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Yorkshire and The Humber

Work redesign and health promotion in healthcare organisations: a review of the literature

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Introduction

Making Every Contact Count (MECC) is a long-term strategy deployed by NHS Yorkshire and the Humber which aims to ensure that NHS staff take every opportunity to help patients and visitors make informed choices about their health related behaviours, lifestyle and health service utilisation. It uses the *Prevention and Lifestyle Behaviour Change Competence Framework* (PLBCCF) designed to enable the NHS staff to develop knowledge and skills in addressing the health and wellbeing needs of the local population in the following areas: long term conditions; smoking; falls prevention; alcohol abuse; obesity management; medicines management; physical health; and mental health and emotional wellbeing. The framework was launched in February 2010 and is being used by ten NHS trusts across the region and beyond (NHS Yorkshire and the Humber 2011a; 2011b).

This literature review has been commissioned to inform the design of the initial MECC evaluation. It will briefly discuss recent academic literature relevant to the programme. The purpose of this discussion is threefold. First, it will attempt to combine the sources from two distinct domains: literature on work redesign, on the one hand, and literature on health promotion implementation programmes, on the other hand, thus reflecting the fact that MECC could be viewed as a workforce development intervention operating in the field of health promotion. Secondly, it will aim to identify major gaps in the academic literature in relation to work redesign in health promotion. Finally, the review will produce a list of broad research questions for the programme evaluation.

The review is structured in the following way. The first section explores the literature on job redesign and workforce management in the context of health services, touching upon the classification of work redesign approaches, contextual challenges to implementing workforce redesign at different levels, and lessons learned from a number of work redesign initiatives. The second section examines the role of non-specialist public health workforce in health promotion interventions in primary, secondary and community care, touches upon the applicability of competency frameworks in health promotion and discusses results obtained from the evaluation of a large-scale health promotion initiative. The third section summarises the key points of the

previous discussion, identifies the main gaps in empirical evidence and proposes a number of research questions for the evaluation of the MECC initiative.

Work redesign in healthcare organisations

Background

In their extensive literature review on health workforce management, Dubois and Singh (2009) classify possible approaches to work redesign into two major categories. The first of them is concerned with *staff-mix management*, which emphasises the numbers and types of personnel and includes: (1) managing the number of personnel, (2) mixing qualifications, (3) balancing junior and senior staff members, and (4) mixing disciplines. The second category, *skill management*, gives more attention to the conditions that determine how staff members' skills are used and aims to ensure that personnel work to their full potential. As the latter concurs with MECC programme objectives, skill-mix management will be discussed below in more detail.

According to Dubois and Singh (2009) skill-mix interventions can be further categorised as follows:

1. Skill development

- a) Role enhancement—a vertical and upward extension of work enabling the staff to take on a wider and higher range of responsibilities through innovative and non-traditional roles. In a specific healthcare context, this approach to work redesign maximises workers' use of in-depth knowledge and skills to meet patients' health needs. However, it occurs within the scope of a given discipline and does not normally entail adding functions from other professions. Examples include nurses becoming responsible for providing lifestyle counselling or GPs becoming GPs with special interest.
- b) Role enlargement—the horizontal accrual and diversification of skills, whereby staff are able to take on roles and functions at parallel levels (horizontal enlargement) or lower levels (downward enlargement). Examples include healthcare practitioners' acquisition of additional, basic patient-care skills or

nonclinical skills related to programme management, quality improvement and team dynamics/communication.

2. Skill flexibility

- a) Role substitution—working across and beyond traditional professional boundaries to develop competences and perform activities which are usually considered to be outside traditional practice scopes, e.g. substitution of health care assistants for nurses or substitution of nurses for physicians.
- b) Role delegation—a transfer of certain responsibilities or tasks from one grade to another by breaking down traditional job demarcations, e.g. removing simple tasks from GPs and delegating them to other general practice team members.

The following intervention-specific challenges to implementing these approaches may be identified. While skill development, especially its 'role enhancement' dimension, may lead to increased satisfaction and motivation by giving the staff increased responsibility, advancement and recognition, it could also intensify workloads to the point of excess thus resulting in increased levels of "*dissatisfaction, demotivation and distress*" (Adams et al., 2008: p.8). A danger with role substitution is potential lack of ownership: skills shared by a broad range of professionals may become a low priority for individual practitioners. As far as role delegation is concerned, removing simple tasks from GPs and delegating them to other staff members may negatively affect the sense of connection between GPs and their patients, deprive physicians of variable interludes in their work and create the perception that a more powerful professional group is off-loading tasks onto another.

While various work redesign initiatives have been presented by policymakers as a way of optimising costs, increasing job satisfaction and promoting patient-centred care, the evidence about their effectiveness and efficiency remains mixed and inconclusive (Sibbald *et al.* 2004; Dubois and Singh 2009). This is especially true in relation to measuring cost-effectiveness of such interventions. As Sibbald *et al.* (2011; p. 9) conclude in their report on the efficiency of labour substitution in healthcare, 'labour substitution... [i]s a plausible strategy for addressing workforce shortages; [c]an reduce (wage) costs – under certain conditions which can be challenging to meet; [c]an improve efficiency – under restricted conditions which are difficult to meet'. It could also be argued that work redesign is a multisystem intervention affecting

organisations at different levels and there is a growing recognition that the outcomes of a workforce redesign initiative are contingent on the context in which this initiative is implemented (Parker and Wall 1998; Dubois and Singh 2009; Macfarlane *et al.* 2011). In light of that, contextual factors important for designing, implementing and evaluating workforce redesign interventions will now be discussed. For the sake of clarity, these are categorised into individual, group, organisational and policy contexts.

Contexts

Individual factors

At the level of individuals, several issues should be taken into consideration. First, in the context of endless and often disruptive organisational change affecting the NHS over the last two decades, the employees could potentially look sceptically at any workforce redesign initiatives conceived at the top, with the feelings of ambivalence, anxiety and anger towards further change (McMurray 2007; Ball and Regan 2010). Second, work redesign initiatives as such can result in increased workload and stress which may negatively affect the employees' quality of working life (Vagharseyyedin *et al.* 2010). This is especially important given that the NHS employees often tend to be very committed to their jobs and accepting of the increased workloads without bargaining, with their concerns remaining unheard by the management (Bach 2005). Finally, as shown by a wider management literature, individual actors vary in their capability, capacity, motivation and interest in particular innovations, which will inevitably affect the implementation of work redesign initiatives (Macfarlane *et al.* 2011; Parker *et al.* 2001; Greenhalgh *et al.* 2005).

Group factors

At the group level, one of the most important issues is the effect of work redesign on professional groups which traditionally have well established boundaries and jurisdictions in healthcare. There is a possibility that work redesign initiatives may threaten the power, status and autonomy of certain professions thus causing resistance to change and leading to conflicts between professional groups (Leverment *et al.* 1998; Dubois and Singh 2009). In addition, the implementation of redesign initiatives may lead to role blurring and challenge professional

identities. For example, in a study on the effects of role redesign on the work of midwives, Prowse and Prowse (2008) show that role redesign did not allow midwives to extend their influence, provoked feelings of being deskilled and losing power, and painfully challenged the existing boundaries between midwifery and other medical professions. Finally, work redesign programme evaluations show that these initiatives may create winners and losers—for instance, in a study of business process reengineering at a large hospital, Leverment *et al.* (1998) show that acceptance of change was more evident in more senior nursing staff, who felt a sense of enrichment in their roles, whereas more junior nurses (whose jobs had not actually been redesigned but who were experiencing change in role as a result in changes in the ward hierarchy) expressed more negative feelings towards the intensification of work.

Organisational factors

The issue of resources is one of the most important, with lack of finances/resources frequently cited as a main barrier to role redesign projects (McBride *et al.* 2005). As far as the financial incentivisation of staff is concerned, it has been suggested that remuneration should be settled prior to implementation of role redesign, with employees expecting a pay rise either before they start with a new role or once they have demonstrated its effectiveness (Parker and Wall 1998; Hyde *et al.* 2005). Another issue is management and accountability arrangements for redesigned roles, which often need to be reconsidered where redesigned roles involve job widening across professional, organisational or intersectoral boundaries or where the duties had to be transferred from registered to non-registered staff (Hyde *et al.* 2005). Finally, whereas the importance of education and training may be considered a truism, there is some evidence that job enhancement is not always accompanied by sufficient training (Dubois and Singh 2009); that there may be conflicts between in-house training provision and accredited training provided by educational institutions (Hyde *et al.* 2005); and that widely reported financial difficulties currently experienced by NHS organisations provide an unfavourable context for investment in education and training activities (Bach *et al.* 2008).

Wider context

Although the factors of the wider policy context are largely non-modifiable, an understanding of them is important when implementing work redesign initiatives since the latter get inevitably

affected by these factors. It has been noted that, unlike the Nordic countries, the UK lacks an adequate infrastructure for promoting workplace development (Payne and Keep 2003); furthermore, instead of supporting strategic human resource management in the public sector, the national workforce policy, Agenda for Change, often provides little more than the red tape, impeding both the introduction of redesigned posts and their spread across organisations (Macfarlane *et al.* 2011). The existence of centralised pay determination usually leaves little scope for managers to alter employment conditions (Bach and Kessler 2007), with healthcare assistants and support workers receiving relatively poor pay in spite of the increasing scope of their responsibilities, attainment of accreditation and degree of substitution for registered staff (Thornley 2008). Finally, work redesign in the NHS is likely to be influenced by the current reform which is accompanied by a large-scale restructurisation, financial constraints and high level of uncertainty (Hudson 2011).

Lessons from previous evaluations

In view of the importance of contextual factors illustrated above, traditional, linear, stage-of-change approaches to work redesign, similar to the one presented in Figure 1, do not seem to provide an adequate account of the complexity of the actual implementation process. There is a need for more comprehensive, iterative, context-specific models and frameworks. As demonstrated by Hyde *et al.* (2005) in an evaluation of the Changing Workforce Programme (CWP), tailoring the implementation approach to local priorities and the availability of external facilitation could be crucial for the success of an initiative. To address known barriers to change and minimise resistance, CWP provided project managers and workforce designers to each of the participating sites; potential roles were identified and redesigned through the local redesign workshop bringing together local stakeholders; and a contingent, emergent approach to work redesign was deployed, linking both with local priorities and, at a broader level, with professional bodies and educational institutions. The authors also suggest that the issues related to remuneration, accountability and training should be settled prior to the start of the work redesign initiative.

As part of a realist evaluation of the Modernisation Initiative, Macfarlane *et al.* (2011) identify the following factors enabling successful implementation of workforce development programmes:

- An adequate pool of appropriately skilled and qualified individuals either already working in the organisation or available to be recruited;
- Good human resource support and a culture that encourages staff development and new roles;
- Enhancement, rather than undermining, of staff roles and identities by proposed role changes;
- Opportunity to negotiate local development goals rather than follow an inflexible set of externally-imposed, top-down requirements;
- Embedding the required skills and responsibilities required for achieving modernisation goals throughout the workforce rather than tying them exclusively to designated support roles.

Underlying approaches to change as well as enabling and constraining factors identified in the process of evaluation are presented in Figure 2.

Based on an extensive literature review, Dubois and Singh (2009) propose a comprehensive framework (see Figure 3) conceptualising HR optimisation as the result of multiple integrated interventions concerning staff-mix and skill-mix as well as the wider practice and policy environment. According to this system-wide perspective, successful work redesign implies an attempt to achieve the following:

- A horizontal fit among different concurrent HR activities, including: (1) planning and staffing policies, (2) education and training activities, (3) working conditions and (4) performance management;
- A vertical fit with other organisational policies, goals and structures; and
- An external fit with the changing sets of rules and requirements imposed upon an organisation by its social, legal and political contexts.

Health promotion interventions

Background

Settings most frequently described in the literature as venues for implementing health promotion interventions include schools, primary care practices, hospitals, communities and the workplace (Tones and Tilford 2001; Naidoo and Wills 2000). A public health workforce responsible for implementing health promotion interventions could in turn be classified in the following way (Barry 2008):

1. Dedicated health promotion specialists, who facilitate and support the development of policy and practice across a range of settings;
2. The wider health promotion workforce drawn from across different sectors, such as health, education, employment and non-governmental organisations.

This review will mainly discuss issues related to involving the wider non-specialist workforce, employed by healthcare organisations, in health promotion programmes, specifically focusing on the role of physicians, nurses and lay health workers in primary, secondary and community healthcare settings.

Interestingly, while many practitioners are willing to enhance their public health role, some clinicians do not view themselves as promoters of public health and do not have competencies to deliver public health interventions at the individual patient level (Sim *et al.* 2007). In other words, these individuals exclude themselves from a wider 'community of public health practice'—either because of perceived lack of connection between their role and the public health domain or because of the perceived difficulties penetrating the 'health circles', the latter often seen as controlling public health practice locally (Popay *et al.* 2004). In some cases, it is the NHS managers who lack understanding of public health and health promotion, which may potentially affect the whole 'community of practice'. For example, even for those professional groups whose responsibilities include a public health role, such as community nurses, clinical/medical aspects of their work, rather than the wider health promotion related issues, might be given priorities by managers (Popay *et al.* 2004). Similarly, specialist community public health nurses report poor understanding from others of their work and the presence of tensions with managers and the wider team as to the importance about their public health role (Coverdale 2010).

Contexts

Primary care

In a study of primary care staff's views and experiences related to routinely advising patients about physical activity, Douglas *et al.* (2006) show that the vast majority of clinicians express positive views about health promotion as a core aspect of primary care but have relatively little knowledge of current guidelines related to promoting physical activity. Paradoxically, most think they have sufficient knowledge to promote physical activity with their patients. Health visitors and practice nurses are more likely to offer routine advice than GPs, the latter frequently reporting lack of time and resources as the main barrier to routine advising. Other studies conducted in primary care settings show that practice nurses are seen to have the main responsibility for cardiovascular health promotion in primary care (Steptoe *et al.* 1999) and that while GPs believe they should advise on health promotion activities, in practice, they are less likely to do so because they are sceptical about the effectiveness of their advice (Brotons *et al.* 2005). It has also been argued that health promotion intervention strategies do not fit into the current primary healthcare context, which is aimed almost exclusively at caring for disease and that new interventions to address multiple risk factors are required (Grandes *et al.* 2008).

Another finding to be taken into consideration is the influence of clinicians' own health related behaviours on their health promotion role. For example, GPs who smoke feel less effective in helping patients reduce tobacco consumption whereas GPs who exercise feel more effective in advising patients about regular physical activity (Brotons *et al.* 2005). Not surprisingly, GPs who are regular exercisers are three times more likely to regularly promote the same behaviour in their patients, while for practice nurses the same difference quadruples the likelihood of them promoting physical activity (McKenna *et al.* 1998). Patients seeking care from non-obese physicians indicate greater confidence in general health counselling than patients seeing obese physicians (Hash *et al.* 2003). Being a primary care practitioner and having related healthy habits have been identified in a US study as the most significant correlates with self-reported prevention-related counselling and screening practices (Frank *et al.* 2000a). Another US study (Frank *et al.* 2000b) has demonstrated that physician disclosure of healthy personal behaviours improves credibility and ability to motivate patients to adopt healthy habits.

While the lack of financial incentives was reported as a barrier to providing health promotion advice in a number of studies conducted in primary care (Brotons *et al.* 2005; McKenna *et al.* 1998; Douglas *et al.* 2006), it is debatable whether remunerating primary care staff for delivering health promotion counselling could actually improve the provision of health promotion advice to patients. Szatkowski *et al.* (2011) show that since the introduction of the Quality and Outcomes Framework (QOF) in 2004, the rate of recording of cessation advice in primary care medical records has tripled and significantly exceeded that of patients recall. They conclude that the financial incentive provided by the QOF for offering cessation advice may simply have increased GPs' propensity to document cessation advice offered instead of actually increasing their rate of advice-giving (also see Coleman 2010).

Secondary care

The literature on health promotion in secondary care mainly relates to the Health Promoting Hospitals (HPH), an international strategy designed 'to incorporate the principles of capacity building and organizational change, as hospitals steer towards the re-orientation of service delivery to promote health within and outside its physical boundaries' (Whitehead 2004; p. 260). While the main objective of this strategy is a complex re-orientation of healthcare settings towards health promotion activities in addition to their traditional illness-centred work, its interpretation, implementation and outcomes vary across participating hospitals. Four distinct approaches to health promotion have been identified by Johnson and Baum (2001; p. 284): (1) 'doing a health promotion project', (2) delegating it to the role of a specific division, department or staff', (3) 'being a health promotion setting' and (4) 'being a health promotion setting and improving the health of the community'. While the last two approaches are underpinned by organisational leadership, integration of health promotion in the hospital's philosophy and having a health promotion policy or plan, the first two do not necessarily demonstrate an organisational commitment to health promotion. In these cases health promotion gets marginalised to the role of specific staff and does not become integrated into day-to-day organisational practices.

A review of the evidence related to HPH implementation (McHugh *et al.* 2010) has identified a number of areas of concern, some of which might be relevant for the MECC programme and will be briefly discussed below. First, lack of health promotion skills and training has been reported

as barriers to the implementation of the HPH approach, with the ways of overcoming this problem including staff competency training and involving skilled health promotion practitioners who could assist staff in understanding the approach. It should be noted that this lack of health promotion knowledge does not stay unnoticed by hospital patients: while they support the introduction of the HPH and health promoting interventions, they express concerns over the knowledge base and the ability of professionals to deliver health education interventions that would meet their specific needs (McBride 2004). Second, education alone is not enough to address lack of knowledge and improve staff attitudes towards health promotion: a strategic long-term organisational commitment is required to improve attitudes to health promotion philosophy and practice, which concurs with the conclusion made by Johnson and Baum (2001) in their study of the typology of approaches to HPH that has been briefly discussed above. Finally, although HPH standards are judged as being relevant and applicable to hospitals, most hospitals demonstrate only a moderate degree of compliance. Similarly, there is evidence that the HPH framework is underutilised in the process of implementation and that its adoption does not necessarily dissipate the existing barriers to HPH development.

There is a wider continuing debate about the usefulness and appropriateness of competency frameworks for health promotion, which is summarised by Battel-Kirk *et al.* (2009) in their review of international literature on health promotion competencies. With regard to the UK, they refer to the development of national occupational standards (NOS) in the UK, as far back as 1997, with more specific standards focused on redefining and clarifying the role of health promotion developing to the point of the emergence of the UK Public Health Skills and Career Framework (2008) which builds on earlier standards to bring together public health competences, underpinning knowledge, training and qualification routes and registration requirements in one framework, whilst recognising the diverse nature of the public health workforce; recognising the wide range of competencies at various levels within that workforce from school level entry to senior strategic level roles. Although there is a dearth of evidence regarding its implementation and utility in practice, the evidence that does exist suggests that it has achieved widespread acceptance as a *"unifying force across the multidisciplinary public health community irrespective of whether the usual roles of individual staff focus on, for example, health promotion, public health information or some aspect of public health"* (Wright, Rao & Walker, 2008).

However, opponents of defining competencies argue that this is an overly prescriptive and mechanistic approach discouraging diversity, creativity and innovation; that competencies may undervalue professional judgement and experience; and that they could be misused as a means of bureaucratic and political control. On the other hand, competencies may be useful as a shared language for defining the tasks, skills and knowledge required for practice, as a tool for developing programmes, projects and curricula, and as a contributor to defining and consolidating the discipline. The authors conclude that despite ongoing debate, it is likely that competency frameworks will be incorporated in future training in health promotion as well as in workforce capacity building.

Community care

Since MECC aims to engage frontline non-clinical staff in delivering the intervention, it is worth briefly discussing the evidence about lay health workers in health promotion summarised in a Cochrane review (Lewin *et al.* 2010). A lay health worker (LHW) is defined as any health worker carrying out functions related to healthcare delivery, trained in some way in the context of the intervention but having no formal professional or paraprofessional tertiary education (*ibid.*, p. 6). The review concludes that while LHW interventions are beneficial for promoting immunisation uptake in children, increasing breastfeeding and improving TB cure rates, evidence of their effectiveness for other interventions is so far insufficient to allow recommendations for policy and practice. There is also insufficient evidence to assess which LHW training or intervention strategies are likely to be most effective. However, LHWs are most likely to be useful when they have an effective health care intervention to deliver.

Health trainers

In the 2004 White Paper *Choosing Health* (DH 2004) the Labour government set out its plans to improve the health of people in England. The specific goals of *Choosing Health* were to: *substantially reduce mortality rates by 2010; reduce health inequalities by 10% by 2010 (as measured by infant mortality and life expectancy at birth) and to tackle the underlying determinants of ill health and health inequalities.* One of the proposed initiatives to address these challenges was the introduction of the new role of 'health trainer' services. Health Trainer Services were designed to provide an innovative approach to improving health and addressing

health inequality in areas of multiple deprivation. They provide opportunities for people to address their health and lifestyle choices with trained staff drawn from their communities, able to help them access the services they need and to engage with health and community services and groups.

A number of valuable insights into the role of LHWs in health promotion are provided by a qualitative exploration of a health trainer programme in two primary care trusts (Ball and Nasr 2011). One of the identified challenges was the tension between the pressures for the health trainer programmes to have a national standardised profile versus the need to maintain a local, context-tailored focus. Another challenge described both by the key stakeholders and health trainers themselves was to engage with contemporary healthcare professionals and other community workers. These groups were often unaware of the existence of the health trainer role or did not have a clear understanding of what it entailed. Furthermore, health and social care professionals were perceived as feeling threatened by the health trainers as if the latter were to take patients away from them. Conversely, health trainers described how the perceived 'non-professional' nature of their role encouraged better disclosure from the clientele than did other 'professional' groups. The evidence for their impact on health outcomes has been mixed. In a policy evaluation of the initiative, Netherwood (2007) suggests that while individual support for behaviour change, combining information and signposting and support for members of the community has shown to be effective, the efficacy of the health trainer role may be limited to improving individual level health outcomes however wider environmental determinants of health are unlikely to be effectively addressed by the HTS. South et al (2007) seemed to come to similar conclusions:

“One of the most significant features of the new programme concerns the qualities health trainers bring as non-professionals, offering empathy and support to people in their own or similar communities. It is this aspect that may yet prove to be of most value in addressing health inequalities at a micro level, but there needs to be wider debate on the assumptions about delivering ‘support next door’”(South et al 2007 p. 230)

This is supported by a rigorous meta-evaluation of the evidence by Attree et al. (2011) who question the rigour of some of the evidence from recent evaluations of the HTs in practice. They suggest that the evidence base for the programme is based largely on studies of similar schemes in the developing countries where access to traditional health services is limited and therefore out of context with the UK. Where the scheme has proved more effective has been in

focusing the service on individual behaviour change rather than addressing the wider determinants of health within communities. They suggest that interventions which target deprived areas but neglect the social determinants of health may be limited in their effectiveness.

Lessons from previous evaluations

An evaluation of the Health Promoting Health Service (HPHS) Framework run by NHS Health Scotland (Whitelaw *et al.* 2006) has shown that stand-alone frameworks, tools or resources at best play contributory roles in the implementation of health promotion interventions in healthcare settings. For example, people working in the settings with no existing expertise in health promotion struggled to understand and utilise the HPHS framework which, as a result, did not play a significant role in the process of initial engagement. The framework was occasionally perceived as overly long, complex and theoretically difficult, which prevented it from operating as an ‘off-the-shelf’ resource. Whitelaw and others (*ibid.*, p. 139) conclude that ‘simply adding a resource to the mix was insufficient to precipitate change’. Instead, they propose a *nexus of conditions* for effective implementation, which involves multiple elements (see Figure 4).

Whitelaw and colleagues argue that conditions critical for successful implementation included the fostering of relevant competencies within sites and the development of mechanisms for spread and sustainability. Dissemination and promotion activities were most successful if they were coordinated by someone with a specific remit to implement a coherent health promotion strategy and provide training, support and management. The authors offer a ‘sequential cyclical vision of the implementation process’ (*ibid.*, p. 142-143) (see Figure 5) which comprises several components. First, project workers need to acquire basic skills and competencies, preferably within the practical context. Second, skilled support is crucial in the early stages of implementation. Finally, a small group of enthusiastic practitioners is unlikely to get a wider support if they don’t understand the organisation’s mechanisms, get a ‘buy in’ from a critical mass of ‘multipliers’ and secure an effective leadership to integrate the work into existing structures and procedures (see also Whitelaw *et al.* 2011).

Discussion

Both for work redesign initiatives and health promotion interventions, the inner and outer context of implementation seems to be of superior importance to the type of intervention or tool utilised. In relation to that, the synthesis of the two broad strands of literature presented in this review allows us to identify a number of common themes that may be relevant for the evaluation of the MECC project. First, in the unique context of healthcare, it could be anticipated that workforce development initiatives will be perceived differently across different professional groups, that these initiatives are likely to create winners and losers and that the perspectives of multiple stakeholders should be taken into account when designing, implementing and evaluating these initiatives. Second, there are often tensions between the wider (national, regional or programme-level) context and the local context of implementation which the people in charge of implementation activities have to address when tailoring interventions to their local circumstances. Finally, the issue of incentives is important: although some healthcare employees, who believe that this is part of their normal scope of work, may be happy to do some health promotion work without extra financial remuneration, others will be reluctant to do so. In designing the incentivisation systems it is also important to look at how they link in with existing pay-for-performance systems and to avoid introducing perverse incentives.

A number of aspects are, however, specific to the implementation of health promotion interventions in healthcare settings. First, clinicians' own health-related behaviours may have an impact on their engagement in health promotion programmes and on patients' acceptance of health promotion advice. Second, healthcare organisations still largely remain illness, rather than health, centred with the level of understanding of public health related issues varying greatly across individuals and groups. Some clinicians and managers exclude themselves (or feel excluded) from the wider 'community of public health practice', with health promotion frequently becoming deprioritised. This highlights the importance of 'fostering a public health 'workview' in the wider community of practice' (Popay *et al.* 2004; p. 348). Finally, an emerging theme is the importance of coordination, integration and capacity building to embed interventions in the organisational routines and sustain behavioural change even after the health promotion project is completed.

While it is widely recognised that capacity building is a crucial ingredient for successful implementation of health promotion interventions (Yeatman and Nove 2002; Whitehead 2006; Sim *et al.* 2007; Barry 2008; Whitelaw *et al.* 2011), we still know relatively little about what are the best ways of achieving effective capacity building and how this could be facilitated both within the NHS and in a wider range of settings. The role of internal and external change agents facilitating the implementation of workforce development and health promotion interventions has also received little empirical attention. Also, with the majority of studies focusing on doctors and nurses, the perspectives of lower-status occupations and NHS frontline staff on workforce redesign (by which they are almost always directly or indirectly affected) are underrepresented, and their potential contribution to health promotion remains unexplored.

In light of the above, some provisional questions to guide the initial stage of MECC evaluation could be proposed. Some of them raise issues around 'what works', while others will investigate how this works, for whom, and in what circumstances, thus addressing the context, mechanism and outcome components of the realist evaluation approach (Pawson and Tilley 1997).

- What are the attitudes of different stakeholders towards the initiative and its (perceived) outcomes?
- What are the perceived (contextual) facilitators and barriers to successful implementation of the MECC projects?
- How is the PLBCCF competency framework adapted at different sites and tailored to their specific contexts? How useful is it?
- How are the roles redesigned to enable the implementation of the programme in different contexts?
- What training is provided at the sites to enable the implementation of the programme? How useful is it considered by its recipients?
- To what extent do employees doing the (redesigned) jobs feel (dis)empowered about their new role?
- How do perceptions of and approaches to MECC implementation differ across various professional and organisational groups?
- What is the strategy for sustainability and further spread of change that has already been achieved by MECC projects?

- How is the implementation process affected by the current organisational and financial climate?
- How does the programme implementation link in with existing organisational financial structures (payroll, QOF, etc.?)
- What is the role of internal (and possibly external) facilitation in the process of implementation?
- How does the implementation process address the issues around capacity building in relation to health promotion?

By reviewing literature on work redesign and health promotion interventions, identifying common themes and formulating research questions, this work has thus attempted to provide a basis for a study which could potentially enhance our understanding of the mechanisms underlying workforce development interventions in the area of health promotion.

Figures

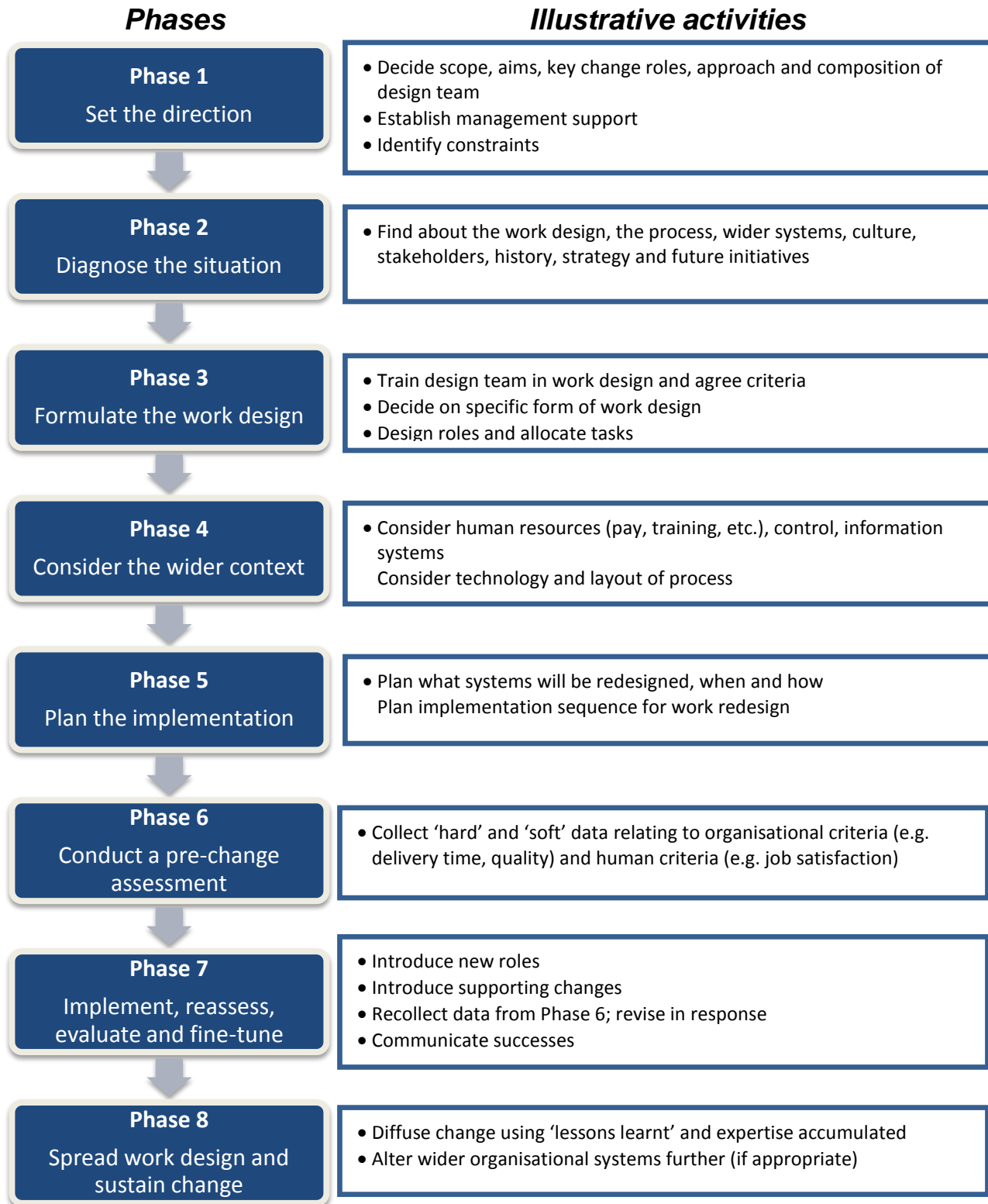
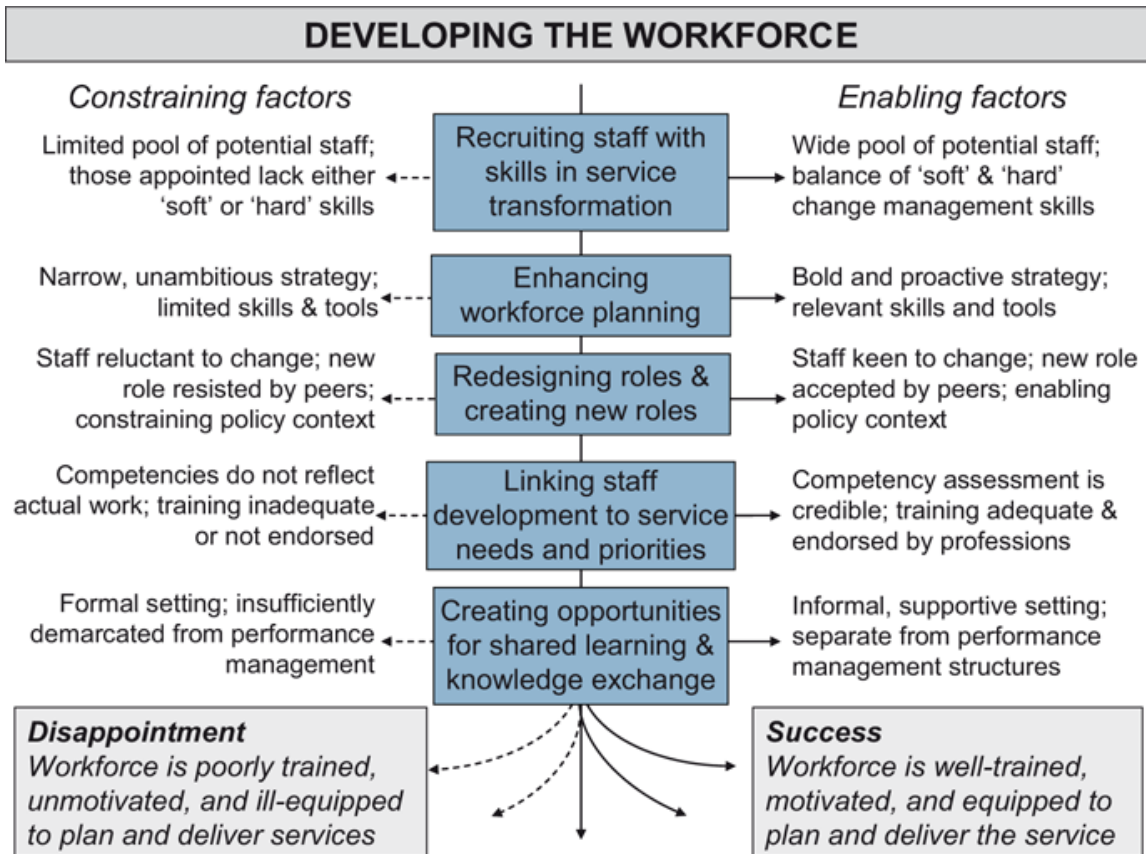
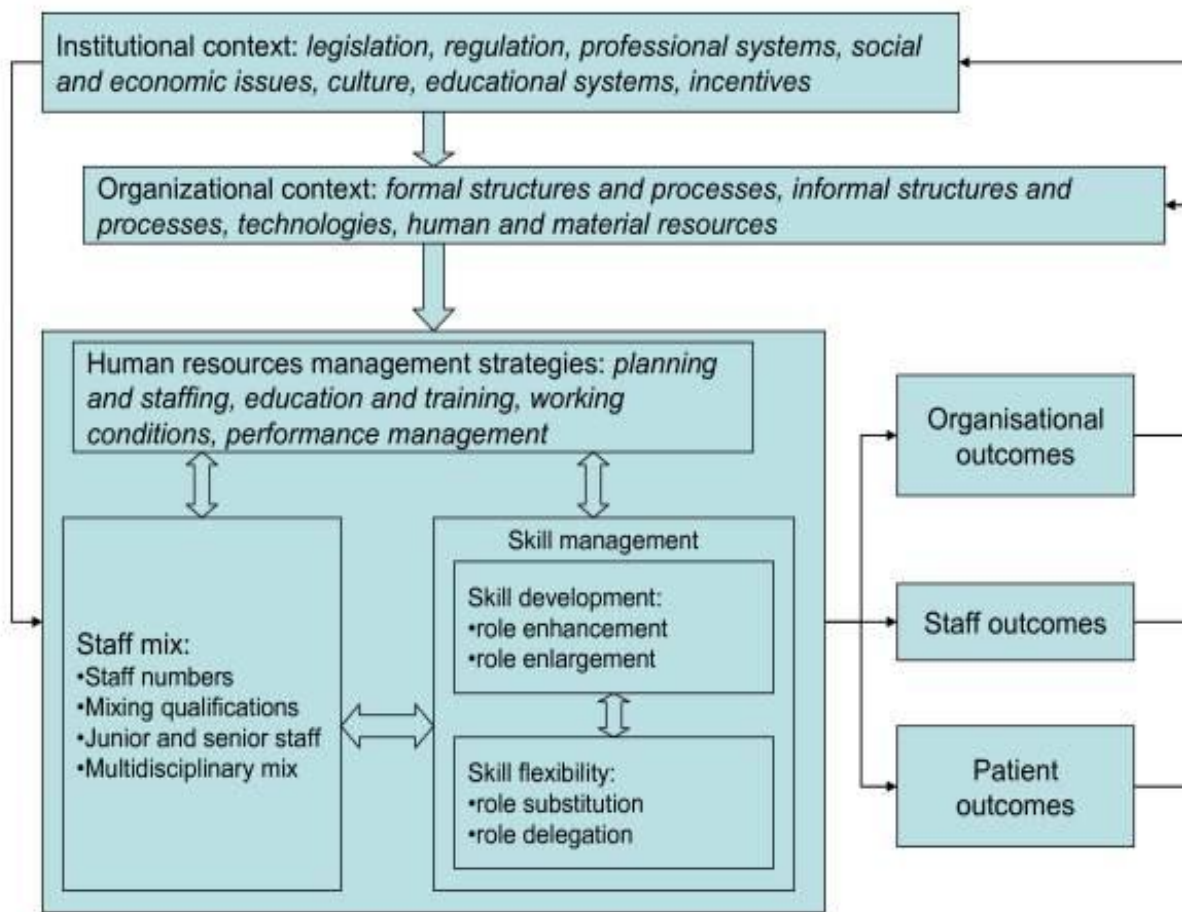


Figure 1. An example of a linear, structured approach to planning work redesign initiatives (adapted from Parker and Wall 1998; p. 123).



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Figure 2. Mechanisms of change and their enabling and constraining factors as identified in the evaluation of the Modernisation Initiative projects (Macfarlane, F., Greenhalgh, T., Humphrey, C., Hughes, J., Butler, C. and Pawson, R. (2011). A new workforce in the making? A case study of strategic human resource management in a whole–system change effort in healthcare. *Journal of Health Organization and Management*, 25(1), 55–72.)



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Figure 3. A framework for optimising human resources in health care (Dubois, C. A. and Singh, D. (2009). From staff–mix to skill–mix and beyond: towards a systemic approach to health workforce management. *Human Resources for Health*, 7(87), 1–19.).



Figure 4. *Conditions for effective health promotion practice* (Whitelaw, S., Martin, C., Kerr, A. and Wimbush, E. (2006). An evaluation of the Health Promoting Health Service Framework: the implementation of a settings based approach within the NHS in Scotland. *Health Promotion International*, 21(2), 136–144 by permission of Oxford University Press)

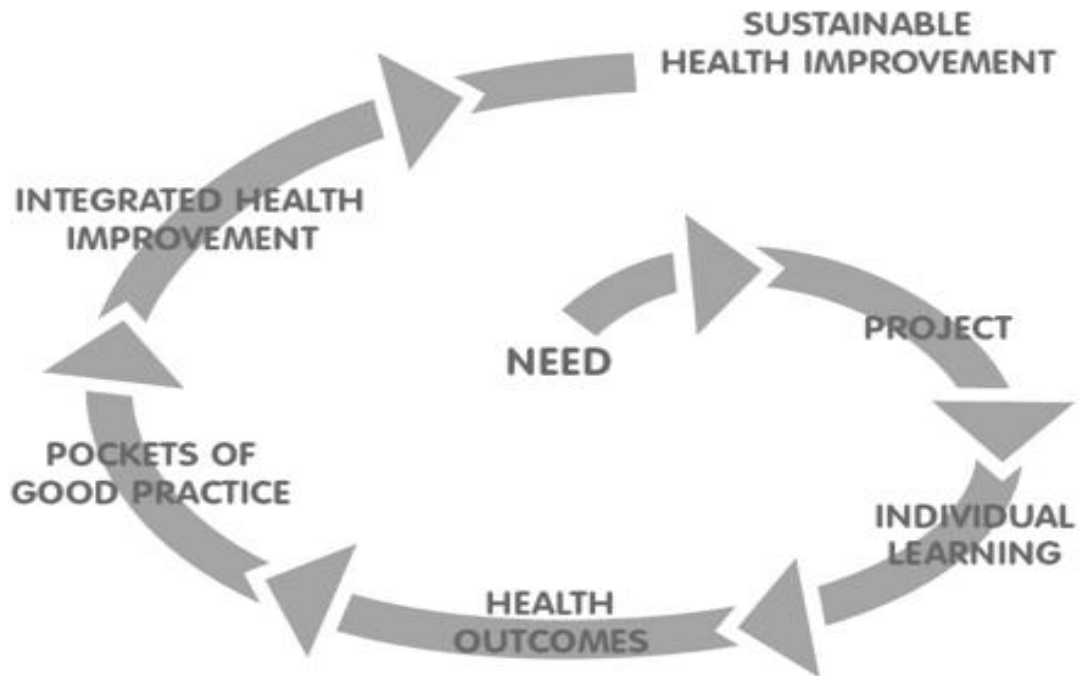


Figure 5. A spiral process of HPHS implementation (Whitelaw, S., Martin, C., Kerr, A. and Wimbush, E. (2006). An evaluation of the Health Promoting Health Service Framework: the implementation of a settings based approach within the NHS in Scotland. *Health Promotion International*, 21(2), 136–144 by permission of Oxford University Press)

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