help members to appreciate better the perspectives of other members of their social setting?
- Catalytic authenticity: Has the research acted as an impetus to members to engage in action to change their circumstances?
- Tactical authenticity: Has the research empowered members to take the steps necessary for engaging in actions? Bryman (2004: 276).

As Bryman (2004) suggests, Guba and Lincoln's (1994) criteria around authenticity have an affinity with action research. Whilst I did not adopt an action research approach, there are elements of the authenticity standard

which I believe my research meets. I hope that I did achieve fairness by correctly representing different participants' viewpoints. On sharing my research with participants, I hope they will be helped to appreciate perspectives of their peers and managers around policy issues (educative authority). Catalytic and tactical authority are dimensions which may be addressed following wider dissemination of my research. In terms of tactical authenticity, empowering public health nurses to engage in further actions around enhancing their role in the policy process is something I intend to do in further research or practice development work.

As well as considering the trustworthiness and authenticity of my research, I have reflected further on its strengths and limitations. During the course of the research, I was concerned at times at what I viewed to be comparatively low numbers of respondents to the online questionnaire. With many reminders and following up, my final numbers of respondents across all five organisations was sixteen. I can speculate as to why I did not receive more- pressure of time, lack of knowledge or interest in the subject area etc- but I do not really know why the response was comparatively low or what I might have done to improve it. I followed up several times through the managers, but eventually I ceased to do this as I did not want to harass them or coerce people into participating. Prior to starting phase 1 of data collection (the online questionnaires) I had in my mind a target of maybe ten responses from each organisation (fifty in all). So my actual number of responses fell some way short of this.

Low response rates can be a factor in postal or online surveys. One way I could have potentially increased the number of responses was by arranging to conduct face to face interviews or focus groups in the organisations themselves at a time when there was a 'captive audience'- for example,

following a staff meeting. However, due to my living and working outside the UK whilst conducting the research, this was not really feasible. However, the aim of the phase 1 data collection was to get an overview of participants' perceptions of the interface between policy and practice in order to develop themes for the interview questions for use in phase 2. I believe I was able to achieve this aim even with a relatively small number of respondents. I found that, even with only sixteen respondents, I reached saturation of data on most key themes. In phase 2 of the data collection (one to one telephone interviews) the eight respondents I talked to provided rich and enlightening data, and I believe the number of respondents in this phase was sufficient.

A strength of my approach, as mentioned previously, was that I did not rely solely on one data source (for example interviews) to answer my research questions. Triangulation allowed me to combine data from questionnaires, interviews, policy analyses and extant documents in an integrated way to address my research questions and to develop new theory. However, this form of iterative, ongoing data collection can create ethical problems for the researcher in that the changing requirements for data collection throughout the process can be problematic in terms of demands for anonymity and informed consent. One way I attempted to circumvent this was to ask participants in the initial on-line questionnaires if they would be prepared for me to follow up with them further in the telephone interviews. One of my telephone interviewees volunteered that I could call her email her at any time if I had follow-up questions. However, it might have been both logistically and ethically difficult to return to my other participants two or three years into the process to ask follow-up questions. This was another advantage of going to the extant documents to address and gaps in the data.

As stated in the introduction, my initial research question was to consider the impact of the two documents CAPLNHS and OHOCOS on public health nursing practice in England. In order to answer this question, I needed to start with an in depth policy analysis. This enabled me to understand the main policy directives in the documents within their context. Popple and Leighninger's framework helped me to structure the initial analysis and to ask the 'right questions'.

Following the first stage of the analysis, I went on to consider the role of public health nurses as actors (Walt and Gilson 1994) in the policy process.

Aimed at increasing my understanding of the role of public health nurses as actors in the policy process, my research questions were:

What do they know about the policies?

How do they engage in the policy process?

What affects their implementation of policy?

Is there a policy-practice gap?

A core part of my research involved analysing the policies using Popple and Leighninger's framework (2008). The emphasis that this framework puts on social and political analysis encouraged critical review of the policies in these two domains. This aligned with the critical social theory perspective I adopted throughout the research study. New knowledge was created when I went on to look in depth at the role of public health nurses as actors in the policy process (Walt and Gilson 1994), and combined this with the knowledge gained through analysis of the individual policies using Popple and Leighninger's framework. There are many examples of policy analyses in the literature and, as presented in this document's literature review, some discussion of the role of public health nurses in policy development and

implementation. However, there were no instances where the two approaches were combined as I did in this research.

Adopting this approach enabled me to produce a holistic and multi-dimensional account of public health nurses' role in the policy process, including whether they have a part to play in bridging the policy-practice gap. A policy analysis on its own is an interesting academic exercise. However, I believe this exercise was enhanced by critically evaluating the perspectives of the actors who are at the interface between policy and practice.

The critical social theory stance I took in analysing the responses from public health nurses caused me to examine the finding that nurses on the whole felt relatively powerless in the policy process and to ask 'why?'. Some explanations included nursing's historic lack of power as a profession when compared to other professions such as medicine. This is linked to both gender issues and to other factors such as stereotypes, a lack of visibility of nurses' scope of practice and a devaluation of discourses related to 'caring' and 'the body'. (Gordon and Nelson 2006; Adams and Nelson 2009).

As mentioned above, a key question for critical social theorists, once they have identified a phenomenon or problem (in this case, public health nurses are not empowered by society and their work context to be fully engaged in the policy process despite this being a mandated part of their role), is to ask what can be done about it. This relates to Gortner's call (2009) for social theorists to take seriously the charge for action and to address the 'consequential and liberating act' (Gortner 2009: 280)-that is 'what's to be done?'

There are a number of possible proposals which I believe might lead to public health nurses' more effective involvement in policy. Many of these solutions are based on examples of existing good practice, both in the UK and outside it. They will be discussed further in the recommendations section of this document, but, before I consider these recommendations, it is pertinent to draw some overall conclusions- these are presented in the following chapter.

Chapter 9

Conclusion

In summarising and drawing conclusions from the study, I need to ensure that I answer the original research question (Holloway and Walker 2000). The overall aim of the project was to use policy analysis to explore the reciprocal impact of health policy on public health nursing and public health nursing on policy and was to be operationalised by addressing the following four research questions:

What do they know about the policies?

How do they engage in the policy process?

What affects their implementation of policy?

Is there a policy-practice gap?

What Do They Know About The Policies?

From the questionnaires and telephone interviews, I found that the nurses who participated in my study knew a lot about the particular White Papers CAPLNHS (DOH 2005) and OHOCOS (DOH 2006). Having undertaken a detailed policy analysis of them using Popple and Leighninger's framework (2008), I was able to develop an in depth understanding of the two White Papers and this helped me determine the main policy thrusts of the two documents.

I found that the research participants had a good understanding of the documents' main priorities and how they were expected to impact on practice. They may not have had the detailed contextual and more academic knowledge of the papers that I was able to gain through undertaking the policy analyses, but they did have a good overall understanding of policy content.

Furthermore, the public health nurses were able to name several other policies which they felt were greatly influenced their current practice, including the government's strategy for children and young people's health, Healthy Lives, Brighter Futures (DOH 2009). I did not ask the public health nurses how they had acquired this knowledge of policy- for example, was it through their own reading of newspapers, professional journals or possibly through further education or professional courses. In retrospect, this would have been a relevant question to ask. Nonetheless, I was impressed by the depth and breadth of knowledge on policy (both on the two specific White Papers and more generally) possessed by the study participants.

It may have been that the self-selecting group who agreed to take part in the questionnaires and telephone interviews had more of an interest and understanding of policy than other public health nurses who did not take part in the study. However, the level of understanding and policy awareness demonstrated by those who did take part led me to conclude that they would be in a position to engage in the policy process. This leads me to the next research question: How do they engage in the policy process?

How Do They Engage in the Policy Process?

Through the examination of extant documents, there was some evidence that employers envision a role for public health nurses in policy development and implementation. An example is one of the recruitment bulletins I accessed for a health visiting post which stated that an expectation for health visitors to become involved in developing practice in response to a wider public health agenda: 'You will develop and deliver plans to improve health outcomes for individuals and families and communities which contribute to the wider public health agenda...You will need to be adaptable and demonstrate the ability to innovate and improve services.'

Public health nurses themselves spoke about wanting to be involved in policy. Many referred to the third principle of health visiting ('Influence on policies affecting health') as evidence that policy was a fundamental part of their role. They engage in policy in a number of ways: by being aware of and actively engaging in current policy, with evidence of critical engagement, by attempting to adapt their practice to reflect policy priorities (such as the move towards greater interprofessional working) and by attempting to influence policy. The attempts to influence policy were usually at an organisational level and not always successful. There was a feeling that consultation with practitioners on policy could amount to tokenism at times.

As far as engagement with policy at a national level was concerned, professional journals such as *Nursing Times* and *Community Practitioner* had extensive coverage of policy, for example the coalition government's proposals to reform the NHS. This coverage can be assumed to reflect the fact that the editors perceive a need for nurses to be 'policy aware' and engaged in the debate. However, the limited response by nurses in online discussion threads could indicate that this engagement is not widespread across the profession. This leads us into the next research question:

What Affects Their Implementation of Policy?

This question can be answered in two words: limited resources.

Overwhelmingly, all sources of data (primary data, policy analyses and secondary data) reflected that public health nurses were unable to spend time engaging in and influencing policy because of resource constraints. However, where this had the most constraining influence was probably in the area of policy implementation. Public health nurses had been forced by limited resources to provide a reactive, crisis response service mainly centred on safeguarding children. Although new policy initiatives continued to be produced, public health nurses were on the whole unable to respond (for example, to develop their services to support people of all ages who have long term health problems as mandated in both CAPLNHS and OHOCOS). This had a negative impact both on clients, but also on practitioners themselves who reported being burnt-out, frustrated and dissatisfied.

I hope that the current government initiative to educate more health visitors will partly ameliorate the situation, although more resources still need to be found for the beleaguered school nursing service.

The final research question pertained to the extent to which policy is played out in practice.

Is There A Policy - Practice Gap?

The short answer to this is 'yes'. Both primary and secondary data sources confirmed this. The main explanation appears to be the resource limitations discussed above which have severely hampered practice development and

innovation over recent years. However, I think there are also other dimensions to this problem. Public health nurses talked about the changes in management and service delivery that they had experienced in recent years. Within these changes, some reported that they no longer had a clear 'voice' in the policy process and felt that sometimes practice developments were being imposed in what they saw as an *ad hoc* manner. They perceived these developments as not always reflecting government priorities and not always being in the best interests of the client.

However, I find it is very difficult to separate these practice issues from that of resource limitations. For example, the directive from many Trusts to provide a targeted health visiting service with less home visiting may have been partly in response to policy (Hall and Elliman 2003), but was probably mainly instigated as a response to greatly reduced resources. Likewise, the need for school nurses to focus on screening and immunisation as opposed to health promotion (so being unable to breach the policy-practice gap in implementing Healthy Lives, Brighter Futures (DOH 2009) for example).

As well as answering the research questions as discussed above, I was able to propose three theories which I see as encompassing the 'new knowledge' which emerged from my work. The main points which emerged in terms of new knowledge/ theories were:

- The utilisation of a new integrated comprehensive 3 stage policy analysis involving primary data collection, application of two policy frameworks (Popple and Leighninger 2008 and Walt and Gilson 1994) to two specific White Papers (CAPLNHS and OHOCOS) and analysis of extant documents. This led to an in depth understanding of public health nurses as actors in the

policy process (including supports and constraints). This enabled me to examine and report of how public health nurses view themselves in the policy context. This is not something which has been widely reported in the literature to date.

- I was able to offer explanations for current barriers to public health nurses' meaningful participation in the policy process. These include lack of time and resources, lack of status and decision-making power and the current lack of 'politicisation' of nurses both in their education and as part of their professional identity and role.
- There is a clear policy-practice gap in public health nursing which can be partly explained by policy overload, lack of resources and the continued alienation of public health nurses from the policy process.

Although these last two points appear rather negative, in the next chapter I make some recommendations for how they can be addressed.

Chapter 10

Implications of Research Findings and Recommendations for Practice

Based on my findings, I have a number of recommendations concerning how public health nurses can be more effectively engaged in the policy process. With this greater engagement, I would hope that policies such as CAPLNHS and OHOCOS can be more comprehensively implemented in the future, helping to breach the policy practice gap. This recognises the crucial role of public health nurses in policy development, interpretation and implementation.

My findings support the work of Fyffe (2009) who, in a comparison of the situation in the UK and The U.S., concluded that strategies that support nurses and nursing to influence policy were in place (in the United Kingdom), but much could be learned from the U.S. She argues that more needs to be done in conjunction with all levels of nursing to 'find creative solutions that promote and increase the participation of nurses in the political process and health policy'. (Fyffe 2009: 698).

I will discuss my main recommendations under five headings: develop nurse education, enhance nursing leadership, encourage direct involvement of practicing nurses in policy at the government level, harness untapped potential of public health nursing staff in policy at the local organisational

level and government to fully invest in a comprehensive public health nursing service in order to address the policy-practice gap.

Recommendation 1: Develop Nurse Education

From my research findings, my first recommendation is that nurse education programmes develop a stronger curriculum emphasis on policy and politics. This would enable student nurses to become more politically aware and informed about both the policy process and their potential role within it. This is already taking place in some cases, and is a recommendations supported by other researchers in this area, including Fyffe (2009) and *Gebbie et al.* (2000). However, more could be done in this area. In order to increase nurses' effectiveness and influence in the policy arena, politics and social theory, including the ability to analyse research through a critical social theory lens, should be adopted. Wilson-Thomas (1995) advocates the adoption of critical social theory in nursing education to 'bridge the gap between theory, research and practice'. (568).

I could conceptualise the development of social policy and social theory being introduced as a key 'threshold concept' in all UK nursing curricula. Meyer and Land (2003) pioneered the concept of threshold concepts within higher education. For them, a key point is that threshold concepts may represent, or lead to, 'seeing things in a new way'. Nurse educators should be prepared for such topics as politics and social policy as initially presenting difficult or 'troublesome knowledge' (Meyer and Land 2003) for students, but ultimately as allowing them to see their role as nurses in an entirely new and potentially empowering way. This has been my own experience as a nurse educator- for example, when teaching social policy as part of an undergraduate community nursing module. Many students find the concepts difficult to grasp initially, or

they question what they have to do with 'nursing'. However, over time they are helped to cross the threshold and begin to incorporate these concepts into their ways of knowing and being as a nurse.

Meyer and Land (2003: 1) succinctly convey the idea of a 'threshold concept' thus:

A threshold concept can be considered as akin to a portal, opening up a new and previously inaccessible way of thinking about something. It represents a transformed way of understanding, or interpreting, or viewing something without which the learner cannot progress. As a consequence of comprehending a threshold concept there may thus be a transformed internal view of subject matter, subject landscape or even world view. This transformation may be sudden or it may be protracted over a considerable period of time, with the transition to understanding proving troublesome.

I believe it is only through enabling this transformed understanding through a new emphasis in nursing curricula on social and policy perspectives through a critical social theory lens that nurses can be prepared to meet the challenges of their untapped potential in policy development and implementation.

An excellent example of engaging graduate nurses in the policy agenda in a Canadian context (which could be adapted to a UK context) is a workshop and accompanying work book facilitated by the Canadian Nurses Association (CNA 2009) and aimed at enhancing nurses' capacity, strategies and tactics in influencing policy (CNA 2009). This workshop was developed in response to

the Canadian Nurses' Association's belief that '...nurses and nurses' associations often lack the skills, experience and leadership capacity to overcome their exclusion from policy processes' (Salewski *et al.* 2010: 51). The workshop has been delivered in Canada, and also with a number of the CNA's partners- national nursing associations in Vietnam, Southern Africa and Senegal. In Ethiopia, workshop facilitators from the CNA worked with the Ethiopian Nurses' Association to facilitate their becoming active participants in helping the government to introduce policy around health professional regulation and the accreditation of previously unregulated private schools of nursing. (Salewski 2010).

An important question to consider in connection with this recommendation ('Develop Nurse Education') is the extent to which nurse educators would be willing and able to integrate a course or module on policy and critical social theory into an already crowded curriculum. One would have to present a convincing argument (based on this research and that of others (Reutter and Kushner 2010), that these aspects should be introduced into the curriculum (possibly in place of others). Since carrying out my research, I, along with colleagues, have successfully developed and introduced such a course as an 'option course' for final year Bachelor of Nursing students at a university in Calgary, Canada. The course is entitled 'Influencing Health, Equity and Social Action'. When developing such courses, it is important to introduce students to concepts such as critical social theory, policy, social justice and so on not just as theoretical concepts, but also as key skills and guiding principles for practice. So, for example, students in our course are asked to compose a policy brief around a health issue of importance to them. Another challenge is to achieve this in a balanced way, 'without privileging particular ideologies'. (Parker, 2012, personal communication).

Whilst it may be difficult to make room for policy studies in an already full curriculum, there is evidence to show that this is a good investment of time in terms of students' later engagement in policy when they become registered nurses. For example, Byrd *et al.* (2012) found that active learning in public policy as part of a baccalaureate education program increased the knowledge and skills that future nurses need to influence public policy.

Recommendation 2: Enhance Nursing Leadership

A second recommendation is to increase and enhance the effectiveness of nursing leadership in the area of policy development and implementation. However, employing a critical lens, I need to be mindful of not explaining nurses' present lack of engagement as a problem intrinsic to nursing and wholly explained by knowledge deficits and lack of leadership. As Davies (2004) so rightly says, the concept of developing political leadership in nursing, while potentially helpful, does not take into account the 'cultural and structural disadvantage nursing operates within'. (Davies 2004: 236). She goes on to argue that nurses who increase their political awareness need to be able to do this whilst acknowledging 'the power of external forces and the way in which these may work against even the most skilled and aware'. (Davies 2004: 236). Any programme of education to increase political awareness amongst nurses would have to take these structural factors into account and try to prepare nurses to overcome them.

One means of enhancing nursing leaders' effectiveness in policy is to provide continuing education opportunities such as the RCN's Political Leadership Programme (Antrobus and Kitson 1999) or the Canadian Nurses' Association's workshop and accompanying workbook ('Influencing Public Policy- Capacity Building Strategies and Tactics'- Canadian Nurses' Association 2009)

discussed earlier. From her experience facilitating these workshops in Canada and in the CNA's partnership projects in Africa and Asia, Tanya Salewski from the CNA said that: 'training can make a big difference in helping nurses to directly influence health policy'. (Salewski 2010). Topics included in the workshops were strategies for defining policy issues and relating them to the mission and objectives of the organisation, identifying resources, building leadership skills, framing issues to achieve success, engaging stakeholders, working with allies and resisters, developing effective messages, working with the media and developing and using position statements and briefing notes. I would argue that such a practical, skills based approach (probably delivered to registered nurses) would effectively augment education around the more theoretical foundational learning around aspects of social policy and critical social theory (probably delivered to undergraduate nursing students).

Recommendation 3: Encourage Direct Involvement of Practicing Nurses In Policy Development and Analysis At Government Level

A third recommendation is to create opportunities for nurses to undertake policy fellowships or internships, as suggested by one of the research participants, Suzanne. This exposure to the world of policy making would hopefully serve to increase nurses' expertise in this area and their ability to influence policy both during the internship and subsequently on returning to the workforce and examples of good practice have been related in the literature. (Gebbie *et al.* 2000). As discussed previously, such fellowships are common in the U.S.A., where they are an 'integral part of the culture of nursing...and funding is available from a variety of sources'. (Fyffe 2009). If such a strategy were to be implemented in the UK, it might necessitate a return to the literature to see 'what works' elsewhere: for example, the Robert Wood Johnson fellowship which was mentioned in the literature

review of this document. (Gebbie et al 2000). Recommendations to address current structural and power issues which appear to limit nurses' involvement in policy through direct action reflects an important aspect of my critical social theory perspective. As Bryant (2009: 46) states, '...critical theory has a social action agenda which can democratize policy analysis'.

Recommendation 4: Enable Employers To Harness Untapped Potential of Public Health Nursing Staff In Policy At The Local Organisational Level

A fourth recommendation is for PCTs and other organisations employing public health nurses to consider ways in which they might harness and utilise the untapped potential of this group of staff to contribute more fully to policy development and implementation. As I found in my research, although some staff reported feeling already engaged in this process, the majority did not. I would recommend a shift from a 'top down' approach to implementing policy to a more 'bottom up' approach, which emphasises consultation with public health nurses and encourages them to own policy and practice. Those who are on the front line dealing with clients every day have great insights and knowledge that can help to guide practice development in a time of scarce resources. Their function as 'street level bureaucrats' will to a large extent determine the way in which policies are interpreted and implemented, so it makes sense for employees to acknowledge this and work with them. This would necessitate a shift in power relations and a willingness to bestow greater political and organisational power onto front line staff.

In terms of this shift of power, Collins and Ison (2006) note that Arnstein's ladder of citizen participation (Arnstein 1969, cited in Collins and Ison 2006) showed how much 'participation' does not result in a necessary concurrent

shift in power relations. This results in tokenism, where participation is not meaningful. The author suggest, therefore, that it is time to 'jump off Arnstein's ladder', and they look to social learning theory as a more useful mechanism for explaining and promoting participation within organisations. They see the move to increase participation as not being fully explained by a linear and hierarchical model as proposed by Arnstein. For policy making which involves participation by the public (or in my case, by the front line practitioners), Collins and Ison (2006) believe that one must confront a 'messy situation' and address the domains of an appreciation of context, constraints and conditions, institutional and organisational framings and practices, stakeholders and stakeholding and appropriate facilitation. Interestingly, they see policy development, particularly around participation issues, as a dynamic and context- driven process. This fits in with ideas in my work around the importance of context through a critical social theory lens. For Collins and Ison (2006), social learning theory should be used as an organising principle for policy making in complex and uncertain situations. For them, epistemologies of participation in policy development 'are grounded in the assertion that knowing occurs with the act, or the process, of 'constructing' an issue and seeking improvements, whereas traditional policy making instruments are built on an epistemological foundation of fixed forms of knowledge'.

This reminds me of Melissa, the school nurse in my study who commented that she had been involved in writing policy, but that it had '...gone up to the higher levels and never come back down...' I would suggest that PCTs and other organisations that wish to involve community nurses in policy making and implementation in meaningful ways which go beyond tokenism begin by looking at some of the recent literature on involvement in policy making such as that by Collins and Ison. This work builds on linear models such as that

proposed by Arnstein and reflects the complexities of enhancing participation in complex organisations, where context is constantly shifting. Whilst acknowledging the complexities, such work is also optimistic, believing that true participation can be achieved if there is a willingness to shift organisational practice.

Recommendation 5: Government Should Fully Invest in A Comprehensive Public Health Nursing Service In Order To Address The Current Policy-Practice Gap

A fifth and final recommendation is for government to reverse the trend of service cuts and for primary health care commissioners and social enterprises to fully invest in public health nursing services so that this sector can properly fulfil its crucial and unique role in implementing government health policy. This is currently being addressed in relation to the health visiting service, despite widespread cuts in many parts of the public sector. This reversal in policy is welcome, but comes following years of a policy implementation deficit caused by the service being reduced to a crisis intervention service.

Critical social theory was central to my research philosophy, and I believe it helped me to answer my research questions by going below the surface to ask what was happening at a structural and societal level that kept nurses relatively powerless in the political process. As discussed earlier, Holter and Kim (1995: 221) present seven steps of a critical research method as proposed by Comstock (1982, cited in Holter and Kim, 1995).

1. Identification of specific social agent(s) who are interested in change of practice and able to participate in research.

2. Development of a hermeneutic understanding of participants' meanings of the situation.
3. Empirical analyses of social structures and processes of the context.
4. Construction of integrated understanding through the dialectics of individual interpretations and meanings within a specific context with its history, structures and processes.
5. Enlightenment of participants of their oppression by identifying the elements of truth in an ideology from the context of falsity.
6. Emancipatory education of participants in which participants themselves develop new understandings and actions.
7. Participation in critical education that is a theoretically grounded program of action for the elimination of further social injustice.

Future research in this area and the implementation of the recommendations outlined above would involve a continued critical theory perspective, but with a (participatory) action research emphasis as opposed to a grounded theory approach. For example, I could work with teaching colleagues and nursing students to plan, implement and evaluate a programme of study on politics and policy as part of a community nursing module. This aligns closely with stages 6 and 7 in Comstock's framework.

The centrality of a critical social theory perspective in my work helped me to articulate my belief that public health nurses can and do already have an impact on health policy implementation, but that they should be empowered to have more of an impact on policy implementation, as well as policy development and implementation. Their potential influence on health (through political power) should be recognised and nurtured by public health practitioners and their leaders at all levels of health organisations. Sir

Kenneth Calman, former Chief Medical Officer of Scotland and England, recognised the impact of both group and individual action at all levels on the health agenda:

Health is very much a political issue (with a big 'P' and a small 'p'), and will not change unless those who have political power at all levels wish it to do so and the population want it to happen and see value in it. Almost all change is wrought through people, as individuals and as groups. (Calman 1999: 263).

At present, as found in my research and in other studies, nurses, both as individuals and as a professional group, do not yield a great amount of political power. However, with the acknowledgement of this fact, and a willingness to address it through educational and organisational means, this can change. However, I believe that the recommendations which emerged from my research would not necessarily be easy to implement. There is no 'quick fix'. They would take time and would depend on the willingness of public health nursing managers and practitioners, as well as those in more 'powerful' professional groups such as doctors, to see value in the involvement of nurses in policy and to be committed to making it happen. A current example of this is the RCN campaign for nurses to be included on the new Commissioning Consortia in primary care.

It is likely that this culture change would take time to develop. The fact that introducing more policy and political education into undergraduate or pre-registration nursing curricula is my first recommendation is a deliberate strategy. I believe that we have to start with education of new generations of nurses to think in new ways which would foster a practice environment that

values the 'bigger picture' in nursing and encourages nurses' involvement in a way that goes beyond tokenism. Owen- Mills (1995) argued for the development (in a New Zealand context) of a synthesis of caring practice and critical social theory in an 'emancipatory curriculum' where teachers are able to help nursing students to understand and engage with 'the mandate for social action'(1191). Whilst it is true that many nurses (particularly community nurses) are committed to policy work, there is great potential to harness the knowledge and enthusiasm of many more for this crucial work. However, this can only be achieved through organisational and structural means.

It should be noted that current government policy in the UK is to educate and train many more health visitors. (The target is 4,200 new HV's to be employed by 2015, Gainsbury and West, 2010). This process is currently underway, and it would be interesting to carry out further research in a few years' time to ascertain whether the greater number of health visitors and greater funding will allow for increased engagement in the policy agenda.

All of the above recommendations could potentially be applied not just in England, but also throughout Europe. However, consideration would have to be taken of the contexts and special considerations inherent to each country. For example, public health nursing is a stronger feature of some European countries (France, Scandinavia) than others. From my reading of the situation in the U.S. and Canada, I believe many of the suggested recommendations could be introduced there. This is reinforced by the work of authors such as Reutter and Williamson 2000; Rains and Barton-Kreise 2001; Stevens and Hall 2007; Wold *et al.*, 2008, and CNA 2009, who all discuss the importance of including a more secure base of political science and policy theory in nursing

curricular in a North American context (this aligns with my recommendation 1 above: 'enhance nurse education').

In some cases, as described earlier, the U.S. and Canada are ahead of what I found in England. For example, they have made greater strides towards involving practicing nurses directly in policy making and analysis at the national level (aligns with my recommendation 3 above).

An important question to address when considering this recommendation is where the resources would come from to re-invigorate the public health nursing services. A recent government report *Health Visitor Implementation Plan 2011-15: A Call to Action* (DOH 2011) recognises the importance and value of the health visiting service and proposes strategies to revitalize and reorientate it. However, it is unclear in this report where the money is going to come from.

Recommendations for Further Research

As discussed earlier, as a nurse educator I am particularly interested in carrying out further research related to my first recommendation around developing nurse education courses in policy and politics. This research would probably take a participatory action research approach, involving students, other educators and stakeholders (such as practicing community nurses) in developing and evaluating specific educational courses or materials. It would be important to return to the literature before embarking on such a project to see if there is evidence of existing successful strategies in this area. I agree with Carnegie and Kiger (2009), who argue that 'nurse educators must prepare nurses for political participation' (1976) and that this preparation is best delivered through a critical social theory lens. In this way, Carnegie and Kiger believe that nurses can be supported in developing a comprehensive

understanding of global and local policy, social justice and to work with communities in the pursuit of community health (1976). The educational emphasis on policy and politics would not just apply to pre-registration nursing courses, however. This has long been a core concept in post-registration courses which lead to qualification as specialist community public health nurse and would continue to be so. However, further development of these key concepts at both pre-and post-registration level is needed.

As well as a belief that these concepts would be best delivered through a critical social theory lens, I also believe that a critical social theory lens would best be used in much of the future research around nurse engagement in the policy process. This is because it both fits with the subject matter (policy and politics) and also because it encourages researchers to think critically, to go beneath the surface and to ask the 'why?' questions as well as the 'how?' questions.

In addition to my personal interest in future research around the effect of educational strategies in helping to enhanced nurses' involvement in policy (and perhaps to narrow the policy-practice gap), there are other potential areas of future research which could be explored. These include action research projects which help to facilitate and evaluate strategies discussed in my recommendations, including opportunities for policy internships and development of workshops for registered nurses who want to develop their skills in this area, along the lines of those facilitated by the Canadian Nurses Association. Because many of the examples of 'good practice' in harnessing nurses' enthusiasm and potential for policy work is found in a North American context, there is also the possibility of future research which involves participants from both the UK and Canada and /or the U.S.

Chapter 11

Some Reflections on the Research Process

When I come to reflect on the PhD research journey I have made over several years, it is very difficult to sum it up succinctly. A number of adjectives come to mind: including challenging, stimulating, time-consuming, anxiety-provoking, frustrating, and exhilarating: a roller-coaster which was ultimately enlightening. As discussed earlier, part of the uncertainty came from being a novice in grounded theory methodology. However, as Charmaz (2006) advises, I stuck with the process through uncertainty, in the knowledge (and hope) that significant findings and ultimately new theory would arise from the data.

Initially, it was not easy for me to articulate what that new theory is: that is, what links my findings to my recommendations? However, through the use of critical social theory I was able to think about my data in particular ways, and eventually to take a step back from that data and create new theory from it.

One theory is that traditional policy analysis as advocated by Popple and Leighninger (2008) in their comprehensive framework is insufficient because it does not allow for a thorough consideration of the actor in the process. This consideration is vital because it is the actor who both interprets and

implements policy and so can greatly influence the extent of any policy-practice gap. The theory of the importance of the actor in this process is not mine, but has been proposed by Walt and Gilson (1994) and others. Where I believe I have created new theory and new knowledge is in combining the policy analysis frameworks of both Popple and Leighninger and Walt and Gilson. This has led to a detailed and comprehensive policy analysis of two particular health White Papers, in terms of policy content and social and political analysis, but also in terms of how public health nurses played such a key role (as actors) in interpreting and implementing the policies at grassroots level. I did not find any examples of published policy analyses that had combined these approaches, or instances where the voices of the actors were heard to the extent that they were in my research. Also a new approach was in including 'findings' from my policy analyses as data to help address my research questions.

The process of listening to the voices of the public health nurses regarding their experiences of engaging in policy, and interpreting these voices through a grounded theory approach, was challenging, but ultimately rewarding. I was able to develop new knowledge and theory about public health nurses' engagement with the policy process which ultimately formed a basis for the recommendations made in this report. I found the nurses I spoke with on the whole saw a role for themselves in the policy process, but for various reasons felt alienated from the process. Through a critical social theory lens, I propose a theory that, in the professional and structural systems in which public health nursing is currently situated, nurses are greatly disempowered from fully engaging and realising their enormous potential in the area of policy development and implementation. There are multiple possible reasons for this: from nursing's low status and relative powerlessness as a profession when compared to other professions (historically linked to gender and to

other issues such as a lack of recognition of the legitimacy of 'caring' as a professional attribute), to the failure of nursing education to 'politicise' students and prepare them adequately for a policy role, to structural factors (mentioned by all of the participants in my study), where severe cuts and vacant case loads in public health nursing over the past ten years or so has necessitated a return to a core, crisis service (focused on child protection and vulnerable families and children). This has severely hampered (and in some cases prevented) innovation and new ways of working. In this respect, the government can produce any number of new policies, but without adequate staff and resources to implement them, the policy practice gap will never be breached.

I was able to meet the aims of my research in that the data I collected through policy analyses, questionnaires, one to one interviews and discourse analysis of extant documents helped me to answer my four original research questions (as outlined in Table 1.). Furthermore, through the grounded theory approach involving iterative data collection and analysis, I was able to create new theory around the reciprocal impact of health policy on public health nursing and public health nursing on policy, as discussed above.

Stimulating and interesting as this research journey has been, I am not yet at the end of the journey. I remain deeply interested in the area of community nurses' engagement in the policy process and plan to continue my research in this area. However, these plans will be approached with some trepidation as well as enthusiasm and commitment. As I make plans for further research, I find myself wholeheartedly agreeing with Howlett and Ramesh:

Public policy is a highly complex matter, consisting of a series of decisions, involving a large number of actors operating within the

confines of an amorphous, yet inescapable, institutional set-up, and employing a variety of instruments. Its complexity poses grave difficulties for those seeking a comprehensive understanding of the subject. (Howlett and Ramesh 1995: 198)

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Appendix 1

Letter To Participants



Vice-Chancellor:
Professor Paul Curran
BSc MBA PhD DSc CGeog
EROS FRSPS FCIM
Institute of Health & Community
Studies

January 2008

My name is Judy Gleeson. I have a professional background in nursing and health visiting practice and education. I am currently studying health policy and its impact on public health nursing practice as part of a research degree at Bournemouth University. This study has NHS ethical approval through the South West Research Ethics Committee and Research Governance Approval by your PCT.

I am contacting a number of public health nurses and managers in your organisation to see if they are able to participate in this study by filling out a questionnaire about current policy and practice issues in public health nursing. If you are willing to be involved, could you please complete the on-line questionnaire by clicking on the following link:

www.getfast.ca/students/index.cfm?Randomcourse=72695169. The password to access the questionnaire is policy. The questionnaire can be returned to me by clicking on 'submit' once you have finished filling it in.

By filling in and returning the questionnaire, your consent to take part in the study will be assumed and your answers will become part of the research

data to be analysed. Your answers will be treated in the strictest confidence. Your name and the details of the organisation you work for will not appear in the research report. If you have any questions or would like to discuss the project further, please do not hesitate to email me at jgleeson@bournemouth.ac.uk

I appreciate that you have a lot of demands on your time. Whilst your input would be valued, please do not feel under any pressure to participate in this study. If you wish to make a complaint about the way you have been approached or treated during the course of the research, please contact

Professor Kate Galvin
Head of Research
School of Health and Social Care
Royal London House
Christchurch Road
Bournemouth
Dorset BH1 3LT
Email: kgalvin@bournemouth.ac.uk.

If this questionnaire raises issues which you find stressful, please refer to me or your occupational health department.

Many thanks for your interest,
Yours sincerely,

Judy Gleeson
RN, HV, MA, BSc.

Appendix 2

Questions from Phase 1 Data Collection: On-Line Questionnaire

1. What is the name of the organization you work for?
2. What is your job title and role within this organization?
3. How long have you been employed by this organization?
4. Have you heard of a government White paper called 'CAPLNHS' (DOH 2005)?
5. If yes, can you outline some of the main policies put forward in this White Paper in the space below?
6. Have you heard of a government White paper called 'OHOCOS' (DOH 2006)?
7. If yes, can you outline some of the main policies put forward in this White Paper in the space below?
8. In the last two years, has there been a change in the way in which your service is managed?
9. If yes, please give examples of this change below.
10. In the last two years, has there been a change in the way in which your service is delivered?
11. If yes, please give examples of this change below.
12. Within your job, do you have a role in planning or delivering health promotion services? (Health promotion being 'the process of enabling people to increase control over, and improve, their health- WHO 1984)?
13. If yes, what are the main features of this role?
14. Within your job, do you have a role in planning or delivering services to people with long-term health problems? (e.g. diabetes, asthma).
15. If yes, what are the main features of this role?
16. In what way, if any, has the White Paper CAPLNHS had an impact on the management and/or 'on the ground' practice of public health nursing services in your organization?
17. In what way, if any, has the White Paper OHOCOS had an impact on the management and/or 'on the ground' practice of public health nursing services in your organization?
18. What factors enable and/or prevent you from changing practice or service delivery in response to government health policies/
19. Any other comments?

20. Would you be willing to take part in a telephone interview during phase 2 of this research project? If yes, could you please provide me with your name and a contact number where I can reach you during work hours?

Appendix 3

Emergent Themes from Original Scoping Questionnaires Which Were Further Explored in Follow Up Telephone Interviews.

The themes I identified from the questionnaires which were then explored in Phase 2 of the primary data collection process (telephone interviews) were:

- More centralized management- does this mean less opportunity for practitioners and line managers to make decisions. More detail/examples around this point.
- Do policies really affect practice in meaningful ways, or is it about 'ticking boxes'?
- Is there an issues re: staff cuts/shortages within your organisation? If so, how is this impacting on service delivery?
- To what extent are you engaging in multi-agency/ inter-professional working- e.g. using the Common Assessment Framework?
- Health promotion as collaborative process- examples.
- If you could name one government policy which has the greatest impact on your practice, what would it be? Why?
- More details on factors which enable/prevent them from changing practice or service delivery in relation to government policies.
- Do you think public health nurses could/should be more involved in policy development, implementation and evaluation? If so, in what ways?
- If you could name 1 or 2 priorities for health visiting/school nursing over the next 5 years, what would they be?
- Any other comment

Appendix 4

Coding and Memo Writing from Raw Data.

Telephone Interview 6: C.H. 26/2/2009.

J.G. : Do you think policy affects practice in meaningful ways, or is it just about ticking boxes?

Suzanne: Do you mean Government policy or PCT policy?

JG: I was thinking more Government policy.

Suzanne: Yes, do I think they really make a difference, or is it just a tick box thing?

JG: Yeah.

Suzanne: Umm, it would depend on what we were looking at because my mind is taken to a significant child protection incident in Haringay recently where, in the analysis, they were talking about the fact that the Government want children to stay with their families and so they don't remove them as quickly. And so in a way that might affect care on the ground and I perhaps see a bit of that in practice as well, but it seems to be a lack of resources that seems to affect what we're doing, and so I would imagine that ultimately that's a government issue.... **Lack of resources-government issue/problem**

JG: Yes, thank you for that because the lack of resource thing is something I'm hearing from lots of people. Has that been a particular problem in [name of PCT], Suzanne?

Suzanne: Yes, it has. I can give you an example if that helps?

JG: Yes please.

Suzanne: Well, one of the examples that's affected us personally is recently we lost a 3-day-a week health visitor at a very busy practice with a 60% ethnic minority caseload and well you know it's obvious that we do need this other health visitor post, but we were told they wouldn't be able to recruit because there was no money in the PCT. **Job losses**

JG: Oh dear...

Suzanne: Yeah, but now that has been overturned because we put a special case in for ouror a special case was put forward for our particular GP practice, and so now they are....but there is then a sort of 3 month period where this case load isn't

adequately covered- and it's because essentially there is no money. We also need to move out of our premises, because the premises we are in at the moment is extremely small and we're all falling over each other. But it seems to be a lack of money that's holding that up as well. **Had to fight for resources/'special case'**

Poor working conditions

JG: Right.

Suzanne: So ultimately that does affect the people that we are working for or working with... **Lack of resources- impact on clients**

JG: Oh thanks, that's a good example, yes. So I think that's a problem isn't it- all the policies going towards health visiting doing more and more and more, but resources aren't always following that.

Suzanne: Um, we've just had a Director of Nursing services come to do a ...look at the practices within [.....] area and she's going to make some radical changes, and so she's had a round of talks with us and she's looking at possibly stopping corporate working, going back to geographical and all these kinds of things...So at least we are having a say ... **Importance of voice being heard**

JG: That's good.

Suzanne: It just seems that umm you know, money is at the heart of everything and also equity of practice as well. Umm yeah....equity of **workload**. And that's even within each practice as well. For example, I'm sure you're aware of how they categorize Children In NeedChildren In Need are in blue folders, children under a Safeguarding plan are in red ,families needing extra input in yellow and children with a disability in green.

JG: Aha.

Suzanne: Well, you know , we might have 20 children in blue, but some of those might be heavier than others. So it's a way of working out...because some people are getting very stressed within the service, because you feel as if you're holding such a lot of work, quite a lot of emotive things..... I mean, what I was doing in practice when I first became a health visitor bears no resemblance to what I do now,

JG: Really? And it wasn't that long ago was it?

Suzanne: 2000, so it's 8 years.

JG: I think that's my perception- an awful lot's changed since then, yeah.

Suzanne: My role, although I started out as a searcher-out of health needs and health promoter and ill-health preventer, I'm now a Safeguarding nurse- that's what I feel like. **Core work: child protection**

JG: Right, yeah. And do you find, I'm sure you find that stressful, because you say you're holding on to all that

Suzanne: it is very stressful, because you go into a family to do an assessment so you base your assessment around that Triangle you know..d'you know what I...?

JG: Yes, that Common Assessment Framework?

Suzanne: Yes, that's right- where the three arms are parenting capacity, child developmental needs and environment and family factors. And so you go in and do

your assessment, but the things people tell you and the situations they find themselves in is sometimes dire and you're holding that until you can get some other voluntary and statutory agencies on board to start helping that family. You also have a very high level of drug use and a high level of people who have no status here...so a lot of Asylum Seekers, a lot of people who don't have English as their first language. And so that's why it's more difficult to be a health promoter or a public health nurse ...

JG: Yes, because you are more of a Crisis Management-type thing, yes it sounds like it's significantly changed in that time.

Suzanne: Yeah it has. We do have skill mix now. I'll just let you ask your questions. If you don't feel I'm answering the questions quite as I should, you could put them another way and...

JG: You're doing great! You're giving me lots of detail, thanks. I really wanted to know, cos I got some good information from the questionnaires, and it's just to follow up and say o.k. how is it at the moment where you are? What's kind of impacting on practice and it's great to hear...well, it's not great to hear cos it's quite stressful for people, but it puts it in a context for me, so that's great.

Suzanne: Yes, something we have ...we are now working with skill mix and it's the first time I've worked with skill mix, and so we've just got a community nursery nurse within the practice who obviously just does routine follow-ups and the OA hearing screens, behavior management and we also work closely with the Children's Centres and they are you know- they are brilliant...

JG: Yes.

Suzanne: And so we refer to the Children's Centres if we've got any err ...if a family has an issue like housing, debt, problems like that.....and so the Children's Centres are an excellent resource ,um, but we found around here as well is that the Core Program suggests that we have so many contacts and that we see as many people in the clinic, but the people around here don't come to clinic.....

JG: Oh, that's interesting....

Suzanne: ...and with the best will in the world , we have difficulty getting people out to attend things within the community.

JG: Right.

Suzanne: Some do, but they're not the ones you need to see!

JG: That's true. So does that mean you still have to do home visits then Chris to people?

Suzanne: We still have to do home visits to make sure that we get those contacts and to check the environment as well. We work closely with the CYPD as well- that's the Children and Young Peoples' Directorate so we work closely with social workers, and ofcourse we do quite a lot of observations and report back. So if there is a Safeguarding plan in place, whereby we are assessing home conditions, we're assessing parenting skills, we're assessing whether parents are putting in routine

boundaries and discipline, and then we report back to social workers- so we're doing a lot of that as well as part of Safeguarding children plans. **Implementing policy around inter-agency working in safeguarding children.**

JG: Right, so it sounds like there's a lot of multi-agency work- probably more going on now than there used to be. Would you agree?

Suzanne: Yes, there is and something that we are working with is something called the CAF the 'Common Assessment Framework' and that's a budget-holding.....the CAF has a budget ..it's part of the SHAPE team, so the SHAPE team work with the criteria for Every Child . And so obviously if there's a shortfall, you can apply for...you can make recommendation that this family should have a CAF , but the problem is it's the personnel who actually start the CAF off who is going to be the lead of the CAF- so who is going to hold the baton and pass the baton around. For example, if the CAF shows that there are many different needs like housing, benefits, drug work, er parenting, then each of the professionals makes an assessment to add towards that CAF- but it's such a very slow process because you might be doing your work and thinking, well, this isn't going to change actually until this person is able to move house, and then fighting for housing to do their bit, but there also seems a lot of Red Tape which prevents us from streamlining our work. For example, we can't access, or we've only just been able to access and we're still having problems with it- accessing a safe drive for us to write our case conference reports. **Barriers to inter-agency working in practice.**

JG: Right.

Suzanne: What we would usually have to do is write them in long-hand (well you probably could write them on a word-processing document, but you'd have to print them out that day so nothing's saved. And you'd then have to print it out and get it to the Safeguarding office for them to print it out and distribute it rather than just putting it straight on to the computer and email it.

JG: Right

Suzanne: So they're quite slow in getting electronic links going as well so it feels like.....sometimes it feels like we're not getting anywhere and you know you feel quite burnt-out because you know you try and access all the specialities yourself, so all multi agencies yourself- I'm talking about Housing , blood(?) workers etc. So you feel like something is being done so you're actually containing the family and giving them some confidence err in what's going to be done to help them. But it's exhausting you know and we you know , we don't have enough time to do it....

JG: Yeah, and what about student health visitors at the moment Chris, 'cos I heard that there was a freeze on training, but has that changed again?

Suzanne: Well, we had an intake in September, but they're employed as Band 5 as community nursery nurses on a programme, so there're actually,um, this is my understanding, they are um training insitu if you like and then they have to continue with their competencies, and they obviously still have a dissertation to do, but they are employed as Band 5..

JG: Oh, that's a bit different then so there's a bit more 'on the job' type learning..

Suzanne: Yes, which I think is a good thing , but obviously they have to do the theory behind it, especially the community part

JG: So this last September they did have an intake? That's good.

Suzanne: Yeah, they're not going to be doing any training ,like I know last September there was some money for the community practitioners' training- well, they're called Practice Educators and Practice Trainers. They want to educate and train, if that's the right word, practice teachers who can then become practice educators- I think that's the right way around. Basically what they want- and I think that would be good for Quality issues, so things like making sure the policies and protocols are being followed and if anybody has a question- for example, someone wants to know how long you've got to correct the documentation of a child's growth if they were born prematurely, something like that, or you wanted some more training on Schedule of Growing Skills or something like that, there would be some link person to help you to facilitate that. And, know, just making sure the Quality is remaining high.

JG: That seems like a good idea....

Suzanne: Cos it's the paperwork, I find it's the paperwork . We're all supposed to be putting our documentation under those 3 headings from the Common Assessment Framework or the Health Needs Assessment rather, and what we're supposed to be doing hopefully is when we document an initial assessment- which would be er the Health Needs Assessment, then, when we visit and make any sort of observation, obviously we have to use our analytical skills against our initial assessment as to what the problems are likely to be. So that we can obviously help with early intervention if that's possible. But usually there are significant needs for the child because of what's gone on historically. So what you're doing is you're working with 'damaged goods'

JG: Aha....

Suzanne: You know, damaged in terms of parents are finding it difficult and er, that's had a negative impact on the child. For example, you know a mother will use a dummy to pacify a child , rather than taking it for a walk and showing it the wonderful things that are in the park.....and then she does that, and that has a negative impact because it makes the child dependant on something and then it affects its speech and language skills.

J.G: Yeah, yeah...

Suzanne: And I don't know how you're going to make it better. It seems like parenting is such a public health issue ..it should start in primary school (laughs).

J.G. I agree- it's lots of things are taken for granted ..well we used to take them for granted, but I don't think we can anymore- about 'oh, people know that!" ...but no, we have to go back to basics really don't we?

Suzanne: Yeah, but the other side of that coin is that people know it but don't do it anyway. You know, I'm finding that parents are selfish- it feels like they aren't

prioritizing and they aren't putting their children before themselves. And I don't know where that's coming from- it's like in the news (and stop me if I'm ranting...)

JG: No, you're not...

Suzanne: Our teenage pregnancy rates are going up again. Well, why is that happening because there have been so many drives- it just feels like people don't care! **Disillusionment: policy (e.g. reducing teenage pregnancy) may not lead to actual changes for clients.**

JG: Yes, there's been so much resources put into that hasn't there?

Suzanne: Yeah, and I don't know how we can change that around...

JG: No, it's big- it's a cultural shift I think, it's a big society thing. That's interesting...so all the policies I guess are as good as how we are able to implement them on the ground aren't they?

Suzanne: And the people we employ to implement them because we have to really stand back a little bit to see what is going on for that parent. Are you familiar with the Solihull approach? **Importance of competent staff to implement policy/new practice initiatives.**

JG: Yes, I have heard of it. Tell me about it, because I've heard of it but that's about it.

Suzanne: Well, basically it looks at containment and reciprocity..and what you're doing is you observe- before you go in with a great long list of how they can change, and giving instructions..you go in and see what's happening for that person and their ability, their capacity if you like, for motivation to change what they're doing. Cos what's going to motivate that person to give that child a dummy rather than taking it out for a walk and doing something positive with it...you know, we have to look at that parent's capacity.

JG: Yes.

Suzanne: And so we have to get that person on side, we have to get them to trust us, we have to look at why they're doing that and their understanding....whether they've understood how this is affecting their child's development and how ultimately it's going to affect their speech and language which might affect them accessing what they need at school, which might then affect their emotional wellbeing....and so that, Judy, is time-consuming .And that's the problem It feels like they want us to go in, tick a load of boxes and then come out again. But it's not like that. And it's difficult to be able to articulate um what we do...because another move we've just had in this PCT is they're going back to 'diary sheets'

JG: Oh, are they?

Suzanne: Yeah, and so that means that on a daily basis we have to write down on a diary sheet everything that we do, which in itself is time-consuming. **? Lack of trust and professional autonomy? Need to account for what you do.**

JG: Sure.

Suzanne: But you know I can look at a day where I look back and I think I've had 4 visits, that's not seven and a half hours, but then I think well yes, I've telephoned so

and so ...you know your feet don't touch the ground. And so you've got to remember to put all the telephone calls in, every bit of 'oh yes, I popped to see so and so because they're having chemotherapy for this , that and the other...And you know, it feels like you're doing a lot of plate-spinning ...

JG: Yeah, and in a way they're saying 'what have you done today?', they're trying to quantify it and as you say it's so difficult to quantify. Surely it's more about quality isn't it?

Suzanne: Yes, especially if they do want us to start making a difference. We do have to work with people, and we have to engage with them and we have to let them know that we've got time to facilitate this change. Maybe it's that we can identify it, but somebody else can do that. But we need them, where are they? **Lack of resources- no staff to follow up on identified needs.**

JG: Where are they- that's true, It's definitely a resource issue ...

Suzanne: Yes. so, when you say about Government policy making changes, I think you know the money they've put into Sure Start and obviously in Children's Centres – it is going the right way, But obviously we need to keep, we all need to stay motivated to get people in to use the resources and to learn about child development and to feel confident in their parenting. So, in answer to your question , I suppose yes- it is changing and we are doing it, but it seems we are very much going uphill. **Policy can affect practice, but difficult, slow, 'going uphill'.**

JG: Yes, so in The Children's Centres then Chris, I'm not familiar with that because I'm actually in Canada at the moment....so some of the things I've been reading about, but I'm not hearing about first hand. So The Children's Centres- who runs that? Is it social services or is it Sure Start or....?

Suzanne: Well, the managers- I suppose they are an off-shoot from Sure Start- and so the managers um- we've just had a new manager who's been appointed and she does have a social services background, and so that's going to be an improvement in that service I think. And then she....people who have been employed are people who have been Community Family Workers in Social Services- they'll be part of the community team that go out and visit people in their homes.

JG: Right I see and so from what you're saying, the multi-agency working that seems to be something that is good and maybe over the past few years has really come out....

Suzanne: Yes. I do think it has improved, yes. **Example of successful policy implementation- multi-agency working**

JG: Great, thanks Chris- there's just a couple more questions. One is that I was wondering- because I'm looking at a particular couple of White Papers...that I just picked out really to look at, but obviously policy is coming out all the time. And if you could name one Government policy which you think has had the greatest impact on your practice, what d'you think that would be?

Suzanne: Ummm...

JG: If any- maybe none! It could be that they don't....

Suzanne: (Pause...)

JG: Somebody mentioned the.....

Suzanne: I think 'Every Child Matters' is a good one...is one that has affected my practice because what it does for me particularly is I keep those criteria in my head, and then when I'm looking at a child... because in this job I'm in now, what I find is my threshold is higher. **'Every Child Matters' an influential policy as safeguarding an important part of key HV work.**

JG: Right.

Suzanne: People who I see in this job I do now I would keep ticking along, whereas if I had seen them when I was first a Health Visitor, I would be referring in to social....I would probably be jumping up and down and be really worried about them. But I still try to keep in my head that they still need to be able to achieve and to access health ...you know, all the criteria- economic wellbeing, I can't remember them all off the top of my head...but I think that's quite a high standard to work to, but it's what the children do deserve to have.

JG: Yes.

Suzanne: Umm, what I find then could often be lacking is actually putting that in place or making sure they have that.

JG: Right.

Suzanne: It takes a long time to do...

JG: Yes, I can imagine! And like you say, it's a standard isn't it ...it's working towards...to those policies and saying 'O.K. I'm going to do this' ...I guess that's individual- maybe not all health visitors do do that d'you think?

Suzanne: Yes, well ...I couldn't say that. I think I'm nearly burnt out because I do try to. **Stress/difficulties of trying to implement new policy with limited resources.**

And I see that in the colleagues that I work with- they do the same. Er some other things that obviously impact on my practice are the cultural issues. For example, in the Indian culture they don't have toys- they don't have toys in the house at all. And so the house is very sparse, and so it's very difficult then to discuss and to help the family to understand that this will help their child develop...you know, and then we've got another ethnic minority who don't talk to their children

JG: Right..

Suzanne: ..and so they just feel that their children should be seen and not heard and they will just pick up language when they go to school and that's the school's...and then we have people from other ethnic minorities....um, Slovaks, for example, where they don't want to send their children to school until they're 7 and don't see any need to send their children to pre school...

JG: Right. Oh....

Suzanne: Yeah, and so these are the things that you're working with as well...and ofcourse when you're working with those you've also got to have an interpreter with you.

JG: Yes.

Suzanne: ..to be able to out those things across.

JG: D'you find you...are there enough interpreters around or not really?

CH: We've never had a problem with interpreters.

JG: Oh that's good.

CH: The PCT have just paid for Tapestry to do all our interpreting and so ..I mean it's still, obviously it's still time-consuming to arrange because you have to make a phone call to arrange an interpreter, and you have to call the interpreter, you have to make sure the parents are aware the interpreter's coming and it's a bit of a faff really...

JG: I can imagine....

CH: Yeah, but we do do it and it works very well.

JG: Yes, that's good that the service is there because in some areas that's not the case I guess so...

CH: Yes, and we use Language Line as well.

JG: One final thing that I was going to ask you- if you could have one or two priorities for health visiting over the next five years, what would they be?

CH: (Pause) Priorities for health visiting?

JG: Yes, I guess I'm saying for health visiting umm..in terms of the service- where would you like to see it going?

CH: Well, er, I'd like to see more skill mix er and, I'd like to see more in the way of health promotion where we're actually sort of doing more with the community rather than individuals. But I don't know how we'd achieve that in this area. And a way of remaining skilled- you know, being able to access all the training things , so that your caseload isn't so heavy that you don't feel as though you can take time off to do the training. **Priorities for health visiting: increase skill mix, increase health promotion role (links to CAPLNHS and OHOCOS) and increase numbers of health visitors (links to HV Implementation Plan 2011).**

JG: Yes.

CH: ..and policy thing- so I think it would probably be more health visitors (laughs).

JG: Yeah! I'm sure....

CH: so that's what we could do- more health visitors, but then also increase the skill mix as well, and perhaps make it equitable across the geographical area, because I'm sure there are pockets of areas where there are different types of needs like er the 'worried well' I suppose we would categorize them as whereas, you know, you're looking at research for them because they're looking at research on the Internet themselves, and so they want to have your input to reassure them. So there's that type of person. And then there's, on the other end of the scale, there's the person who isn't feeding their child three times a day.

JG: It is, it's such a spectrum really isn't it and um....

CH: Yeah, I think what the Service has got to do is look at who's doing what in more detail so that they can make the Service equitable. So that there might be one Health Visitor in the first type of team, but then there are obviously more health visitors in the teams that need more help. Because if you're looking at Maslow's Hierarchy of

Needs, then you need more Health Visitors to be able to help people achieve or the basic needs don't you, if they're not? **Need to put more HV's into deprived areas.**

JG: Yes, you do....and then others working at the top.

CH: if it's the self-actualization at the very top where yes all you're doing is confirming or otherwise or helping to critique a piece of research then in my book, you know they can go off and do that on their own...but the person who needs facilitating to put meals on the table, you know needs a lot of people to help them do that.

JG: I agree, yes...

CH: Or to search them out as well. Search them out and get them on board. Because you can get the skill-mix on board once you've made the plan, but you know you have to see these people.

JG: Yes and I think that's a key health visiting skill isn't it....about the searching out and finding the health needs really?

CH: Yeah, definitely.

JG: That's something that not everyone can do that as well so ,yeah...

CH: And for people to have the communication skills as well to be able to you know, to facilitate this open communication and get to the nitty gritty of what's happened with each family.... **Health assessment is skilled work- needs to be done by an HV**

JG: Yes, it's really skilled isn't it work like that? Which is not always recognized I think...

CH: No.

JG: But it is really skilled. And just then very finally- do you think, because you were mentioning before that there's quite a lot of consultation at the moment with health visitors about maybe going to corporate caseloads, that kind of thing, do you think that as a whole, health visitors or public health nurses, do you think they are involved enough in policy development and implementation, or d'you think they could do more?

CH: I think they could do more. They are highly-skilled practitioners who've got lots of ideas because they work ,you know, at the 'coal face' if you like. But I don't know that they're always given the opportunity to because of lack of time. I mean when we get policies and procedures through, we might scan them and then put them in so that we can then access them when we need to. So the answer I think is yes, definitely. Yes we could do more. And we've got a lot to offer in terms of information that would be valuable to say commissioners and um anything that affects our service. And the Government, you know... **HV's have a lack of control and influence over policy making at present: wasted potential.**

JG: I think so, they could have more input maybe directly into Government , The Department of Health and all that stuff- maybe seconding ...

Suzanne: Definitely.

JG:health visitors in. Because you know, you do know what's happening at the coal face and I think that would be good....

Suzanne: Yes, I mean you know what I feel with the situation at the moment, with this Director of Nursing Services coming in, and she's going to make some huge changes...you know I feel that she should just come and work in this practice for one week. Then she could see exactly what we are dealing with... **Decision-makers need to see what is going on at the 'coal face'.**

JG: That would be good.

Suzanne: Because I don't think ...you can't articulate it and it would take too much time to start talking about it and really going into enough detail, but I think they're going to have to do that to appreciate what we're doing...what we're holding.

JG: Yes. That would be really good wouldn't it?

Suzanne: I think that health visitors could, definitely should, er get more of a voice and get more involved in Government policy.

JG: Yes. I'm hoping that that's one of the things this Study might show- that they've got so much experience to give....and sometimes it's like this stuff is sent down from 'on high' you know, and they can be more involved.

Suzanne: Yes.

JG: And even in the evaluation of policy as well....so, we'll see.

Suzanne: Oh, definitely. But I would say one thing. That every Health Visitor I know is exhausted... **Stress, exhaustion, 'lost their fight'.**

JG: Yeah, I know..well I don't know but I keep hearing that...

Suzanne: And they have been managed a little bit , and so they've lost their fight...

JG: Aaaahh

Suzanne: Yes, and because they're working so hard a lot of them are burnt out. So we have to address a lot of that as well before we can move forwards with that...or employ some fresh ones to take up some of the..you know to ..I mean it may just be a management thing, I don't know, but that's what I can see in my area and so to be able to inform Government, we have to be able to give people opportunities like secondments maybe ..you know, to sit in a Government office or something like that... **Take out of practice role and second to government policy-making positions-like U.S. experience.**

JG: Yes, and actually feed into that ...as you say, when they're so burnt out and they're just rushing around trying to ...yeah, they'd have to be....

Suzanne: I don't think you'd be able to get a health visitor who is carrying a caseload to do anything, but you could second somebody to a Government department, and I think that that would be the way to go. But somebody who's working in an area that is representative of the people that we want to help. Because that way, that person would be able to inform the Government about what is actually happening, what they're finding, what the barriers are, what the drivers are for getting people to do things or not. Er, and then ...because they would have to be current, they would have

to be able to inform them, and I think that's what **Practitioners have an understanding of real issues which influence policy making and implementation.**

JG: Yes.

Suzanne: I'm going to have to go!

JG: Yes, well thank you so much Suzanne- that is brilliant information for me ...

Suzanne: O.K. you can call any other time, or just email me if you need anything else.

JG: I will do. And I'll let you have a copy of the Report when I finish it- which I don't know when that'll be...

Suzanne: Oh, thank you....I appreciate that.

Rich data, authentic data, commitment to the profession and to her clients very evident. Exhausted, but still able to fight for her clients. Angry that unable to provide an optimal service.

1.Code: Lack of Resources

Memo: A government issue because of cuts to service, but its impact is felt on the ground. Many problems arise from this theme of lack of resources- HV's having to fight for limited resources, returning to a core service (safeguarding), also personal cost – exhausted, demoralised. Identify needs, but unable to follow up. Inhibiting policy development by necessitating a return to a core service, inhibiting development of practice in response to policy.

Concepts: Lack of resources are inhibiting policy implementation

Lack of resources are a government issue

2.Code: Importance of being heard in the policy agenda

Memo: Those working at the 'coal face' understand 'how it is' for clients. This understanding could be helpful in policy making and implementation. Appreciates the times where their voices are heard (e.g. by senior management), but these are few and far between. Supports idea of HV's being seconded to gov'n policy making departments and having a voice at the table. Believes PHN's have the skills and capacity to do this.

Concepts: Public health nurses experience a lack of input and control in the policy process.

Public health nurses see a role for themselves in policy and want to be more involved.

Appendix 5

Policy Analysis Framework.

From Popple, P.R. and Leighninger, L. (2008) *The policy-based profession: An introduction to social welfare policy analysis for social workers. (4th ed.)*. Boston: Pearson Education. (p.37).

Part 1: Delineation and Overview of the Policy under Analysis:

- A. What is the specific policy or general area to be analysed?
- B. What is the nature of the problem being targeted by the policy?
 1. How is the problem defined?
 2. For whom is it a problem?
- C. What is the context of the policy being analyzed (i.e. how does this specific policy fit with other policies seeking to manage a social problem)?
- D. Choice analysis (i.e. what is the design of programs created by a policy and what are the alternatives to this design?)
 1. What are the bases of social allocation?
 2. What are the types of social provisions?
 3. What are the strategies for delivery of benefits?
 4. What are the methods of financing these provisions?

Part 2: Historical Analysis:

- A. What policies and programs were previously developed to deal with the problem? In other words, how has this problem been dealt with in the past?
- B. How has the specific policy/program under analysis developed over time?
 1. What people, or groups of people, initiated and/or promoted the policy?
 2. What people, or groups of people, opposed the policy?
- C. What does history tell us about effective/ineffective approaches to the problem being addressed?

- D. To what extent does the current policy/program incorporate the lessons of history?

Part 3: Social Analysis:

- A. Problem description
 - 1. How complete is our knowledge of the problem?
 - 2. Are our efforts to deal with the problem in accord with research findings?
 - 3. What population is affected by the problem?
 - a. Size
 - b. Defining characteristics
 - c. Distribution
- B. What theory or theories of human behavior are explicit or, more likely, implicit in the policy?
- C. What are major social values related to the problem and what value conflicts exist?
- D. What are the goals of the policy under analysis?
 - 1. Manifest (stated) goals?
 - 2. Latent (unstated) goals?
 - 3. Degree of consensus regarding goals
- E. What are the hypotheses implicit or explicit in the statement of the problem or goals?

Part 4: Economic Analysis:

- A. What are the effects and/or potential effects of the policy on the functioning of the economy as a whole- output, income, inflation, unemployment, and so forth? (macroeconomic analysis)
- B. What are the effects and/or potential effects of the policy on the behavior of individuals, firms, and markets- motivation to work, cost of rent, supply of commodities etc? (microeconomic analysis)
- C. Opportunity cost; cost/benefit analysis

Part 5: Political Analysis:

- A. Who are the major stakeholders regarding this particular policy/program?
 - 1. What is the power base of the policy/program's supporters?
 - 2. What is the power base of the policy/program's opponents?
 - 3. How well are the policy/program's intended beneficiaries represented in the ongoing development and implementation of the policy/program.
- B. How has the policy/program been legitimized? Is this basis for legitimation still current?
- C. To what extent is the policy/program an example of rational decision making, incremental change, or of change brought about by conflict?
- D. What are the political aspects of the implementation of the policy/program?

Part 6: Policy/Program Evaluation:

- A. What are the outcomes of the policy/program in relation to the stated goals?
- B. What are the unintended consequences of the policy/program?
- C. Is the policy/program cost effective?

Part 7: Current Proposals for Policy Reform

Appendix 6

Walt and Gilson's Model for Health Policy Analysis (1994).

