This timely and relevant new edition of an established and well-regarded text is essential reading for those training to become health visitors and those who are practitioners working with and in the community. As we celebrate the 150 year anniversary of the profession in 2012, Health Visiting: A Rediscovery has been thoroughly revised and updated since the last edition to reflect the many developments in health policy, public health priorities and health visiting practice. The focus of the book, however, remains the same: placing the health visitor at the forefront of supporting and working with children and families, ensuring the child has the best possible start in life. The increasing importance of working with communities and reaffirming the public health role of the health visitor are discussed and debated. The new edition takes into account the challenges and increasing need for health visitors to engage with research evidence and to evaluate their practice.

Key features:
- A definitive, comprehensive, updated textbook on the role of the Health Visitor
- Incorporates the practice of public health and working with communities
- Includes a brand new chapter on the importance of safeguarding children and the enhanced child protection role of the Health Visitor
- Timely and topical
- Essential reading for all nurses working in the community, those training as Specialist Community Public Health Nurses and undergraduate students undertaking public health, primary and community care course units
- Features case studies and learning activities

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Introduction

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Over two decades have passed since the publication in 1992 of the Second Edition of Health Visiting: Towards Community Health Nursing and there have been numerous challenges and developments within the National Health Service (NHS), social care and nurse education in the intervening years.

In brief, the role of the nurse has been strengthened both in primary and secondary care by the redrawing of the boundaries between medical and nursing work (for example, nurse prescribing). New careers for nurses have emerged such as, nurse consultants, community matrons, specialist nurses and nonmedical public health specialists. These developments have enabled the nursing profession to have an impact on shaping and developing services for the public.

Skill mix has enabled the refocusing of some roles, for example the building of teams and closer collaborative working among health professionals. Teamwork, with the goal of providing a comprehensive service has been a particular development within the community; with health visiting teams consisting of community staff nurses, nursery nurses, trainee assistant practitioners (TAPs), bilingual support workers and clerical staff.

The health visiting profession is 150 years old in 2012 and the changes and developments in the profession have been immense, and some more welcome than others. A noteworthy change for health visitors was the dissolution of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) (and the four National Boards for England, Northern Ireland, Scotland and Wales) and its replacement in 2002 by the Nursing and Midwifery Council (NMC). The removal of the health visiting profession from statute in 2001 (removing any legal status) and closure of the professional register in 2004.
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(ceasing NMC regulation) has been seen as detrimental to the profession and one in which the professional organisation, the Community Practitioners' and Health Visitors' Association (CPHVA), has been lobbying to get reinstated (Unite/CPHVA, 2010). Health visitors considered that with this loss of statute the importance of their work had been overlooked. Health visiting is included as part of the Specialist Community Public Health Nursing (SCPHN) section of the NMC register. The NMC sets standards of education, training and conduct in nursing and midwifery in the UK, including proficiency for SCPHNs to ensure the maintenance of high standards within this specialist area (NMC, 2004) and these standards are currently being reviewed.

During the last ten years the NHS has been continually changing and improving, but when there is a change of the government, there is often a new strategic vision and new challenges for health professionals working in the NHS. The latest NHS plan (DH, 2010a) sets out a number of radical changes in both the organisation and delivery of services for the NHS. The vision is for the commissioning of services to be organised by health professionals closest to the patient and work has begun on the establishment of General Practice (GP) consortia, and this will be the mechanism which supersedes Primary Care Trusts (PCTs) in England to purchase some specialist and secondary care. In addition, there will be an independent NHS Commissioning Board, which will ensure that resources are allocated and accounted for in pursuit of defined health outcomes. The NHS Commissioning Board will tackle inequalities in access to health and lead on quality improvement (DH, 2010a). Organisational changes have been made with the aim of improving the quality of service for patients and similar developments are occurring in Wales, Northern Ireland and Scotland.

Until recently in England, health visitors have been employed by Primary Care Trusts (PCTs) and some now will become employed by the NHS Foundation Hospital Trusts until GP consortia and local authority responsibilities become clearer. It is likely that services for nought to five year olds (including health visiting) will be commissioned by the NHS Commissioning Board which will have some commissioning responsibilities on behalf of Public Health England. Whatever the commissioning arrangements turn out to be the government has pledged to ensure that more disadvantaged families receive intensive support from the health visiting service. In Scotland, health visitors are employed by one of the 14 area NHS boards, usually within Community Health Partnerships (CHPs) of Child, Family and Public Health Services. Following a review of community nurses in Scotland in 2009 there has been resistance to replacing health visitors with a generic community nursing role and this opposition has been successful in keeping the distinctive health visiting/public health role in Scotland. In Wales, the NHS underwent changes in 2009 and established seven Local Health Boards (LHBs) where health visitors are employed. In addition Public Health Wales is a new NHS trust and responsible for delivering a public health services to each of the seven LHBs. Northern Ireland has a combined health and social care structure with five Health and Social Care Trusts where health visitors are employed but its health visiting services are being modernised in line with the rest of the UK.
The government's vision of a patient-centred NHS, with more patient involvement and choice will require nurses/health visitors to work with and to support patients, clients and families with health care decisions. The emphasis is on self-care and on encouraging individuals to be responsible for their own health, a focus which is central to the work of health visitors.

Role of the health visitor

There has always been much debate around the health visitor’s role, but over the last decade or more there has been an apparent shift away from the preventive role to one with a focus on child protection and safeguarding children issues. The public health role of the health visitor has never reached its full potential. There is a shortage of health visitors and many areas of the United Kingdom (UK) focus on ‘crisis visiting’, rather than delivering a broad range of health visiting services. The health visitor has always been seen as the key health professional for the under fives, offering a universal service in line with policy requirements (DH, 2009). There is a renewed recognition that the traditional work of the health visitor is important and the government is investing in training an additional 6000 health visitors to have 4200 new health visitors in place by 2015 (DH, 2011). The title of this Third Edition (Health Visiting: A Rediscovery) reflects this initiative.

Health visitors are continuing to be seen as the lead professional for children under five and their families in the delivery of a Universal Child Health Service, in line with the Healthy Child Programme (HCP) (DH, 2009). This HCP sets out the programme of health development reviews, screening, immunisation etc, using the evidence base of the revised Health for All Children report (Hall & Elliman, 2006). The specialist skills and knowledge which health visitors have working with families and communities has been recognised with the new service vision of health visiting being involved in:

- improving public health;
- developing community resources;
- maximising family resources (supporting families);
- bridging family services and primary healthcare services;
- accessing specialist services (DH, 2010b).

There will be an emphasis on health visitors, providing family health services, with more contacts and additional tailored packages of care and support where required.

Vision for public health

It is of interest that for England public health leadership will be returned once again to local authority, placing public health specialists alongside environmental health and housing. Directors of Public Health (DPH) will provide the strategic leadership for tackling health inequalities. There will be
an established professional public health service ‘Public Health England’ which will be part of the Department of Health. The purpose of this service is to strengthen the response to health protection and national emergencies, for example a flu pandemic. By 2012, Public Health England will have assumed the responsibilities and powers of the Health Protection Agency (HPA) and National Treatment Agency for Substance Misuse (NTA) (DH, 2010c). Whether health visitors in some parts of the UK will also return to employment under the local authorities, where historically they were established, is not yet clear.

The envisaged public health role of the health visitor has never reached its full potential and there are probably several reasons for this. The declining number of full-time equivalent (FTE) health visitors, is one possible reason. Since 2005 health visitors have declined by nearly 2000 (DH, 2011). Even if we look at data over a 12-month period from October 2009 to October 2010, the number of FTE health visitors dropped from 8262 to 8098 (NHS Information Centre, 2011). In addition the increased health visitor’s role in child protection and safeguarding children involving multi-agency working is time consuming and leaves little time for other work.

Health visitors are one of the few health professionals who receive training in public health. Because of the planned increase in numbers of health visitors and with public health high on the government’s priorities there will be a renewed attempt to get health visitors involved in the public health agenda. Health visitors have played a key role in health needs assessment (HNAs) and community profiling. The reaffirmation of the public health role of the health visitor in recent policy (DH, 2010c, 2011) places them in a key position to improve health outcomes. Health visitors have a role in helping communities to improve their health and well-being for example, in increasing immunisation uptake, reducing obesity and tackling health inequalities.

The number of public health priorities which need to be tackled (DH, 2010c) are growing and lifestyle consequences such as obesity and substance misuse are highly prevalent. The Public Health White Paper (DH, 2010c) takes into account the Marmot Report, *Fair Society, Healthy Lives* (Marmot et al., 2010) for setting out its framework for tackling the wider social determinants of health. Marmot et al. (2010) state that health inequalities will require action on:

- giving every child the best start in life;
- enabling all children young people and adults to maximise their capabilities and have control over their lives;
- creating fair employment and good work for all;
- ensuring healthy standard of living for all;
- creating and developing healthy and sustainable places and communities;
- strengthening the role and impact of ill health prevention.

There is recognition that determinants of health often do not fall within the remit of the NHS and therefore partnership and local area agreements for tackling some issues: for example, teenage pregnancies and smoking are a necessity. The established Association of Public Health Observatories (APHO) has provided some of the infrastructure needed in public health. The APHO
represents a network of 12 public health observatories (PHOs), working across the UK and the Republic of Ireland. The PHOs are key to providing information and data about people's health and health care.

Health visitors have always been in a position to work with families early on in the ante-natal and postnatal period assisting parents with providing children with the best start in life. The preventative health care aspect of the health visitors’ role needs to be recognised as important if work is to extend beyond crisis visiting. Health promotion and assessing the health needs of the community, including understanding and interpreting health data are necessary skills even in undergraduate nurse education, which is now the norm, given by 2012, nursing will be a graduate entry profession.

Working with communities

The focus on communities is very much a part of the government’s agenda, with the ‘Big Society’ and one of the key priorities is to empower communities, with plans for groups or volunteer associations to run organisations such as children’s centres, libraries etc. In the Health Visitor Implementation Plan 2011-2015, we see that health visitors will have a role in building community capacity so that families and communities help develop new ways of providing services as part of the Big Society (DH, 2011). It is important that health visitors with their knowledge of the community undertake such things as HNAs and contribute to joint strategic needs assessment (JSNA) (DH, 2007), which help plan services more efficiently and effectively for the health and wellbeing of the local community.

New edition

The First and Second Editions of this book were well received and were reprinted several times and became the leading text for health visitor courses. Twenty years has passed since the Second Edition and it has to be said that the promise of moving towards community health nursing has not yet been realised. This new edition is called Health Visiting: A Rediscovery, and the health visitor is being placed once again at the forefront of supporting and working with children and families, ensuring the child has the best possible start in life. Public health now has a more distinctive place in the NHS agenda since it is one route into mediating inequalities that adversely affect the health and wellbeing of the population. It is therefore our expectation that health visitors will be able to realise and enhance their public health function.

This is an ideal time to launch this Third Edition. The structure of the book is similar to the other editions, however the content has changed considerably from the last edition. This change has been necessary to keep pace with the developments in health policy, public health priorities and health visiting practice. The chapter on information technology and role of the health visitor has been replaced with a chapter on safeguarding children. This is because
Introduction

‘NHS Connecting for Health’, which maintains and develops the information technology infrastructure is continually evolving with new developments, such as the electronic health record and writings in this area would become quickly out of date. With the central role that health visitors have with child protection, a chapter on safeguarding children is an important addition to this Third Edition. There are some new authors for this edition, some who are teaching public health and health visiting and others who are practising as public health specialists, ensuring that this Third Edition is relevant to meet the needs of those training to become health visitors and those who are practitioners working with and in the community.

Chapter 1, ‘Managing Knowledge in Health Visiting’, previously examined the nature of knowledge and practice of working in the community and in some senses the material included was futuristic and has not been superseded. However, with the emphasis and importance of evidence-based practice, this chapter explores the concept of managing knowledge in health visiting. The concept of evidence-based practice is debated with reference to case studies. The demands on the health visitor to understand the different forms and sources of knowledge in order to ensure the delivery of evidence-based practice is discussed. The issues surrounding use of guidelines and protocols in practice are highlighted. The concept of communities of practice (CoP) is debated as to how they can assist practitioners in working to improve their own practice. In addition generating and managing knowledge in practice using reflective practice is discussed before moving on to the perspective of the clients in terms of what they know and how they know it, drawing attention to the use of social networking sites.

Chapter 2, ‘Health Visiting: Context and Public Health Practice’, which previously focused on health visiting and the community (some of which is now covered in Chapter 3) explores the specialist and public health role of the health visitor in working with families. It examines the tensions between the demands of the health visiting role with children and families and the public health role. The public health role of the health visitor needs to become more clearly defined with a focus on reducing health inequalities and giving every child in the community the best start in life (Marmot et al., 2010) and this is explored in the section specifically about ‘Health inequalities’. This chapter also examines the evidence for health inequities and the contribution health visitors can bring in addressing the wider determinants of health. However, it highlights the importance of good leadership in public health and challenges for health visitors in engaging with a public health role.

Chapter 3, ‘The Community Dimension’, discusses the concept of ‘community’ (some of which was covered in the previous edition in Chapter 2) but also explores the current role that health visitors have in identifying and assessing the health needs of the community using health needs assessment rather than the Second Edition’s focus on community health profiling, which is no longer routinely used. It focuses on understanding the social determinants of health and explores the theory supporting community working and the skills required for community level work, including how to measure community participation...
within a locality. With the renewed focus on working with communities, this chapter will provide health visitors with the knowledge and understanding to participate in building community capacity.

Chapter 4, ‘Approaches to Supporting Families’, previously looked at assessing individual and family health needs, with a discussion of models of interventions in family life which were topical in the 1980–’90s. This new chapter explores the approaches to supporting families and evaluates several child health programmes which are currently in existence. The evidence for successful health visiting interventions to support families, such as the family nurse partnership (FNP), is discussed. The FNP is advocated by the government and provides intensive support and structured visiting. The government has recognised the need for more Family Partnership Nurses delivering this programme to vulnerable first-time young parents from early pregnancy till the child is two years of age and this is being promoted currently. The competing challenges faced by health visitors such as the public health agenda, the level of evidence, and adequate resources in trying to work with these families are debated.

Chapter 5, ‘Safeguarding Children: Debates and Dilemmas for Health Visitors’, is a welcome addition to this book and replaces the previous chapter on information technology. This new chapter focuses on safeguarding and the enhanced child protection role of the health visitor. The key concepts such as child abuse and significant harm are defined, including highlighting the incidence and prevalence of child abuse. The assessment of vulnerable children using the common assessment framework (CAF) and the graded care profile (GCP) for neglect are discussed. There is a debate on the issues and dilemmas around safeguarding children faced by health visitors and which students may encounter through their practice. Child abuse is a public health issue and the value of the health visitor in safeguarding children is clearly recognised.

Chapter 6, ‘Evaluating Practice’, was always ahead of its time in previous editions, in so far as everyday health visitors seldom formally evaluate the impact of their work. This chapter has been updated and explores the importance of evaluation in health visiting practice which is a necessity in today’s economy, to ensure what health visitors are doing is effective and of value. The tools and sources of information which are now more readily available and will assist health visitors in their clinical practice are described. It is important to ensure that health visitors and other practitioners have the skills and knowledge to identify and critique the available evidence and information in their role in supporting families and communities. Health visitors need knowledge about where to get the best information and the skills to be able to access up-to-date resources, for the delivery of evidence-based practice and this chapter goes some way towards providing this.

New for this Third Edition, for each of the chapters are learning activities referred to throughout and details are found in the Appendices at the end of each chapter. It is anticipated that these activities will help students, health visitors and others to reflect and develop their practice further.
There are many challenges that health visitors will face over the coming years but the vision for high-quality care and improving service provision for individuals and their families makes it an exciting time in health visiting. We hope that this new edition will assist with the ‘rediscovery’ of health visiting and the contribution health visitors can make to the health and wellbeing of children, families and communities which will ultimately have an impact on achieving better outcomes for health.

References

Managing Knowledge in Health Visiting

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Introduction

The mantra of evidence-based practice is now heard everywhere in healthcare. This chapter will explore what it might mean, both theoretically and in the context of everyday health visiting practice. Is it a way of enhancing the effectiveness of practice or yet another part of the new managerialism of guidelines, targets, and effectiveness? Why might evidence-based practice be an important ideal? Arguably, when a practitioner intervenes in a client's life the outcome should be that the client is significantly advantaged. In health visiting that advantage could take many forms - the client could have more and better knowledge, they might feel more capable of managing their affairs, they might better understand and cope with difficult thoughts, feelings and actions - the list is extensive and later chapters will detail the ways in which health visiting can lead to better outcomes for clients and communities. However, the proposition that there should be an advantage derived from the practitioner's intervention is particularly important in the context of a state financed - i.e. taxpayer funded - healthcare system. If an individual wishes to spend their money on treatments or therapies of dubious or unexplored value offered by unregulated practitioners, then that is entirely a matter for them, provided that they have not been mislead or missold! However, when the state decides to invest its resources in the development of a particular service and associated interventions then arguably there has to be some level of evidence or collective informed agreement which gives confidence that the choice is justified. In addition, of course, all health visitors must be able to account for what she/he does and doesn't do to the Nursing and Midwifery Council (NMC), if required.
Chapter 6 explores how health visiting might be assessed, measured and evaluated. Here the emphasis is on how we choose, individually or collectively, to develop particular services and perform particular actions which we know with some degree of certainty should lead to better outcomes for the client. But how do we know things with any certainty? How can we define the knowledge we need to make good choices? Although there are very many different ways of categorising or describing forms of knowledge, for our purpose here it will be sufficient to make some simple distinctions.

First, knowledge can be categorised by type. For example, Carper’s (1978) categorisation of knowledge as empirical (largely derived from science), aesthetic (or artistic), ethical and personal, is well known and used in nursing. Or we might categorise it by source and ask where it comes from - books, journals, other people, personal experience, etc.? Or we might use the simple but important distinction between knowing that and knowing how (McKenna et al., 1999). For example, I can know that swimming pools are places people go to and engage in swimming and other water sports, although I need not have experienced it; I can only say I know how to swim if I can do it. In the case of the former I can probably explain how I came by that knowledge but in the case of the latter, I may not be able to explain how I know how to swim or what I am doing when swimming, but the knowledge statement I know how to swim is dispositional: its truth is determined by my ability to swim. Such ‘knowing how’ knowledge is sometimes called tacit knowledge, in contrast to explicit knowledge or knowing that. Our concern here is less about how theoretically you might define knowledge - that’s really a question for philosophers - but about the question of what sort of knowledge should health visitors be using - and who says so - and what sort of knowledge are they using. You will not be surprised to know that there is substantial controversy as various factions argue that their type or source of knowledge is the most important. And the outcome of what might be argued to be a fight to define the ‘proper’ knowledge basis for practice is important as it has the potential to impinge directly on the health and safety of the client as well as the degree to which health visiting can be said to ‘add value’ to clients.

In later sections of this chapter we will look more closely at evidence-based practice, which is currently the dominant knowledge protocol in the NHS, and try to establish what forms of knowledge it valorises and why. The chapter will also look at reflective practice, an alternative protocol for generating and managing knowledge about practice which is supported by many institutions and individuals within nursing, and also the idea of knowledge being generated and managed within communities of practice, an idea which is currently more popular in education and some other public sector service organisations. Each of these can be viewed as a social movement with enthusiastic supporters trying to ‘capture’ the support of key health organisations and institutions, as well as the hearts and minds of individual practitioners. And we will also look at what is known about the types and sources of knowledge which healthcare practitioners actually use in practice - which proves to be somewhat different from any of the ‘ideals’ promoted by these social movements.
But before examining any of these ‘ideal’ types of knowledge management it will be useful to remind ourselves about the practice of health visiting. For evidence-based health visiting or reflective health visiting or any other imported concept to be a reality it must be integrated into the taken-for-granted, existing ways in which health visitors go about their business.

**Defining health visiting practice**

The review of health visiting, *Facing the Future* (Department of Health (DH), 2007), aims to highlight key areas of health visiting practice and skills. It is interesting to note that this is not a research-based document – and makes no claims to be, although there are some references to research. Rather, ‘this review is informed by evidence, government policy and the views of many stakeholders’ (DH, 2007: section 1). The decisions about what health visiting should be about are therefore largely presented as decisions for the community of stakeholders in the context of stated government priorities. Key elements of the decision-making process can be seen as pragmatic and commonsensical – in the best sense. For example, the review argues that the health visiting service should be one which someone will commission, i.e. pay for; it needs to be a supported by families and communities, i.e. is acceptable to the users of the service; and it needs to be attractive enough to secure a succession of new entrants, i.e. there will be a workforce of sufficient size and ability.

In terms of the future skills of health visitors, the review is clear that they will be expected to be able to translate evidence into practice – although it is less specific about what sort of evidence will count and how the process will be managed. However, at the national level it recommended that the relevant research findings to support a twenty-first-century child and family health service must be assembled. There is also some indication that future practice will be guided by clear protocols, ‘Inconsistent service provision with individual interpretation’ will be replaced by ‘Planned, systematic and/or licensed programmes’ (DH 2007: recommendation 8). As we shall see, the reduction in variations in practice is one of the key aims of the evidence-based practice movement. In terms of evidence underpinning practice, the document also draws specific attention to the expanding knowledge base in mental health promotion, the neurological development of young children, the effectiveness of early intervention and parenting programmes and health visiting. Clearly this is a very broad base of evidence derived from a range of academic and practice disciplines.

So, while the review (DH, 2007) is not about the evidence or knowledge base of health visiting and how it might be used, many of the relevant themes in debates about evidence-based practice begin to emerge, for example:

- What is the role of the practitioner in assembling and assessing evidence?
- How can evidence be translated into practice?
- What counts as evidence?
- How can other bodies support the practitioner by generating and assembling evidence?
How can any practitioner be conversant with developing knowledge bases in a wide variety of other disciplines?

What will be the role of protocols, guidelines and ‘recipes’ for practice?

A previous document on health visiting, the Health Visiting Practice Development Resource Pack (DH, 2001) raised similar issues, but perhaps gave more emphasis to the importance of evidence-based practice. It drew attention to national statements of ‘good’ practice such as the National Service Frameworks and suggested that health visitors should ‘read widely, keep up to date and engage in debates about what does and doesn’t work’ (DH, 2001: 34). However, it is relatively silent on the debates and controversies surrounding evidence-based practice, which impinge directly on the possibility and effectiveness of individual practitioners relying on reading to keep up to date in the midst of an exploding healthcare literature.

What do health visitors do – and where do they do it?

However, before we examine how evidence can and should be used in health visiting practice it is important to consider the actual practice of health visiting; that is, what health visitors do on a day to day basis. Unfortunately, relatively little is known – other than by those who do it – about the realities of everyday health visiting practice. That such practice is rarely seen as a valid subject either for scientific research or practice narratives, is well expressed in a very exciting article about social work (Ferguson, 2010). He argues that current research is focused on systems and interprofessional communication, which: ‘leaves largely unaddressed practitioners’ experiences of the work they have to do that goes on beyond the office, on the street and in doing the home visit,’ (Ferguson, 2010: 1100).

In his work he is trying to refocus on actual practice and further argues:

Reclaiming this lost experience of movement, adventure, atmosphere and emotion is an important step in developing better understandings of what social workers can do, the risks and limits to their achievements, and provides for deeper learning about the skilled performances and successes that routinely go on.

(Ferguson, 2010: 1102)

Of course, this is just as true for health visiting where a significant part of the practice is leaving the office, driving to the client, thinking about how the visit will work, knocking on the door, and so on. Ferguson’s account of the excitement and fear of walking through disadvantaged neighbourhoods and of managing to negotiate home visits with obdilging clients is focused on social workers working in child protection, but it must resonate with all practising health visitors.
So how would the ever-useful sociological Martians describe health visiting practice? They would be bound to notice that health visiting practice is largely about doing things with words. Note the emphasis on doing; talk isn't just something which surrounds the doing, it is the doing - praising, blaming, asking, advising, persuading - every utterance is an action produced for a purpose, although the speaker is rarely consciously aware of this at the granular level. The skills involved in talking are so deep that, just like walking, they are not normally subject to constant ongoing analysis. Most of us do not consciously think about how to walk - we just do it. But talk is the health visitors' key performative skill, and because doing things with talk is a primary skill, health visitors need a more profound understanding of how it works - just as a ballet dancer would need a more profound understanding of how her body works than the person taking the dog for a walk. Of course, as well as talking, health visitors also make notes and write reports but text is still doing things with language in order to interact with others, just like talk.

In the 1980s there was considerable interest within sociology in researching how interactions, largely based on talk, could constitute various forms of institutional practice. This idea was rather neatly defined in an edited volume of studies called 'Talk at Work'. The editors argue:

that talk-in-interaction is the principal means through which lay persons pursue various practical goals and the central medium through which the daily working activities of many professionals and organisational representatives are conducted.

(Drew & Heritage, 1992: 3)

Health visiting is one such profession and organisation. Within health visiting, the collection of audiotaped practice has allowed analysis of actual rather than reported practice. Both Robinson (1986) and Heritage and Sefi (1992) recorded the ostensibly 'private' world of health visiting in client homes (at the time it was considered that video recording home visits would be too intrusive, but subsequent work by Lomax and Robinson (1998) within midwifery showed that it was acceptable to practitioners and clients). Their analyses variously looked at entry and exit, topic initiation and storytelling (Robinson, 1986) and the giving and receiving of advice (Heritage & Sefi, 1992) but the point to be made here is that the recordings showed that the visits are recognisable as relatively lengthy conversations with both the health visitor and client contributing. The key feature of any conversation is that each party 'takes a turn' and allows the others to do so. It is interesting to note that turn-taking is such a fundamental human skill that it is exhibited by very young babies and is one of the last skills to be lost by people with dementia - the ability to turn take is far deeper than the knowledge of the meaning of words. While the observation that health visitors and clients hold a conversation may seem obvious, contrast this with the rather more regulated style of client-GP interactions in the GP surgery (Heath, 1986) or the way in which classroom teachers may take extended turns and control how and whether pupils can...
speak (Delamont, 1976). Elements of the conversation could be typical of a non-professional conversation:

Mother (M): My two little cousins there they were dying to see her weren’t they and they were sort of holding her [disturbing her]
HV: Mmm
Father (F): [Five minutes each
M: [Yeah
HV: Oh you've got it down. Yes well done. Yes
M: And um then it was a bit embarrassing that has to be said as dad says dad said it isn’t sort of worse um going out of the room to do it
HV: Um …

(Robinson, 1986: 107)

However, analysis of the relative distribution of the talk, and in particular the right to initiate and close down talk, showed how the health visitors use the framework of the conversation to achieve certain goals, thus turning it into a professional conversation. For example, extracts from Robinson’s data showed how a different style could be introduced by the health visitor.

HV: How are you feeding her
M: Breast
HV: And everything’s all right. You’re comfortable
M: Yes
HV: Lovely. Aren’t you going to be a lovely mum
HV: Yes. You’re not on the phone here in the cottage are you
M: (unclear response)
HV: It’s all right the first visit that I um just to go through the routine (…) things which I know mainly from what you’ve told me anyway which is um just to see what the labour’s like um just to fill in these little bits …

(Robinson, 1986: 99)

Here the health visitor imposes an interrogatory form on the interaction but, interestingly, feels that it requires an explanation ‘It’s all right …’ because it breaches the conversational norm. However, other extracts show how the client need not follow the lead of the health visitor. The health visitors used the devices of making polite but inconsequential remarks about the baby (or occasionally the family pet) and not taking their turn to speak (the figures in brackets are seconds of silence and in conversational talk prolonged silence is unusual and noticeable) to try to encourage the mother to initiate talk about topics of importance to her, but it rarely worked and the health visitors had to fall back on their list of potential problems:

Example 1

HV: … except it won’t be Christmas day. (2.5) She’s blowing raspberries (laughs)
F: She's found herself already.
HV: Has she (1.5) She’s very alert isn’t she. She’s following round. (5.0) Lovely any rashes or anything anywhere
Example 2

HV: Yes hello. You are having a good look round. (3.0) Yes. Did you get sore having to feed her nonstop (0.5) yesterday morning.

Example 3

HV: ...One day you'll look for it and find it's not there. Yes. Anyway you're beautiful aren't you. (3.5) Is she good for you at night.

(Robinson, 1986: 88, 91)

Note: in all cases the transcription has been simplified from the original. Each example refers to individual clients. It is useful for health visitors to consider their own interactions with clients and this is further explored in Activity 1.1 (see Appendix 1 at the end of the chapter).

The argument here is not that any of the talk is 'good' or 'bad'. The important point is that it shows how complex it is to use talk as a primary practice vehicle. Health visitors' common-sense knowledge of talk is fundamental to their practice but it is rarely fully acknowledged as a knowledge requirement for practice. Moreover, it could be argued that the relatively recent enthusiasm in many healthcare curricula for teaching 'communication skills' often fails to deal with the richness and complexity of institutional language use, especially in venues outside the formal control of the health system.

The above examples are samples of actual health visiting practice and provide evidence of the realities of practice within private homes in the context of mothers with new babies. They are evidence about health visiting. The fact that health visitors practise within people's homes is a significant defining characteristic of their work. While the issue of locality underpins all healthcare encounters, the home visit brings to the fore questions of the status of the home and the control of that space. Robinson (1986) showed how, in her sample, health visitors (rather than clients) managed both entry to and exit from the clients' homes. However, Luker and Chalmers (1990), using accounts of practice by health visitors, showed how the practitioners saw negotiating entry as problematic and occasionally difficult as can be seen in these extracts from respondents:

The first time I went the older child was about four and I didn't actually get into the house because she met me coming up the garden path ... she said 'we'd had no problems at all and I don't think I need a health visitor' ...

I knocked on the door on the 11th day and said 'hello, I'm the health visitor' and she sort of left me on the doorstep ...

(Luker & Chalmers, 1990: 76)

Health visitors also work in clinics, general practitioner (GP) surgeries, children's centres, church halls, social services departments, etc. So a further defining characteristic of health visiting is that it does not have a fixed locality or place of work. There is an interesting literature on the issue of place in healthcare (see, for example, Angus et al., 2005; Poland et al., 2005) and of course it relates to the issue of mobility which is central to Ferguson's (2010)
work cited above. Poland et al. (2005) argue that, while practitioners are sensitive to issues of place, this has largely been ignored in debates about best practice and evidence-based practice. He argues that:

Interventions wither or thrive based on complex interactions between key personalities, circumstances and coincidences ... A detailed analysis of the setting ... can help practitioners skilfully anticipate and navigate potentially murky waters filled with hidden obstacles.

(Poland et al., 2005: 171)

By ‘place’ Poland et al. (2005) mean a great deal more than mere geography. The concept includes a range of issues, notably the way power relationships are constructed and the way in which technologies operate in and on various places. Alaszewski (2006) draws our attention to the risk involved in practising outside ‘the institution’. While there are ways in which physical institutions mitigate the risks from their clientele, it is different outside the institution:

The institutional structure of classification, surveillance and control is significantly changed in the community. Much of the activity takes place within spaces that are not designed or controlled by professionals, for example the service user’s own home.

(Alaszewski, 2006: 4)

The accounts above show that everyday health visiting practice is not a simple enterprise. It is not always conducted in premises controlled by the state nor can health visitors wholly control the responses of clients. Indeed, the fact that health visitors themselves need to locate their clients sets the occupation apart from much of adult and children’s nursing and places it alongside occupations such as social work and mental health nursing. So how can the concepts of knowledge management such as that of evidence-based practice fit into the everyday realities of health visiting practice – if at all? Or are there better ways for health visitors to manage their knowledge? First, what is evidence-based practice?

Evidence-based medicine

What has come to be known as evidence-based practice had its foundations in the evidence-based medicine (EBM) movement which started in the United Kingdom (UK) in the early 1990s. There was increasing dissatisfaction among some key individuals in the medical profession, notably (Dr (now Sir) Muir Gray, who was an NHS Regional Director of Research and Development) that, within medicine, treatments which had been proven to be effective were not being used. Similarly, treatments which had been shown to have no or little beneficial effect continued to be used despite considerable efforts to change practice. For example, the GRIPP project (Getting Research into Practice and Purchasing), which was developed in the Oxford NHS Region, looked at four treatments:
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- the use of corticosteroids in preterm delivery;
- the management of services for stroke patients;
- the use of dilation and curettage (D&C) for dysfunctional uterine bleeding;
- insertion of grommets for children with glue ear.

Activity 1.2 (see Appendix 1 at the end of the chapter) enables further exploration of the evidence around interventions which health visitors deliver.

Good research evidence was available to underpin decisions in all these areas of practice and health authorities within the Oxford Region sought to ensure that practice adhered to the research-based recommendations. However, variations in practice proved difficult to eradicate and it was felt that more needed to be done. Did the practitioners not understand the research? Did they need motivating to change from their traditional ways of practice? Perhaps a more widespread and coordinated effort to base practice on research needed to be developed.

The fundamental proposition of the subsequent EBM movement was that practice should take account of the latest and best research generated evidence to underpin both individual clinical decision-making and collective policy-making. At its heart is the idea that EBM provides a vehicle by which the practitioner can continually examine and improve their individual practice by testing it against scientifically validated external evidence and importing proven treatments. Sackett et al. (1997) define EBM as consisting of five sequential steps:

- identifying the need for information and formulating a question;
- tracking down the best possible source of evidence to answer that question;
- evaluating it for validity and clinical applicability;
- applying it in practice;
- evaluating the outcomes.

So, for example, a doctor, faced with a patient with a severe infection, might ask ‘which antibiotic will best cure this infection?’ and look to the literature on drug trials to provide an answer. Thereafter they would evaluate the validity of the trial and its relevance to their patient, administer the drug (or not) and see what happened. Or, to use one of the examples from the GRIPP project, the doctor treating a child with ‘glue ear’ might ask ‘will surgery to insert grommets make a difference in the long term compared with conservative treatment?’ A search of the literature would indicate that surgery to insert grommets is not necessarily cost-effective in the long run in terms of outcome. But this example illustrates the complexity that the rational model of EBM does not necessarily deal with. At the point that the doctor opts for conservative treatment, what message is conveyed to the parent with a child who has suddenly gone deaf and who is losing speech (and friends at playgroup)? The research evidence on cost-effectiveness may not fully acknowledge the social issues surrounding the clinical problem. Evidence-based medicine is essentially a linear model for change which assumes that clinicians should make rational choices based on the scientific evidence available to them. It does not necessarily take into account the choices which clients make which might be