Exploring health visitors' interprofessional working experiences: implications for their collaborative public health role

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Abstract

Interprofessional working is key to delivering positive public health outcomes and reducing health inequalities which requires a whole system effort. Health visitors are key public health practitioners who can make a significant contribution to interprofessional teams working with individuals, families and communities to improve public health. However interprofessional relationships in a health visiting context are not well understood. This paper presents data from a larger grounded theory study reported elsewhere (Machin et al 2012) which included their interprofessional interactions. Theoretical sampling resulted in twenty interviews and ten observations from seventeen health visitors, in different work roles, in two community healthcare organisations. The category "interprofessional working" emerged from constant comparative analysis as one of four key data categories. Lack of role awareness and role overlap were identified as factors affecting the health visitors' interprofessional working relationships with doctors, nurses, nursery nurses and in interagency working. Interprofessional learning in health visitors' education and a health visitor commitment to workplace interaction with others, may improve clarity and awareness of their role, their experience and outcomes of their interprofessional public health working.

Introduction/ Background

Public health working requires health visitors to engage with others in a whole systems effort to address persistent health inequalities (Department of Health, 2010). Positive outcomes will be dependent on effective collaborative, interprofessional working. Interprofessional working can be defined as deliberate interactive partnership working toward a shared goal, between those in traditional professional roles but also including service users, communities and organisations (Barr et al 2005). Interprofessional team working is often characterised by: service user involvement; regular face to face interaction; collective decision making; shared goal setting; agreed roles and responsibilities; where the contribution of everyone is valued (Graham and Machin, 2009). This differs from more traditional multi-professional working models where professionals and services work more independently of each other, relying on referral mechanisms rather joint working to enable service user access to relevant services. National enquiries (Laming 2003; Laming 2009) have suggested that ineffective interprofessional relationships and cross system communication difficulties have in part contributed to failures in care. However health and social care systems are complex and there are many barriers to successful interprofessional working: such as lack of role understanding, unclear responsibilities, different funding streams and incompatible information sharing mechanisms (Valios, 2009).

Although health visitors are important practitioners who could lead interprofessional, family focused, public health teams (Department of Health, 2011), inconsistencies have been identified within the profession, in the general understanding of public health work in practice (Pearson et al 2000; Carr et al 2003; Brocklehurst 2004; Goodman-Brown and Appleton 2004; Smith 2004; Machin et al 2012). In part this can perhaps be attributed to the breadth of practice legitimised within the health visiting principles for practice (Cowley and Frost 2006). For example health visitors public health work might include: working with primary care teams in immunisation, smoking cessation and other healthy lifestyle behaviour change facilitation; working with social and voluntary services, promoting positive family mental health and a positive childhood experience; or with community groups enabling them to address their own public health priorities. This breadth presents a real challenge to

individual practitioners in prioritising their work (Machin et al 2012) and it illustrates the need for interprofessional and interagency working in health visiting.

Different professionals are likely to have been socialised with some differences in knowledge, skills, perspectives, and priorities (Clark, 2006). In any interprofessional team, agreeing which public health issues they should be addressed first and how, will be a challenge when they potentially include: medical and other health professionals; social care professionals; voluntary sector organisations; community groups; and importantly the individuals and families who can potentially benefit. For effective interprofessional working it is essential that team members understand and value each others' similarities, differences and perspectives (Derbyshire and Machin, 2011). This requires productive partnership working relationships. Building productive working relationships positively influences client outcomes in health visiting (Kendall, 1993; De Le Cuesta, 1994; Normandale, 2001). In addition, relationships with vulnerable families have been identified as key to tackling poverty through the public health role (Craig and Smith,1998; Smith, 2004). Concepts of collaboration, dialogue, advocacy and partnership have been identified as core contributory processes within the principles of health visiting (Cowley and Frost 2006, p.19). These apply as much to professional relationships as to health visitor client relationships. Although there are several research studies about health visitor client relationships, there is a gap in knowledge relating to the interprofessional relationship experiences of health visitors in a public health role context. In this paper, further data from a larger study reported elsewhere (Machin et al, 2012) is presented, focused on interprofessional working experiences of a group of health visitors. It aims to generate better understanding of key factors that may influence the public health practice of health visitors, as part of a whole system, interprofessional team. The original research process is presented here for context (Machin et al 2012).

Research design

A grounded theory (Glaser & Strauss, 1967) research design was used to generate theory about social issues and processes through participant and researcher interpretations (Chentiz and Swanson, 1986). Participants' accounts established theory (Strauss and Corbin, 1990) which was developed through "constant comparative analysis" (Glaser and Strauss, 1967 p.101). This is where theoretical sampling, data collection and increasingly theoretical data analysis occur concurrently no new data is adding to the emerging theory and "data saturation" is reached.

Ethics

Local research ethics committee approval and relevant organisational permissions were granted for the study and participants gave signed, informed consent.

Sampling

Theoretical sampling (Glaser and Strauss 1967) was undertaken whereby participants were selected over time, on the basis of their relevance to the themes and theoretical propositions identified through ongoing constant comparative data analysis (Glaser and Strauss 1967). In order to identify a range of potentially relevant characteristics in the sampling population, forty eight postal questionnaires were completed and returned by staff working in two participating community healthcare organisations. Answers to questions such as professional role, length of time qualified, percentage of time spent on public health work and types of public health activities undertaken were transferred onto a sampling matrix (Miles and Huberman, 1994). This was used to aid theoretical sampling. For example one health visitor was selected because they said their role was 100% public health, followed by another in the same role who said they did no public health work, through lack of time. Another indicated in an interview that there was a mismatch between their public health related health visitor education and practice reality, therefore a community practice teacher was chosen from the matrix next to explore educational issues further.

Data collection

Seventeen initial individual semi-structured interviews were undertaken. Three follow up interviews were also undertaken to explore changes over the time such as policy. An interview guide was used containing themes of relevance to the interview but which also allowed new lines of enquiry to emerge from participants (Strauss and Corbin, 1990). Interviews were recorded and data transcribed in full. Recordings and notes were stored securely, destroyed once the study ended. Direct observation of ten health visitors' practice, were also undertaken in the early phase of the study. This represented an opportunity to triangulate interview data to determine if what the participants were saying about their public health work was actually what could be seen in their practice. Observation field notes were taken and developed into expanded accounts immediately afterwards (Spradley, 1980). After ten observations it was clear that there was a close relationship between the observation and interview data and that the latter were a more effective way of exploring the issues in depth from participants' perspectives. Observations were stopped at that point. Fields notes were stored securely and destroyed once the study was complete. Data from interviews and observation formed a single set of data for the analysis, in keeping with the grounded theory notion that everything in the situation can be viewed as data and analysed to uncover the social processes existing in the setting (Clarke, 2005).

Data analysis

Transcripts were analysed line by line using, open, axial and theoretical coding (Strauss and Corbin, 1990 p.204-207). This meant reading transcripts, making notes in the margins to identify emerging issues of relevance then grouping these "codes" into themes. Themes were then grouped into data categories and attached labels which represented the grouping. These labels changed over time as sampling, data collection and data analysis progressed, becoming increasingly targeted and theoretical, until the labels attached became stable, providing confidence that data saturation had been achieved. Recordings were listened to again and transcripts re read in their entirety to ensure that the

categories and theory was consistent with the perceptions of participants in the context of the interview interaction, adding rigor to the process. Data analysis was also peer reviewed.

Findings

Data was collected from seventeen health visitors from a range of role settings including those in: caseload work, attached to GP practices; in corporate caseload teams; in specialist roles such as health visitor for transient families; and roles not entitled "health visitor", such as a general Trust manager. All participants but one were female and length of service as a health visitor varied between less than one year and more than twenty years. Three were community practice teachers. Four data categories were identified from the analysis (Figure 1): *professional role in action,* analysis of participants' actual roles seen and discussed; *professional role identity*, the core category linking the others, illustrating what impact the changes in public health role were having on participants' identity; *micro systems for practice*, analysing policy, frameworks and others structural influences on participants' identity; and *interprofessional working,* representing the influence of other people in the practice setting on role identity. The links between categories have been discussed elsewhere in relation to implications for the equilibrium of the identity of health visitors (Machin et al, 2012).

Data presented here are additional findings from the category interprofessional working (Figure 2) identified in the larger study (Machin et al, 2012). The aim of this paper is to better understand health visitors' interprofessional working experiences. Focusing on only one category enables a more in-depth discussion of its sub-categories and their relevance for health visitors' interprofessional public health working relationships. Participants are identified by number and the transcript line number source of the data quote identified.

Category: Interprofessional working

Sub-category: Working with Medical Professionals

Professional autonomy relating to interprofessional working with medical professionals was discussed. Most participants were PCT employed, yet GPs had some control over the health visitors' public health role:

> *With our practice the drive came from the GPs – would we set up a smoking cessation clinic because they were getting a lot of referrals (P2 42-44)*

One participant prioritised referrals from the GP:

> *Yes I do tend to do them as soon as possible. I suppose out of a sense of "obligation" - it must be worse for people based within the GP practice building. I'd never get any of my own work done for referrals from the GP (P2 Ob1)*

"Obligation" is used to suggest health visitors had to comply with the GP. This is at odds with the notion that all professionals have a level of autonomy (MacDonald, 1995). It does, however, suggest the continued existence of a hierarchy in the health professions (Turner, 1995).

Although participants generally felt valued by their GP colleagues, there was a perceived general lack of role awareness expressed:

> *Some GPs, don't really understand what health visitors do here ……. we get our 100% targets, so they're quite happy with that (P9 274-275)*

One health visitor felt that there had been a change in their relationships with the GP, because of public health targets such as smoking cessation which represented a shared goal. In this case, the targets represented opportunity to measure health visiting outcomes, perhaps leading to a greater interprofessional role understanding.

Sub-category: Working with Other Nurses

The term "role interchangeability" could be used to describe a situation in which different disciplines could undertake the same task with the same output. One participant described role interchangeability with the district nurses in their practice:

> *We have a weekly GP meeting on a Monday and the district nurses are there…so yes I will go and visit someone who has just come out of hospital having had an MI and has been commenced on NRT …. .(P2 78-89)*

. Another health visitor described role interchangeability a similar situation:

> *Either a district or myself will get a referral just to see if there's anything, you know, support etc.. (P10 380-382)*

This might be explained by the core skills both roles have from their pre-registration preparation for nursing practice. However some health visitor participants did attempt to differentiate themselves from nurses they worked with:

> *A lot of the district nurses ..would argue that they can provide that level of em, public health that health visitors do as well and we're generic….do they really have a specialist skill to address other family concerns? (P16 492-495)*

Several participants described changes in collaborative public health working with school nurses:

> *For my first two years as a health visitor I liaised with them* [school nurses]*every year when I was handing over children who were starting school but I didn't really get very involved with them and now we are hoping to set up a group in a school to try and tackle smoking and obesity (P2 257-262).*

This change in practice was attributed to locally facilitated development work as part of a national initiative to promote public health practice development in health visiting (DOH 2001a). This is an

example of how policy change can positively influence interprofessional public health working, although it is of note that funding, time out and training was available for these initiatives, in order to enable the interprofessional team to work together.

Sub-category: Working with Nursery Nurses

The nursery nurse was valued highly by participants:

> *We've got a nursery nurse who's excellent who shares within the team…. (P8 300)*

Whilst their support was highly valued, Young-Murphy's study (Young-Murphy, unpublished observations 2007) indicated that the health visitor - nursery nurse working relationship can be difficult in practice, with potential issues arising around control, responsibility, trust and role clarity. Although some role overlap may exist between health visitors and nursery nurses around specific tasks, there were clear limits to this observed, in relation to more medically oriented health visiting practice:

> *Mum asked NN about baby being off his food and a bit off colour. Told will need to speak to health visitor. (P2 Ob1)*

Not all participants were positive about the development of health visitor led public health teams employing skill mix to deliver health visiting, described in strong terms by one participant:

> *A "nightmare situation" (P17)*

For successful interprofessional working with children and families there is a need to acknowledge the necessary existence of role overlap, balanced with recognition of the unique contribution each practitioner in the collaborative working situation (Graham and Machin, 2009). This is likely to require the facilitation of interprofessional workforce development.

Sub-category: The Inter-agency Dimension

Cross agency working was identified as essential to improve public health however participants acknowledged that it will need time to develop due to its complexity:

> *They'd need to work together .....to make this thing work and trying to co-ordinate and facilitate that on the scale that you know, it needs to be is quite a task for the time that people have .. (P8 432-434)*

Some participants suggested a power imbalance existed between health visitors and others in the interprofessional team:

> *It seems to me certain people have a lot of influence* [in cross agency working] *and we've* [health visitors] *have got loads of information that nobody asks us about (P3 183-185)*

> *In a lot of places the voice of health visiting and public health hasn't been heard .....(P16 470)*

> *What I'm finding increasingly difficult is with cross-organisational discussions, is the perception of other organisations about health for social care ……. they don't seem to be able to value or understand our* [health visitors'] *contribution (P14 72-85)*

These examples convey a sense of disempowerment, perhaps linked to a lack of understanding of the health visiting contribution to cross agency public health working context; for example, their knowledge of local networks and established relationships with community members. However, another participant talked about their own lack of awareness of the social work role:

> *We had no real understanding of what their* [social worker] *job was….that was unfortunate because given the kind of close links you had to develop.. with social services, particularly in areas of great deprivation, it kind of almost provided barriers that were unnecessary, if you had a bit more information about how each other worked (P17 290-25)*

Professional stereotypes were also an identified cause of misunderstanding, impacting negatively on the experience of inter-professional working:

> *But I think how we're perceived also depends on the sort of fixed cultural stereotypes…. I think that is a real barrier to try and change and make progress on (P14 95-97)*

Unhelpful stereotypes are a well recognised a barrier to interprofessional working and one of the drivers for interprofessional education (Carpenter, 1997).

Discussion

The aim of this paper is to explore the interprofessional working experiences of a group of health visitors and their implications for the health visiting collaborative public health role. Although the findings presented were drawn from a qualitative study and not intended to be generalisable to all health visitors, their "fit" (Strauss and Corbin 1990) with professional debate and other research suggests they are likely to have wider relevance for others working in interprofessional teams and implications for their practice.

The experiences of study participants indicated a perception that doctors are sometimes either unaware of or have an unclear understanding of the scope of the health visiting role, outside of how their work can impact on public health related practice targets. There was also a perception that an informal professional hierarchy existed which meant the doctor had some influence on their role, despite them valuing their autonomy. Professional hierarchies have been identified as a potential barrier to true collaborative interprofessional working where each professional's input is valued equally (Lingard 2012). Participants also reported a lack of awareness of the potential for health visiting input into public health work in an interagency setting. One participant did acknowledge however, that their own awareness of the role of others in this context was sometimes limited. Role awareness is well documented as important in interprofessional working (Meads and Ashcroft, 2005). A lack of understanding of the health visiting public health role and the role of others in the team presents a potential barrier to productive public health interprofessional working relationships. For example, building relationships with communities and their residents to address the social

determinants of health inequalities is at the heart of current public health and health visiting policy (Department of Health 2010; Department of Health 2011). Health visitors working in a locality are likely to have pre-existing relationship with families living there and through this an understanding of the difficulties they face. Raising awareness of and utilising that knowledge and those relationships could save any new interprofessional public health initiative significant time and money in the planning stages. However unless the interprofessional team is working effectively, actively seeking to learn about and value each other's role contribution, this health visiting resource could go unused.

Role overlap was also noted in participants' work with nursery nurses, other nurses and in interagency public health working. Given the potential breadth of the health visitor public health role described earlier, it is perhaps inevitable that aspects of it will overlap with others, especially around core professional skills such as assessment, relationship building, advocacy, information giving, empowerment and safeguarding (QAA 2006). However this breadth of practice has in part contributed to a lack of a consensus on the health visitors' perception of their role in public health in the local setting of participants reflecting the national picture (Smith, 2004; Machin et al, 2012). Differences in the way in which the health visiting role is executed may cause role confusion for the interprofessional team, especially where large teams involving several health visitors, are undertaking collaborative public health work at a population level. This has implications for practice because role confusion can lead to unclear responsibilities, duplication of work and an increased risk that something important is missed.

The Common Assessment Framework (Department for Education, 2009) for children and the Single Assessment Process (Department of Health, 2007) process for older people, are examples of national systems put in place to facilitate clarity in collaborative working and avoid unnecessary duplication of effort. However on-going implementation evaluations indicate difficulties due in part to lack of role understanding (Brandon et al, 2006). This suggests that system change does not in itself always lead to improved role awareness in interprofessional working. If health visitors are to engage productively in interprofessional public health working there is a clear need for them to ensure that they have the skills and confidence to enable those within their team understand their role and its contribution.

Interprofessional learning (IPL) is identified as a key strategy for securing the collaborative practice needed to improve global public health and the quality of healthcare delivery through the development of interprofessional, collaborative working knowledge and skills (Hammick et al, 2007; World Health Organisation, 2009). It was introduced into UK pre-registration health professional education, including nursing, as a means of minimising potential barriers to safe, effective inter-professional practice. Through IPL professionals and students can learn about each other's role, where they overlap and where they are different, through interactively challenging each others' unhelpful professional stereotypes and role misconceptions, thereby developing mutual role respect (CAIPE, 2012). IPL differs from the traditional approach of learning about other professional roles by observing or shadowing them in practice. Although the latter is still a valuable role modelling exercise and develops health visitor students' knowledge of the range of roles and services available for public health work, it is IPL that provides the opportunity for the development of interprofessional working skills, as a foundation for the collaborative public health role.

Although IPL was not the focus of this study, it is likely that some participants will have experienced it in their pre-registration nurse education, though perhaps not those who qualified as health visitors before IPL was enshrined in policy (Department of Health, 2001b). However, the relevance of their IPL as a nurse may not readily transfer to a health visiting context. Other data from this study published elsewhere (Machin et al 2012) suggested that many participants had moved away from a strong nursing identity, perceiving their role as a health visitor to be something different, a new role developed through additional specialist educational preparation (Nursing and Midwifery Council 2004). This suggests that new health visitors may need further support to learn to confidently articulate their health visiting role to others. Providers of health visitor education should consider how they can create and use IPL more effectively to prepare students for the complexities of interprofessional working in public health and improve others' understanding of their health visiting role; for example, learning interactively with GPs in training or social work students with the specific aim of improving interprofessional working. Once equipped with the interprofessional working skills

and confidence needed, instead of accepting lack of role awareness as a barrier to interprofessional working, individual health visitors could be proactive, creating opportunities for improved interprofessional interaction in their own workplace, thereby taking responsibility to ensure practice colleagues understand their unique health visiting public health role contribution.

Conclusion

This paper has presented the interprofessional working experiences of a group of health visitors. It has shown that interprofessional relationships can influence their public health role. The complex interplay between individual and team in an interprofessional context is evident. Interprofessional learning can potentially improve the interprofessional working experience of health visitors. However, further research is needed to determine the degree to which it makes a difference. It is only through effective working relationships with other disciplines across whole systems that health visitors can hope to make a significant contribution to addressing public health priorities and health inequalities.

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Keywords

Interprofessional working, qualitative research, health visiting, nursing

Key points

- Relationships with other professionals are important to the success of the health visiting contribution to public health
- Health visitors in this study worked interprofessionally with doctors, nursery nurses, other nurses and in interagency settings.
- Their experience of interprofessional working, both positive and negative, influenced how they viewed themselves in their role.
- Lack of role awareness and unclear role overlap affected the health visitors' interprofessional public health working.
- Interprofessional education in health visiting education provides an opportunity to promote the health visitor role, to clarify role boundaries, minimise the development of unhelpful stereotypes and foster mutual trust.
- Further research is needed to determine the impact of interprofessional education on the interprofessional public health role of health visitors and its outcomes.

Further Reading

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