



Action on Health Visiting

Getting it Right for Children and Families:
Defining research to maximise the contribution
of the health visitor

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Background

Children's policy and research evidence for the importance of early intervention in the pre-school years of a child's life has developed rapidly over the recent years. This has emphasised the importance of reducing negative health issues later for the individual, and improved public health for the population through investment in health promotion and preventative strategies (Department of Health & DCSF, 2009, DH, 2009 (a,b)).

However, the health visitor, the professional traditionally seen as central to assessing need in families and ensuring the delivery of prompt interventions where necessary, has seen their service severely compromised in recent years as numbers of health visitor training commissions have been reduced and posts frozen or lost (Adams, Craig, 2008).

Despite its nearly 150 year history, there has been little investment in research to explore the unique contribution of the health visitor role to the health and well being of children and this will have partly influenced investment decisions. Whilst the government has made clear its own commitment to increasing health visitor posts, any arguments for employing more health visitors, rather than cheaper workers, to deliver specific public health-based work with families, have been harder to articulate to children's commissioners. The provision of a robust research base demonstrating the value of local investment in health visiting services, and what shape they should take, is essential to support the case for investment when there are so many competing investment demands for NHS commissioners.

It has become clear that, as the profession has reduced in number, identification of developmental concerns, including behaviour problems, autism and, speech and language deficits has often been delayed, general practitioners used inappropriately, and there are very real concerns about the failure to address levels of health inequalities and to safeguard vulnerable children (Adams 2009, Health Select Committee, 2009, Laming, 2009).

The Action on Health Visiting programme was launched by the Secretary of State for Health in March 2009. Its purpose was to articulate clearly the key roles of the health visitor and to take measures to

promote reinvestment in the profession, including identifying the available evidence base for its work. Getting it right for children and families, the result of phase one of that work, was published in October 2009 (Department of Health (c)) and has been very well received by the profession. It clearly communicates what the unique contribution of the health visitor is, as agreed by the profession and their advisors.

It also provides examples of supportive evidence for commissioning health visitors, and describes how to create a sustainable workforce. However, very little evidence was found that describes, explicitly, why it is necessary to employ health visitors rather than other workers to deliver their traditional role.

It is hoped that some future learning for the universal health visiting service will come from the Family Nurse Partnership project which works with very vulnerable families, and this organisation understands, the leaders of the project are currently clarifying a series of effective interventions which could be made available to health visitors for working with all families.

New challenges to public spending budgets are indicating that rather than benefiting from new investment the professional contribution of the health visitor remains very vulnerable as many Primary Care Trusts are planning across the board reductions in spending. The policy directive that health spending decisions should be made locally makes it much harder for the government to intervene without a robust evidence base for health visiting.

Significant skill substitution with cheaper workers is also becoming commonplace, despite a lack of evidence for safety or effectiveness in delivering children's policy from such grade mix. The government has though made clear that all service providers must demonstrate innovation, the promotion of quality and prevention, and take measures to ensure productivity (QIPP) in the months ahead.

Traditionally, health visitors held sole responsibility for a specific number of families ('a caseload') derived from the general practice or geographical area in which they worked. This has changed quite rapidly, with an increase in different types of team and corporate working to ensure coverage in the face of many part-time workers, sickness and vacancies. There is

also little research about the impact of these different approaches and, whilst some forms of team can be extremely successful, there have been concerns about the extent to which they have been implemented to cover staff shortages without adequate care. In particular, consumers dislike a lack of continuity with a named professional and there is a risk of serious concerns and safeguarding issues being missed and lines of accountability can easily become confused.

It has been clear to Unite/CPHVA for many years that unless there is investment in research to demonstrate the specific contribution of health visiting to the health and well being of children and families the profession will continue to be a soft target for disinvestment when budgets are stretched. Currently, it will struggle to be able to demonstrate its contribution to the QIPP agenda despite the profession, itself, being convinced the service it provides can lead to cuts in health expenditure later in the life cycle. This fact was also acknowledged by the Secretary of State for Health, the Rt. Hon Andy Burnham, as a way of ensuring that the NHS manages its expenditure in the longer term and he has called for investment in more health visitors and early intervention strategies for promoting the health of children and families. The, soon to report, Marmot review of health inequalities, has equally highlighted the importance of health visitor led interventions to reduce health inequalities, and such leadership is core to the delivery of the healthy child programme.

The Department of Health commissioned a review of the impact of health visiting research on health policy related to children and families in the UK, and this scoping of research requirements, and suggested research proposals from Unite the Union in August 2009. It forms one component of the Action on Health Visiting programme which the Department of Health are delivering in partnership with Unite. The work has been undertaken by a specially convened group of academic members of the Community Practitioners' and Health Visitors' Association in the 3 months since.

The challenges of undertaking research into health visiting practice

There are several challenges in undertaking research into health visiting practice. Firstly, much of health visiting work is undertaken in people's homes – in effect in private space. Hence much of the research that has been done depends upon interviews and records completed after the event, or focus groups with those involved, because an observer present in an encounter might radically affect the content. Over the years a range of strategies have been employed to capture more immediate data on health visiting activity and intervention strategies, including audio (Kendall 1991, Cowley, Mitcheson and Houston 2004) and video recordings (Bidmead and Cowley 2005), simulation (Bryans 2004) and questionnaire (Deave, 2003, Cowley et al, 2007, Condon, 2008) and new digital technologies are becoming less intrusive year by year. Other studies have focused more on health visitor work in clinic and group settings.

The second important challenge is in identifying sufficiently sensitive outcomes for work that is essentially about health promotion and prevention. Consequences of health visiting interventions may be long term, and causality difficult or impossible to track in an environment of rapid change and multiple interventions. Most studies have made use of intermediate outcome measures to address this issue. Part of this challenge is to implement processes to enable the routine collection, in practice, of input, process and outcomes data. The work of Christensen (2009) provides a basis for meeting this challenge.

Thirdly, the shape of health visiting practice has changed considerably over the past two decades, as set out in the previous section. There are several workforce models in existence. Many have developed organically and may not therefore be directly comparable with each other. Clarity about the mechanisms operating is therefore essential. The large-scale Scottish demonstration project, Starting Well provides a basis for this work (McKenzie et al 2004, McKenzie and Shute 2006)

Fourthly, work from Canada and elsewhere indicates that we should be seeking to examine the impact of health visiting practice over a whole system. However, identifying acceptable outcome indicators for one arena is problematic. Drawing together health, social care, benefits, education and others is a challenge of monumental proportions. This may just possibly be achievable through Health Innovation Education Clusters (HIECs).

Relevant research already being commissioned by government

- Ongoing evaluation of Sure Start by Birkbeck College, which has already identified better outcomes in Local Programmes where health visitors are engaged (Belsky et al 2006)
- Randomised controlled study of the Family Nurse Partnership as a delivery intervention for vulnerable children
- Large scale economic appraisal of the evidence base for early interventions within the Healthy Child Programme (DH(d))

When complete it is likely the learning from these, will in part be able to be utilised in developing health visitor practice.

Research required

What has been required for many years is research to develop a better understanding of how to maximise the health visiting professional contribution itself to the health and wellbeing of families.

This needs to be considered from the point of view of the unique role for health visitors in the context of the breadth of children's services. In particular the Unite/CPHVA Action on Health Visiting research group believe it is necessary to research health visiting in the context of:

- modern service structures such as skill mix
- health visitor education requirements
- health visitor outcomes
- practice delivery
- children's policy
- their influence on reducing health inequalities
- their power to work with whole communities
- in relation to safeguarding all children and families.

The group also believes that outcomes for children and families should be the focus of any research programme.

Development of recommendations for a proposed programme of research

An Action on Health Visiting research group was established by Unite/CPHVA from their academic networks in late August. The group was brought

together and facilitated by Dr Cheryll Adams, Lead Professional Officer for Strategy and Practice Development, Unite/CPHVA. The group met 3 times and held 2 teleconferences. Different members worked together on different research proposals between meetings and shared drafts by email. This work built on previous research priority setting activities by the Unite/CPHVA research forum.

Existing data sources available to influence health visitor service development:

- A UK-wide survey of health visitors' workload and working practices undertaken in 2005 by a team led by Professor Sarah Cowley at Kings College, London (Cowley et al 2007)
- An overview of types of research, including randomised controlled trials, and how they can be used to inform health visiting practice (Cowley and Bidmead 2009) – see appendix 6
- A systematic review of health visitor domiciliary visiting (Elkan et al 2000)
- A review of reviews of ante-natal and post-natal home visiting, (Bull et al 2004)
- Annual omnibus survey by Unite/CPHVA – this telephone survey uses a sample of 1000 health visitors working across the UK. In recent years due to devolution it has specifically targeted English health visitors. The most recent data available is from 2008, but it is shortly to be rerun. (Adams & Craig, 2008)
- A UK wide postal survey of health visitors education and training needs with respect to the key aspects of mental health promotion (Adams, 2007).
- A survey of the extent to which national child health promotion policy is reflected in health visitors' practice (Condon 2008)
- Family and Parenthood Institute surveys commissioned from 'You Gov' have explored parents' views of the health visiting service and what they expect from it. Also workload pressures and NHS expenditure on pre-school child health. (FPI, 2007, 2009)
- Netmums have surveyed their members to specifically consider services for parents suffering from postnatal depression but also where parents want to go to get support and information (Russell, 2008, www.netmums.com)
- A review of national policy and qualitative literature, undertaken to identify requirements for

pre-registration health visitor programmes, which revealed 12 key areas explaining the distinctive nature of health visiting practice (Prime Research and Development/UKCC 2001)

- Unite funded economic analysis looking at the cost benefits of health visitors intervening for postnatal depression. Expected to be completed soon and demonstrate a benefit for health visitors over GPs in assessing and intervening for postnatal depression. (Knapp, 2008)

- Education requirements
- Skill mix analysis
- Qualitative surveys of client views of the required service
- Effective health visitor interventions for perinatal depression, domestic abuse and the promotion of effective partner and parent child relationships
- Economic analysis of the contribution of the health visitor to health and social outcomes

Broad areas felt necessary for a research programme:

- Health visitors and children’s policy
- Randomised controlled trials of the contribution of health visitors to the healthy child programme/public health of children and families

Identifying outcome measures for health visitor research

It is essential to be clear on the outcome measures expected from the health visitor service. The table below provide indications of potential health outcomes drawing on DOH (2009d).

Demographic characteristics		
Health visitor	Parent	Child
<ul style="list-style-type: none"> • Number of health visitors employed, by whom • Type of deployment • Years of experience • Job experience • Training/ • Education 	<ul style="list-style-type: none"> • Age • Family composition • Educational background • Family risk status (Browne and Saqi 1988) • Equality status – PROGRESS PLUS (Kavanagh et al. 2007) – i.e. place of residence, race /ethnicity, occupation, gender, religion, education, socio-economic status, social capital, age, disability and sexual orientation • Health status physical and mental wellbeing (Goldberg and Williams 1988) 	<ul style="list-style-type: none"> • Age • Carers in addition to parent e.g. childminder

Specific process and endpoint outcomes (Department of Health 2009)

CHPP criteria	Health visitor	Parent	Child
Strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on parenting, mental health or social issues • Issues resolved • Referrals to other services • Prenatal involvement 	<ul style="list-style-type: none"> • Parenting Self efficacy measure (Teti and Gelfand 1991) • Parenting mental health measure (Cox et al. 1987) • Reported positive parenting behaviours • Reported parenting difficulties • HOME scale (Ertem et al. 1997) • Father involvement with service 	<ul style="list-style-type: none"> • Reported behavioural difficulties • If in pre-school placement • Attendance at school, if appropriate • Social interaction and language abilities • Involvement in community or other activities – e.g. dancing or sport • Attachment assessment e.g. (Condon and Corkindale 1998)
Care that helps to keep children healthy and safe	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on safety • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • Use of A&E, emergency/out of hours GP services • Use of safety equipment in house • Views on safety 	<ul style="list-style-type: none"> • Accidental injuries recorded and reported
Healthy eating and increased activity, leading to a reduction in obesity	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on diet or physical activity • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • Views on healthy eating and physical activity • Family meals/ eating-food diary • Family activities/ physical activity – activity diary 	<ul style="list-style-type: none"> • Food intake diary • When weaned to solid foods • Activity diary or pedometer in older children
Prevention of some serious and communicable diseases	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on immunisations • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • Views on immunisations 	<ul style="list-style-type: none"> • Immunisation uptake

Specific process and endpoint outcomes (Department of Health 2009) *continued*

CHPP criteria	Health visitor	Parent	Child
Increased rates of initiation and continuation of breastfeeding	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on breastfeeding • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • Views on breastfeeding 	<ul style="list-style-type: none"> • If breast fed and for how long
Readiness for school and improved learning	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on cognitive or social development • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • Views on play/ education • Aspirations for children • Reading materials in house and frequency of use • Use of writing, counting or colour activities 	<ul style="list-style-type: none"> • If in pre-school educational placement • If reaching developmental milestones
Early recognition of growth disorders and risk factors for obesity	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on growth • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • Views on child growth • Family members BMI 	<ul style="list-style-type: none"> • Percentiles and trends • BMI • If episode/s of altered growth identified
Early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on development, ill health or safety • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • If concerns regarding child health or wellbeing – where these reported (to whom) and dealt with (by whom)? • Smoking, substance misuse (not mentioned before) • Parental health 	<ul style="list-style-type: none"> • In addition to the above, was child - • Involved in safeguarding children procedures? • Identified as being at risk? • Does child have a physical condition or developmental delay – is it being managed- giving medication, taking up appointments?
Better short- and long-term outcomes for children who are at risk of social exclusion	<ul style="list-style-type: none"> • Difficulties identified • Duration/number of care episodes-action or advice on social exclusion • Issues resolved • Referrals to other services 	<ul style="list-style-type: none"> • Uptake of benefits and local services – registration with appropriate services • Changes in employment or income 	<ul style="list-style-type: none"> • Educational resource uptake • Health and social care resources uptake • Use of voluntary services

User and public involvement

It is necessary to include representatives from user groups and the public to inform this programme of research. In line with thinking from INVOLVE this would go beyond a consultation exercise. The intention would be for user group representatives, parents and young people preparing for parenthood to be involved in the research programme at several levels. Thus, their views and experiences would be sought in the research design stage, their observations and comments on documentation such as ethics approval and their active engagement in development of research tools and methods such as focus groups. Equally valid would be their engagement with analysis and interpretation and the dissemination process. Whilst challenging, these levels of engagement are now recognised as being relevant to all research studies. Members of the CPHVA group have recent and direct experience of involving the public in research, which could be drawn upon to inform the development of this group. Organisations such as the Family and Parenting Institute and Netmums are likely to be willing participants but we would also suggest approaching members of the public via community links such as Children's Centres.

Ethics and Research Governance

All the studies that are indicated as being part of the research programme would need to be subject to ethics and research governance approval through the Integrated Research Application System (IRAS) and local approvals where necessary.

Research proposals

Four research proposals were developed by members of the group to cover what were felt to be some of the most significant priority areas. These include the contribution of the health visitor to influencing and delivering children's policy, to examine workforce structures and service delivery models and to explore the profession's educational needs. Also included are a list of research recommendations. Finally, a paper previously published by this organisation and co-authored by a member of the research group (Cowley & Bidmead, 2009). This reviewed the available high quality research to inform commissioning of the profession, and its services and is based on evidence submitted to the Health Select Committee on Inequalities (2009).

The first proposal in Appendix 1 was commissioned by the Department of Health alongside this work, and has now been completed. It provides a helpful platform from which to consider the contents of this document, highlighting as it does the dearth of evidence from health visiting research which has informed recent children's policy.

If fully funded the total cost of this research programme would be a maximum of £1.65million. It would fit well with the policy research programme, or could be funded by a National Institute for Health Research programme grant. There would be clear value in funding all elements of the programme, these are complementary to one another and reflect areas where there is a dearth of relevant research.

Conclusions

In conclusion the CPHVA expert group has offered the Department of Health a series of research studies, forming a programme of work, which we believe is now essential if we are to move forward on the Healthy Child Programme. We need to ensure that in the future it is possible to inform policy through best evidence, provide commissioners and service providers with the knowledge base required to make decisions about family and child health services and create opportunities for knowledge translation and innovation.

There remain many unknowns in the context of ensuring the best possible future for children and families. The new evidence, as well as the consolidation of existing knowledge that this programme could provide will, we believe, be a significant step towards creating an innovative and motivated health visiting workforce that will lead the Healthy Child Programme and deliver for the future.

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Biographies of research group members

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Formally Lead Professional Officer, Strategy and Practice Development, Unite-CPHVA, Hon. Senior Lecturer, City University

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Following a career in health visiting and NHS research management Cheryll worked for Unite/CPHVA for 10 years, initially on a Department of Health funded secondment, and subsequently as their research lead, and then as a Lead Professional Officer for the past 2 ½ years including leading for research, strategy, practice development and health visiting in England. She has been involved with many work streams with NICE including being the Vice Chair of the National Collaborating Centre for Primary Care for four years. She was the Unite/CPHVA lead for phase one of the partnership work with the Department of Health on the Action on Health Visiting programme. She completed a professional doctorate in nursing in 2007, which considered the education and training needs of health visitors with respect to all aspects of delivering mental health promotion in families with pre-school children.

Cheryll was a founder of the Academy for Nursing, Midwifery and Health Visiting Research (UK) which was launched in early 2009 as a joint initiative with the RCN and RCM. She has facilitated the CPHVA research group for 10 years, sat on the RCGP research group for many years and contributed to the advisory groups of a number of major national research studies which have a relevance to public health practice and community nursing. She has also provided specialist input into a large number of policy development forums such as the DH Child Health Strategy group. She has published extensively and is a frequent conference presenter.

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Janice Christie has 20 years experience in hospital and community nursing, mostly accumulated in health visiting. In 2005, she was appointed to Queen's University Belfast (UK Russell Group University), School of Nursing and Midwifery (ranked the number 7 Nursing School by 'The Times'). Janice teaches pre-registration and post-registration nursing from diploma through to doctoral level. Her teaching areas include: research, public health and theories guiding professional practice; in addition she is the Deputy Director for an innovative Doctor of Nursing Practice programme. She provides research supervision at Masters and Doctoral level.

Janice was awarded a DHSSPS Special Nursing Fellowship to undertake a mixed method evaluation (including cluster randomised trial) of a complex intervention (health visiting postpartum care) 2001-2004. In 2008 she was

awarded an 'All Ireland Cochrane Fellowship' and is currently undertaking a Cochrane systematic review regarding obesity prevention with the Cochrane Public Health Review Group. Janice is a member of the Royal Statistical Society and enjoys undertaking mixed methodology studies using her training in multilevel and multivariate statistical modelling. Currently, she is working with 'Engage with Age'- a voluntary group, providing expert consultancy for a profile of older peoples' psycho-social needs. She is allied to the QUB School of Nursing and Midwifery 'maternal and child care' research theme and is a member of the NI Child Health and Welfare, Recognised Research Group. Janice was a member of the DHSSPS advisory group reviewing school nursing and health visiting 2008/09.

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Sarah Cowley has a professional background in health visiting with expertise in child and family public health. She was appointed to the Chair in Community Practice Development at King's College London in 1997. Her main research interests lie in the field of health visiting, particularly child and family public health, focusing on needs assessment, social capital and qualitative complex evaluations. Her needs assessment research is recognised internationally, and she has advised on studies in Brazil, Australia, Japan and New Zealand. Her recent research, which was the subject of evidence to the Health Select Committee's 3rd Inquiry into Health Inequalities in 2008, concerns the distribution of health visiting services in relation to indicators of deprivation. This led to a worked through model for funding to guide commission and strategic planning, which is being used by a number of Primary Care Trusts, and it is being adopted across the East of England for workforce planning purposes.

Professor Cowley is a member of the National Institute for Health Research, a Fellow of the Queen's Nursing Institute, and was awarded the King's College London Supervisory Excellence Award in 2008; she has supervised 17 doctoral students to completion with a further six in progress. She was part of the DH Health Visiting Review steering group in 2007, contributed to the DH Health Visiting Action Plan in 2009 and is project leader for the DH-funded UKPHA's health visiting regeneration project.

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Toity Deave has a professional background in health visiting and community development work with expertise in child and family public health. Toity is currently working as a senior research fellow in the Centre for Child & Adolescent Health. She has been involved in national evaluations of primary health care initiatives and community development schemes as well as an evaluation of health visiting methodologies. Toity's principal research interests lie in the field of antenatal and perinatal parental well-being, parenting and early childhood health & development, with a particular interest in fathers. She is also undertaking evaluations of complex interventions and working in the field of family and childhood injury prevention. Her interests are primarily from a public health and preventive perspective. In addition, she continues to investigate the influences of maternal well-being in pregnancy and parenting and its effect on child development, using the ALSPAC database.

Toity is an invited member of the Research Advisory Groups for both the NCT and One Plus One, and a member of the CPHVA Research Advisory Forum. In the Cochrane Collaboration she is a member of both the Pregnancy and Childbirth Review Group and the Child Health Field.

Professor Sally Kendall, Ph.D., B.Sc. (Hons), RHV, RGN

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Sally Kendall has a background in nursing and health visiting. Following completion of her PhD in 1991 she was a senior lecturer in nursing at Buckinghamshire College and later became Professor of Primary Care Nursing

there having set up a small but successful primary care research unit. In 1999 she moved to the University of Hertfordshire as Professor of Nursing. In 2001 she was appointed Director of the Centre for Research in Primary and Community Care (CRIPACC), a NIHR funded unit covering programmes of research in child and adolescent health and also the health care of older people. CRIPACC supports 44 researchers and PhD students contributing evidence to the NHS and social care in both practice and policy.

Her main research interest is in primary health care and especially in client/patient perspectives and in family and child health research, having published and supervised doctoral research widely in these areas and generated grants from external sources. Professor Kendall has supervised 16 PhDs to completion and examined more than 21. She has international links with nursing scientists in Japan, Finland, USA, Australia and Canada. She is the co-editor of Primary Health Care Research and Development and the co-chair of International Conferences in Community Health Nursing. She is also a Visiting Professor at Washington State University and a visiting lecturer in global community health at Mikkeli University, Finland. She was a member of the nursing advisory committee on clinical academic careers for nurses and is currently a member of the CPHVA Research Advisory Forum and the Academy for Nursing, Midwifery and Health Visiting research.

Dr Karen Whittaker RGN, HVCert, BN, MSc, PGCE, PhD

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She completed the BNurs degree (incorporating nurse and health visitor professional registration) at Manchester University in 1989. She gained most of her professional practice experience as a health visitor in Salford and moved to the University of Central Lancashire, Preston in 1998. Her teaching responsibilities include the leadership and delivery of the Specialist Community Public Health Nurse (SCPHN) BSc and PGDip programmes and the supervision of postgraduate research students. Her PhD, completed in 2008 at King's College, London, was funded by a DH training fellowship grant which allowed her to research health visiting involvement in parenting support programmes. Her previous research experience concerned the study of the educational needs of community nurses and parenting practitioners. Since PhD completion she has worked with social work colleagues reviewing local authority intensive parenting support services and separately with media and computing colleagues to develop a prototype interactive DVD for adolescents and parents to use together. Currently, she is the research supervisor for a Knowledge Transfer Partnership (KTP) project externally funded by a government Technology Strategy Board organization and East Lancashire NHS. This work is concerned with developing a model of accident prevention from an existing childhood scheme.

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Pauline Pearson has been Professor of Nursing at Northumbria University since 2009. She was previously Senior Lecturer in Primary Care Nursing, and Deputy Head of the School of Medical Sciences Education Development at Newcastle University. She is Deputy Director of CETL4HealthNE (Centre for Excellence in Healthcare Professional Education) – funded by HEFCE to increase the employability of healthcare graduates in the north east of England (www.cetl4healthne.ac.uk). She completed her first degree (BA Nursing) at Newcastle Polytechnic and worked in A&E before training as a health visitor. Pauline practised as a health visitor until 1993, completing a part-time PhD in 1988. She first moved to an academic post in 1993. Her research on interprofessional education has attracted interest from across UK as well as from Italy, Australia and Canada. She has undertaken research on workforce change and educational development as well as aspects of public health and primary care practice. She has supervised 11 doctoral students to completion and has a further five in progress. Pauline's recent research includes work on patient safety education for medicine, nursing, physiotherapy and pharmacy, which was the subject of evidence to the Health Select Committee's sixth report on Patient Safety in 2009, an examination of the development of new roles in the mental health workforce, and an evaluation of the Scottish Early Clinical Career Fellowships Pilot for nurses. Professor Pearson is a member of the National Institute for Health Research, Chair of the CPHVA Research Advisory Group and Vice Chair of the Academy for Nursing Midwifery and Health Visiting Research.

Appendices

Outline research proposals recommended by
Unite/CPHVA *Action on Health Visiting*
Research Group

Appendix 1

Policy

1. To investigate the impact of health visitor's research on policy and how this feeds into transforming community services.

The impact of health visiting research on health policy related to children and families in the UK: Protocol

Bunn F, Kendall S, CRIPACC, University of Hertfordshire

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1. Methods

There are two main methods for determining research impact upon policy. This involves either tracking forwards from research reports or backwards from health care policies. We will mainly use forwards tracing methods but this will be combined with some tracing backwards from policy documents. Our definition of policy will include not only national policies of the government but also policies agreed at national or local level by groups of health-care practitioners in the form of clinical or local guidelines as well as policies developed by those responsible for training and education in various forms (Hanney et al., 2003).

1.2. Forward tracking

Identification of studies

We will identify key health visiting (HV) research by running scoping searches of electronic databases, such as the Cochrane Library and PubMed, and contacting experts and well known researchers in the area. Searches will be restricted to 1997 until the present. These key research studies will then be used as the basis for the impact evaluation.

Framework for evaluation

The evaluation will be structured using a framework that is based on the Payback model (Hanney, 2003) and the Research Impact Framework (Kuruvilla et al., 2006). This framework has been developed and used by the one of the researchers (FB) in another study of research impact upon health policy. The framework is shown in appendix 1.

Methods for evaluating research impact

Literature on the subject of impact evaluation has recommended the use of multiple sources of evidence to identify research impact (Lavis et al., 2003, Hanney et al., 2004). We propose, therefore, to use a variety of methods. This includes:

- Citation analysis to determine impact in research community (e.g. through number of citations)
- Documentary analysis and literature review to identify key citing papers and relevant guidelines
- Informal semi-structured email or telephone interviews with the principle investigator of each research study being evaluated. The purpose of these interviews will be to ask the researcher if they are aware of any evidence of impact of their own research.

1.3 Backwards tracking

Documentary analysis

Tracing forwards from research studies will be combined with some documentary analysis of key policy documents such as relevant NICE guidance, Child Health Promotion, Choosing Health, Every Child Matters and the Children's Plan. We will hand search the documents to see if there is evidence that the policy has been influenced by HV research.

1.4 Reporting

This work was commissioned by the Department of Health and the report 'Has health visiting research influenced health policy relating to children and families in the UK?' submitted with this document.

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Appendix 2

Contribution of health visiting to the Healthy Child Programme

2. The health visiting contribution to outcomes of the Child Health Promotion Programme: a prospective study of models of health visiting

Lead contact: Professor Sally Kendall

Background

There is consensus in the literature that there is an urgent need to undertake large-scale research into the outcomes of health visiting in order to develop the evidence base for practice and to inform future policy (Cowley and Bidmead, 2009, Bunn and Kendall 2009). It is well recognised that health visiting is not in itself a single intervention, neither is there one well-defined and evidenced approach to carrying out health visiting. It is indeed a highly complex process consisting of a range of interventions and a range of 'models' or organisational ways of working. This very complexity has been used as a reason for not undertaking large scale well designed studies and yet there is an imperative to have greater clarity and stronger evidence about what health visitors contribute to the Child Health Promotion Programme (DH, 2009). This is now seen as central to health visiting work (DH/DCSF, 2009) and it has been stated by the Secretary of State for Health (Burnham, 2009) that health visitors will lead on this programme to build a better future for our children.

Research into complex interventions has been recognised by the MRC (2008) as requiring a systematic approach to developing the theory, tools and methods required to evaluate all the components of a complex intervention. This study would form the beginning stages of the complex intervention framework -: a theoretical phase plus development of interventions and appropriate measurement approaches. Earlier research funded by SDO has indicated that the research design discussed below has been effective in the nursing context (Kendall et al, 2009) and we would therefore propose a similar design for investigating health visiting processes and outcomes.

Objectives:

1. Systematic mapping of the literature on health visiting interventions in relation to the CHPP outcomes;
2. Identify the origins and range of health visiting models nationally;
3. Explore the commissioner, user and professional experience of health visiting models
4. Explore the characteristics of an enabling model of health visiting
5. Identify, measure and benchmark outcomes of a selected range of health visiting models
6. Define the key characteristics of cost effective health visiting models.
7. Define the characteristics and mechanisms required for effective health visiting in relation to the key CHPP outcomes.

Design and Methods

Four whole systems perspectives: the causal, data, organisational and user experience will be used to inform methodology and theory development (Kendrick and Conway, 2003). A three-phase study underpinned by case study methods in phase 3 (Yin, 1994) is proposed.

Phase 1: objectives 1,2. A systematic review of the literature and a parallel search of the internet to identify dissemination of good practice in health visiting.

Phase 2: objectives 2,4. Stakeholder consensus conference. Recruited via phase 1 an invited audience will function to refine the debate around health visiting models and reach a consensus on the criteria for selection of case studies in phase 3.

Phase 3: Multiple case study evaluation (objectives 3,4,5,6,7). 4 case studies (maximum) will be evaluated in terms of their processes and outcomes and the contribution of health visiting to the HCP.

Settings

Case study sites will be across England and will be from primary and community care settings.

Sample

Purposive and theoretical sampling will be used, as appropriate, for the qualitative study. Samples of practitioners, commissioners and parents/users will be drawn for each case study. For the benchmarking study, the sample size will be determined following selection of case studies according to applicable known population parameters. Where this is not available a sample will be drawn which will enable future studies to calculate a sample size for the purpose of measuring the health visiting contribution.

Outcomes

The key outcomes will mirror those in the Child Health Promotion programme (DH, 2009):

- strong parent–child attachment and positive parenting, resulting in better social and emotional wellbeing among children;
- care that helps to keep children healthy and safe;
- healthy eating and increased activity, leading to a reduction in obesity;
- prevention of some serious and communicable diseases;
- increased rates of initiation and continuation of breastfeeding;
- readiness for school and improved learning;
- early recognition of growth disorders and risk factors for obesity;
- early detection of – and action to address – developmental delay, abnormalities and ill health, and concerns about safety better short- and long-term outcomes for children who are at risk of social exclusion.

Measurement

Questionnaires to parents/users will include health service utilisation, parenting self-efficacy (TOPSE, Kendall and Bloomfield, 2007), Strengths and Difficulties Questionnaire (Goodman et al, 1998), Edinburgh Postnatal Depression Scale (Cox et al, 1987).

Local data on breastfeeding, immunisation, CAMHS referrals and child protection referrals will be collected at an organisational level.

Data will be collected at three time points (2 months after birth, 9 months and 18 months).

Questionnaire data from service users will be benchmarked against UK national and international cohort data (Millennium Cohort, ALSPAC) and against expected targets.

Qualitative data will consist of semi-structured interviews with commissioners, practitioners and parents/users.

Analysis

The literature will be systematically analysed drawing on recognised approaches for synthesising both qualitative and quantitative evidence (Pope et al, 2007, Thomas and Harden, 2008).

Documentary and interview data will be analysed theoretically drawing on thematic analysis.

Descriptive statistics from the scores of questionnaire data will be benchmarked against UK national and international data.

Inferential statistical analyses will be undertaken as appropriate, using SPSS v14. We will be posing questions such as:

- What is the variance in outcomes between case studies?
- What is the variance in outcome within case studies between parents/children?

- Do outcomes change over time?
- What are the relationships if any between outcomes?
- How do the study children benchmark against existing cohort data on key outcomes?
- Department of Health (2009)⁴ The Child Health Promotion Programme, pregnancy and the first five years of life. DOH, London what are the major confounders and how can the data be adjusted to take account of them?
- What are the key components of health visiting interventions?
- How can the data be used to determine power for a future RCT?

Cost analysis will be from a provider perspective using discounting procedures and modelling data for future costs of relative HV models for 5-10 years.

Indicative Cost: £500k

Dissemination

The findings will be disseminated through reports, publication in professional and academic journals, conferences, seminars, local workshops and through the dedicated project website.

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Appendix 3

Workforce structure and process

3. Examining patterns of workforce change and their consequences

Lead Contact: Professor Sarah Cowley

Health visiting research

Health visiting services are delivered and led by qualified health visitors, but provided in collaboration with colleagues, like children's centre staff and primary care teams. Health visiting has evolved since the mid-nineteenth century, developing as universal services rather than being implemented as distinct, manualised programmes, as happened in some countries, notably the USA. Although there have always been (sometimes quite fierce) debates about the nature, form and purpose of health visiting services, they remained remarkably similar across the country until the last 10-15 years. Since the early 1990s, services have become increasingly diverse, with local commissioners and managers implementing national policies, currently the Healthy Child Programme, in different ways. The result is a workforce for children and families (including early years) that has varying levels of expertise which may be poorly matched with local service needs. This has affected the format, coverage and understanding of 'universality' within health visiting service provision, and led to a variety of different views about how services are best organised and delivered.

There is now a recruitment crisis and shortfall in qualified health visitors, which is further fuelling the diversity in service formats. This situation creates both an unprecedented need, and unique opportunity, to research universal health visiting services. In the past, it has been said that comparative studies could not be undertaken, because it would be improper to withdraw services available everywhere else. There are now places where health visiting services are stretched to the point that they are unable to offer full, universal provision. This variation is giving rise to a new round of debates about what constitute a 'full health visiting service' and which variations might be considered reasonable, possibly even better (ie, more cost-effective) alternatives. Commissioners and service managers need to know the answer to a number of questions, such as:

- How many contacts should be offered routinely to families, and where should they be carried out: at home or at a clinic, children's centres or other base? How long does a visit take?
- Who should carry out the contacts: health visitors, team members through delegation (skillmix) or collaboration (multi-agency working)? Which forms of team working are best?
- What is the optimum ratio of health visitors to pre-school children, and what affects this
- What are the relevant client factors, eg, levels of deprivation?
- How are services affected by local factors such as geography, e.g, distances, availability of other services or different forms of service organisation e.g. GP attachment or locality working; form of caseload management?
- What outcomes can be expected from the service?
- Are there any established indicators of quality and how do we know the service is safe?
- Is it better to provide a proactive, relationship-based service, or is it sufficient to respond after problems have arisen (responsive service)?

Manualised programmes answer such questions before setting up their specific programme, and in theory it would be feasible to manualise the universal health visiting service, to inform commissioning. A basis could be laid, using the phases of the MRC Framework for Complex Interventions (Craig et al 2008), for a programme of studies.

1. Phase 1: Scoping - modelling and theorising, 6-18 months – national

- a) National survey using questions from validated instruments to map service variations and identify what is happening across country (there are a number of validated survey instruments from which to draw, e.g. Cowley et al 2007, Condon 2008)
- b) Scope/map inputs and intended outputs from services, with view to developing a manual of service organisation and provision; this would draw heavily on the Health Child Programme (DH 2009) for activities required and from the survey data to describe forms of service organisation, such as skillmix teams, corporate

caseloads, different underpinning philosophies and so on.

c) Identify outcome measures, sources of information and indicators suitable for economic assessments.

d) Identify suitable sites for Phase 2

Indicative costs: £150-200k, including FeC

2. Phase 2: Exploratory trial and baseline, 30-36 months - selected sites

1. Qualitative arm: 24 months

MRC Phase Evaluation

1. Assessing effectiveness

2. Understanding change process

3. Assessing cost-effectiveness

- a) In-depth case studies of three-four different forms of service organisation, including different forms of team work, delegation or referral patterns
- b) Consumer perspectives: views of different forms of service provision, satisfaction and use
- c) Staff perspectives: views of different forms of service provision; understanding and preferred models, impact on retention, stress and sickness etc
- d) Change management perspectives: how do the different forms of service organisation suit current policies, e.g. roll-out of Children's Centres or attachment to General Practice etc.
- e) Identify comparison sites to be used for cohort study

Indicative costs: £250 - 300k, including FeC, not including service costs

2. Quantitative arm: 36 months

- a) Exploratory trial (ante-natal to 2 years old)
 - Comparing different forms of service provision, e.g., comparing different ratios of health visitor to pre-school children, or use of more or less dilute skillmix in teams
- b) Scope and pilot measures/data needed from to describe service formats for comparison
- c) Scope and pilot outcome measures, sources of information and indicators suitable for economic assessments.
- d) Identify outcome questions for cohort study (Phase 3)

Indicative costs: £450 - 500k, including FeC and economic advice, not including service costs

3. Phase 3: Definitive evaluation, longitudinal cohort study

Consideration is being given to undertaking a new cohort study in Olympic year (2012), which would offer an important opportunity to evaluate a wide range of different service forms if they could be mapped and developed in time. If sufficient clarity is identified in the earlier phases, it would be feasible to specify and record details of health visiting services provided in 8-10 different sites, then to follow up the impact on children as they grow and develop. This would be costly, but by 'piggy-backing' it onto an existing cohort, costs could be minimised.

Reference

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Appendix 4

Education

4. The educational needs of a health visiting workforce

Lead Contact: Dr Karen Whittaker

Background

There is a need to complete an educational analysis of current provision for health visitors to consider what parts of the current programme should remain. In doing this it would be important not to disregard all areas that are currently working well in the programme. For instance it would be important to include what practitioners and commissioners want and to keep the annotation of health visitor for the SCPHN register in order to be able to design the correct education content for the programmes. It is noteworthy that the NMC is now in agreement that alternative entry routes to health visiting need to be considered. It is therefore essential that educational research is undertaken to consider the ways in which to prepare health visitors to be involved in innovative developments and actions necessary for transforming community services.

Rationale for proposed research

- The current health visiting workforce has been depleted through increasing retirement and reduced commissions for training places (Unite/CPHVA 2008). The additional difficulty in recruiting eligible applicants to health visiting educational programmes means that there is a need to determine how entry into this workforce can be broadened (Newland 2009).
- If the commitment to ensuring there are sufficient numbers of health visitors available to deliver services for children and families is to be met, recruitment and retention needs to be strengthened (Department of Health et al 2009)
- The standards for proficiency for SCPHN are aimed at meeting the needs of a group of practitioners (health visitors, school nurses and occupational health nurses) that although share common principles, have varied and different roles in practice which require different skills sets. It has been recently identified that there is a particular need to ensure that health visitors have the education and training to deliver service specification (Department of Health et al 2009)
- A survey conducted by the Community Practitioners' and Health Visitors' Association investigating health visitors levels of education and training for delivering mental health promotion with respect to key areas such as domestic abuse, attachment and postnatal depression, found a very varied pattern, both in terms of access and quality. (Adams, 2007)
- Health visitors are working alongside an ever growing, and yet to be clearly defined early years workforce (CWDC 2009). As leaders of skill mixed universal services they are in a unique position and require specific educational preparation to support positive practice in these roles.
- There are already numbers of practitioners working alongside health visitors as part of skilled mixed teams, or employed within early years services, who are restricted entry to health visiting in the absence of a nursing qualification. This adds to the burden of time and personal expense to qualify (Newland 2009). The process of dual qualification (nursing/SCPHN) also adds hugely to NHS costs
- Specifically to respond to the current workforce crisis the educational needs of various groups must be accurately understood. These groups include those who:
 - a. are newly qualified as health visitors
 - b. are existing registered nurses ready to start a health visiting career
 - c. wish to return to practice as health visitors (previously registered)
 - d. have graduated with a relevant health or social care degree, but **do not hold registration** as a nurse
 - e. have work experience in health and social care, but **do not hold registration as a nurse or a degree level qualification.**

Study Aims

1. To identify the educational needs of a workforce fit to practice in health visiting
2. To develop an understanding of how programmes of education need to be designed and delivered to sufficiently prepare health visitors for professional registration.

Objectives:

1. Establish what the core educational needs of a health visiting workforce are when acting as leaders of skilled mixed universal services as part of the 0-5 healthy child programme?
2. Identify and explain the specific educational needs of different groups, that is, the potential workforce, the existing workforce and those able to return to practice.
3. Identify the sufficiency of current training arrangements for developing a workforce able to lead and deliver the 0-5 health child programme
4. Review recruitment arrangements throughout England for health visitor education

Design and Methods

A three part study incorporating: a review of existing evidence to determine what is already known; a survey of HEIs and partners to establish a national picture of current educational arrangements; and a detailed analysis of selected cases using realist contexts, mechanisms and outcomes principles (Pawson 2006), to determine the needs of those in different circumstances.

Part 1: A review of current literature concerning the educational needs and preparation of health visitors. Including international evidence for preparation of a professional workforce able to lead and deliver health services for families with pre-school aged children. This would establish what is already known, the age/currency and location of data profiling workforce segments, and what remains to be understood about strengthening courses for educational preparation for the health visitor role required to meet service specifications.

Part 2: National survey of practitioners to establish current sufficiency of educational programmes in meeting workforce needs for delivery and leadership of the 0-5yrs healthy child programme.

Part 3: The third part would be designed to develop a greater understanding of educational needs dependent on circumstances of the individual (that is, the potential, existing and returning workforce). Data collection could include group, face-to-face and telephone interviews with various stakeholders. This data would be used to identify the implications for the design and delivery of educational programmes.

Settings

The survey will include HEIs across England. Case study sites would centre around HEIs and their local links and would be located in different regions across of England.

Sample

The national survey would be conducted through HEIs and would use a stratified sampling strategy to include SCPHN-HV course teachers, HV practice teachers, new HV graduates (qualified ≤ 2 yrs) and those completing return to practice programmes, in the national survey. From the survey data, purposively sampling would be used to identify up to three geographical case study sites for inclusion in part 3. Participants within these sites would represent the potential, existing and returning workforce. This would include: new HV graduates; experienced HV practitioners (practicing ≥ 4 yrs); service provider managers (NHS and Children's Centre); HVs interested in or recently returned to practice;

NHS and Children's Centre employees interested in a health visiting career, course leaders responsible for SCPHN-HV programmes and those programmes allied to health visiting, such as psychology, public health, and epidemiology. In addition a service user group would be identified for each case study site and would be invited to comment on current and future workforce needs.

Analysis

The literature will be systematically analysed drawing on recognised approaches for synthesising both qualitative and quantitative evidence (Pope et al, 2007, Thomas and Harden, 2008). Survey data will be analysed using SPSS v14 to compute descriptive and inferential statistics as appropriate. Case study interview data will be analysed theoretically drawing on realist principles to identify context, mechanism and outcome patterns relevant to different circumstances for entering health visiting.

Timescale for completion

Part 1 would be ongoing
Parts 2 & 3 ethical permission and access up to 4 months
Part 2 survey 10 months
Part 3 case study work 12 months
Total up to 2.5 years

Indicative costs: £125-150k

Potential funding source

This project could be suited to a Knowledge Transfer Partnership (KTP 2009) funding stream if there was an emphasis on strengthening existing resources through innovation. KTP is a UK-wide programme concerned with improvement of competitiveness, productivity and performance within organisations. A KTP achieves this through the forming of a Partnership between a company (including NHS organisations) and an academic institution which enables partners to access new skills and expertise to help improve innovation, knowledge generation and translation.

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Appendix 5

Additional recommendations for research

These additional questions were raised by the group. They could form part of a programme of research. Some could also be picked up by Masters or PhD students as part of the research capacity building intention of Modernising Nursing Careers.

1. Case controlled epidemiological research study to examine the effects of poor health visitor/client ratios as compared to similar communities with optimal staff/client ratios.
2. A prospective, randomised controlled study examining different models of health visitor practice to clarify the contribution that health visitors could make to promoting mental health for children and families.
3. An exploration of the criteria on which managers decide practice priorities when determining what to resource with recommendations for effective criteria
4. An investigation of the benefits from having professional leadership from a senior clinician with specialist experience in health visiting services
5. An examination of the factors that influence individuals to take up health visiting as a career
6. Research to examine and agree with the profession the necessary components of a modern health visiting education
7. An examination of the factors which influence decisions with respect to returning to health visiting practice
8. Research into the process of implementing a system of electronic recording of health visiting activity and outcomes {this would in the longer term contribute to a number of the other research areas in this list eg 2, 3.}

Controversial questions (part three): is there randomised controlled trial evidence for health visiting?

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Abstract

Questions are often asked by managers, commissioners and policy-makers to find out what is, or should be, happening within health visiting services. This is the final paper in a series of three that draws on the experience of providing evidence to the Health Select Committee's 2008 inquiry into health inequalities. Material submitted has been adapted and expanded according to three common, often controversial questions. This paper considers the relevance and place of randomised controlled trials in relation to health visiting services. Increasingly, commissioners require that services and programmes that they fund to be supported by this form of evidence, and many ask, 'Is there a randomised controlled trial of health visiting?' The immediate answer to this question is 'no', but there is a wealth of evidence relevant to health visiting, much of it from experimental research and systematic reviews. The question itself is not appropriately framed, so three alternative questions are proposed that can help to guide a search for evidence that is relevant to health visiting.

Key words

Need for health visiting, evidence, health inequalities

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Introduction

In 2008, the House of Commons Health Committee met to consider health inequalities, with a particular focus on how the health service could help to reduce them. They received a great deal of evidence about how pregnancy and the early years constitute such a critical period that it is effectively a social determinant of health inequalities.¹ Comparatively little evidence was submitted about health visiting, but in an oral evidence session, one committee member asked a question that is often heard: 'Is there randomised controlled trial evidence for health visiting?' The short answer to this is 'no', but that is an unhelpful response.

Randomised controlled trials (RCTs) are most suited to evaluating interventions or programmes, not professions. Health visiting is a profession, so it is tempting to regard the question as hostile and retort simply that it would not be a suitable research method. After all, nobody asks whether there is an RCT for general practice, health service managers or surgeons, for example, so why seek one for health visiting? Inquirers may be seeking an excuse to condemn health visiting, but they may also want to support, so a more positive way of asking the question is needed. Health visiting is also a form of service delivery, required in response to a particular need. By and large, RCTs are unhelpful in identifying need or in evaluating forms of organising services, though robust and comparative research approaches are possible. As a particular kind of practice, health visiting is a mechanism for delivering interventions and programmes to support children, families and public health. There is a great deal of evidence from RCTs, and indeed other forms of research, in these fields. Studies designed to describe and identify the distinctive approaches used in health visiting practice are mainly qualitative rather than evaluative, and rarely comparative. Such studies

are valuable, but do not give the information required to evidence particular interventions. Likewise, an RCT can provide evidence for particular interventions or programmes, but not for the whole field of health visiting.

Instead of asking whether there is an RCT of health visiting, three useful questions have been identified that can help to ascertain evidence that is available in a systematic way. These can be applied at both a population level (such as across a primary care trust, to plan levels of service provision) and at the level of the individual and family. The questions are:

- What needs doing?
- How should it be done?
- Who should do it?

Asking these three questions in order demonstrates the primacy of needs in determining service provision, gives an opportunity to demonstrate relevant evidence from RCTs about interventions and programmes, and concludes with research about the profession.

What needs doing?

To improve health inequalities, it is increasingly clear that it is necessary to reach families with young children, because there is so much evidence that behaviour patterns become embedded at this time. Recent evidence from neurobiology and genetic research shows that early behaviour patterns become, in effect, 'hard-wired' into the infant's developing physiology, setting the scene for later risk factors and disease.² This is believed to be one cause of health inequalities – it is the reason that early child development is regarded as a specific determinant of health inequalities.³

Behaviour patterns and activities that lead to later risk factors for disease are not confined to families who are living in poverty, but they are more prevalent in such situations. Families living in the community are not classified according to specific behaviours or activities, nor do they

all fall into known 'groups' or 'diagnoses' as happens with most populations registered for health service interventions, so there are two key issues for health visiting practice.

First, the challenge is to identify, from within an undifferentiated caseload, which health-related activities, risk or resilience factors, or other features are relevant within each family, or which may require assessment (see Box 1).

Second, health visitor assessment skills are used to work in partnership with the family, not only to identify any of these potential risk factors but also to consider strengths and possible protective factors – such as self-esteem, resilience and personal or emotional resources – before reaching a professional judgment about the specific health needs of the infant and family, thus being able to answer the questions:

- What are the needs for this family?
- 'What needs doing' for this family?
- What can they do for themselves, with or without support?

There is a large evidence base about how this needs assessment process works, mainly based on in-depth qualitative research about health visiting.⁴⁻⁶ Some aspects of this process have been subject to experimental research, such as the Family Partnership approach,⁷ First Parent Visitor programme⁸ and Solihull Approach.⁹ The outcomes of such studies are helpful in offering a guide for health visitor education and informing ideas about 'good practice'. Most studies point to the importance of a strengths-based approach and the need to develop a positive health visitor-client relationship before carrying out the assessment process.^{10,11}

A breadth and depth of professional knowledge is needed, and not only to ensure suitable communication skills to elicit health needs without causing offence, which tends to happen if direct questioning is used.¹² It is also to be able to interpret small cues and clues offered by the client, drawing out further information if necessary, and then to link it accurately to evidence of likely health needs. An example of a difficult professional judgment might be when parents describe an infant's behaviour in very derogatory terms. This may warn of the likelihood of over-harsh discipline in future, or might simply mean that the parents have lost sleep, had an argument and are having a single bad day. Examples of a hidden health need may relate to the infant – a child may be

regarded as a 'good baby' by parents who are unaware that a low level of responsiveness can signify a degree of learning difficulties. Conversely, young children may be regarded as 'naughty' when they have specific difficulties such as hearing loss, autistic spectrum condition or other disabilities. More commonly, there may be unrecognised health needs, such as:

- Parental mental health, like postnatal depression and bereavement (including earlier miscarriage) or issues from a parent's own childhood
- Socially-based issues like domestic violence and child protection concerns
- Health-related activity patterns in the family, including exercise, eating, conflict resolution and access to social support.

Each of these examples may occur in any family, but are more likely to remain unidentified and unaddressed in families with fewer resources, thus laying the foundations for later poor mental or physical health, and health inequalities.³ However, these foundations are amenable to change at this early stage, with the potential to reduce health inequalities later in the child's life. This leads to the next question, concerning the selection of appropriate interventions or support mechanisms.

How should it be done?

Having identified specific health needs to be addressed, or prevented despite the presence of high risk, it is then possible to ask the 'RCT question' about that specific need. This can take place as part of a discussion between the health visitor and family to plan the service offer, or at a

commissioning level, after carrying out a community-wide needs assessment. There is a great deal of evidence from RCTs to support particular types of intervention for health needs arising from most of the factors listed here (see Box 1), and many more that a health visitor might meet on any single day. This evidence comes in three categories:

- Specific risk factors or problems
- Particular forms of intervention
- Programmes that target specific population groups.

The majority of studies fall into the first category, having examined specific risk factors or problems and identified interventions or programmes that will address them. A substantial review of reviews,¹³ particularly concerned with parenting for infant and maternal mental health, was collated to inform the new Child Health Promotion Programme (CHPP),¹⁴ now renamed the Healthy Child programme.¹⁵ This identified some 50 reviews across numerous topics (see Box 2), including Cochrane and other systematic reviews, reviews of reviews and National Institute for Health and Clinical Excellence reviews, as well as 23 individual studies. The strength of evidence was evaluated in each case, showing variable levels of support for different interventions and that more research work is needed. While this review identifies most of the relevant evidence in this field, there is a new systematic review of interventions directed at promoting breastfeeding¹⁶ and two concerned with reducing childhood accidents^{17,18} that were not included. Limited evidence about how best

Box 1. Some examples of health issues to be assessed on an undifferentiated caseload

- Smoking, alcohol, use of illicit substances
- Breastfeeding (or not), weaning, family food behaviour
- Factors related to mental health, such as attachment between mother (and father) and baby, which are intimately linked with postnatal depression and domestic violence
- Home environment and safety, including potential for accidental and non-accidental injuries and opportunities for infant to develop cognitive capacity (language, reasoning etc)
- Parenting capacity, skills, knowledge
- Wider family support and/or social isolation, marital or partnership issues, relationships in the family
- Practical social factors such as income level, housing, access to services and facilities, and employment
- Physical capacity of parents, presence of illness, disabilities or wellbeing
- Physical health and wellbeing of infant, including immunisation status
- Developmental progress of infant, including speech and language, social development and behaviour, fine movements, mobility and co-ordination

to prevent obesity in pre-school children is a major gap in the research. Principles used to inform the protocol are available from one on-going exploratory trial,¹⁹ which aims to identify the best way of promoting healthy food behaviour at weaning.

The second category of trials look at particular forms of intervention, such as ‘home visiting’ or ‘community groups’, using systematic reviews or meta-analyses to evaluate whether they provide any benefit.^{20,21} Most indicate that a broad-based multi-component programme leads

to the best outcomes,^{22,23} though there is little evidence that this approach works to prevent child maltreatment.²⁴ One RCT compared the effectiveness of supportive home visiting carried out by health visitors with community groups. This found that uptake of the latter was only 19%, compared to 94% with monthly health visitor home visits to parents in the first year of their baby’s life.²⁵

The third category of evidence overlaps with the second. These are the general preventive and health promoting

programmes that have been developed for vulnerable population groups, rather than specific risk factors. They include the European Early Promotion Project,^{26,27} Olds’ intensive home visiting programme for high-risk mothers,²⁸ the Early Child Development Programme,⁸ a meta-analysis of programmes directed at family wellbeing and prevention of child abuse²³ and a quasi-experimental evaluation of the Scottish ‘Starting Well’ demonstration project.^{29,30} This introduced a broad-based programme of home visiting and community groups across a city (Glasgow) with high levels of deprivation. A comparative analysis of the Early Child Development Programme, which internal evaluation had rated as successful,³¹ with ‘usual health visiting’ revealed little difference in outcomes between the two groups.⁸

In general terms, there is far more evidence for interventions needed in the first year or two of life than during the period leading into the school years. The reverse is true for parenting education and weight management programmes, which have been widely evaluated for school-age children but not for the early years. There are some serious deficits in the knowledge base in specific areas – for example, there are trials in progress about how best to promote approved food behaviour at weaning, but current practice relies heavily on knowledge drawn from action research, qualitative studies and professional experience.

Who should do it?

Only after deciding ‘what needs doing’ and ‘how it should be done’ is it sensible to ask ‘who should do it?’ Asking the three suggested questions in order places this one about occupational groups last, rather than orienting programmes or services to professional interests. The question ‘Who should do it?’ can be asked at different levels – strategically when considering which services should be commissioned to achieve particular outcomes, or locally when considering who within a team should carry out activities according to their particular skill base.

At a strategic level, two linked questions help to focus planning. For example, when planning a service directed at reducing health inequalities, which occupational groups have the skills and abilities to deliver the research-based interventions (as outlined above) to families, especially mothers, babies and pre-school children?

Box 2. Topics reviewed to inform Healthy Child programme¹³

Antenatal period	
Preparation for pregnancy	Antenatal classes Breastfeeding promotion Low birthweight Smoking cessation
Preparation for parenthood	Transition to parenthood Preparation for fatherhood Identification of need or problems Promotional interviews Antenatal depression
Supporting pregnant women who are at risk	Domestic abuse Alcohol dependency Drug addiction Demographically at-risk women
Postnatal period	
Childbirth	Debriefing following childbirth Breastfeeding promotion
Promotion of bonding	Skin-to-skin contact Information about sensory and perceptual capabilities of the infant Infant carriers Supporting fathers
Supporting early parenting	Media-based parenting programmes Primary and secondary behavioural problem prevention programmes Parents of children with behavioural problems Parents with learning difficulties or developmental delay Mothers with drug addiction Parents with severe mental health problems Promoting child cognitive development
Preventing or addressing early infant/toddler problems	Anticipatory guidance Enhancing maternal sensitivity and/or infant attachment Interaction guidance
Promoting mental health of children and families	Parent-infant psychotherapy Postnatal depression Targeting and focusing services
Preventing and treating obesity in infants, young children	Promoting healthy eating Growth monitoring
Supporting families at risk	Smoking cessation Domestic abuse Alcohol dependency Drug addiction Home visiting programmes Teenage parents

Second, who is best placed to deliver these interventions, by virtue of their client base and contact with the target of the interventions? In both instances, as Acheson noted in his independent review of health inequalities,³² the immediate answer (in the UK at least) is 'health visitors'. While other groups may also have a claim, there is evidence of health visiting effectiveness in this field. The measurably better results in health-led Sure Start programmes was attributed to health visitors' universality and the existing engagement of all families in the target age-range.³³ Also, the skills of health visitors implementing the Scottish 'Starting Well' demonstration project contributed to changes in attitudes and parental perceptions.³⁴

In addition, consumer groups strongly support the idea that health visitors are the professionals who should be providing these interventions. In 2007, the Family and Parenting Institute commissioned a YouGov survey of 4775 parents of pre-school children,³⁵ 76% of whom wanted parenting support and advice about their child from a trained and up-to-date health visitor, while only 33% wanted this from a nurse and 16% from a nursery nurse. In 2008, 6078 mothers responded to a Netmums survey, with a clear majority of 70% supporting the idea of having one health visitor who knew the family rather than a mixed team, even if that team provided consistent and sound advice.³⁶

Despite these consumer views, there has been much official enthusiasm for 'health visitor-led teams' as detailed in the CHPP¹⁴ and health visiting review³⁷ in England. In Scotland, a pilot to replace existing occupational groups with a different 'community health nurse', working across age groups and health needs, was halted before completion of the evaluation.³⁸ This was because the loss of dedicated health visiting posts was linked to a marked rise in child mental health problems and fall in timely referrals to speech and language therapy.³⁹

There have been few carefully developed and evaluated projects aimed at introducing different ways of working, and there is limited research to support either substitution by different workers or delegation to skill-mix teams. A UK economic analysis is under way comparing the cost of using universal health visiting services to identify postnatal depression against usual GP care in the absence of health visiting, and initial results appear to favour provision of health

Key points

- Evidence from randomised controlled trials is increasingly regarded as an essential requirement for service delivery and commissioning
- Health visiting services are usually organised to provide universal delivery, which is not automatically aligned with evidence
- A literature search for evidence of the entire profession and service is unlikely to yield evidence from experimental sources
- This paper shows one way of thinking about services, which will help to find a way into the relevant literature

visiting services.⁴⁰ In the US, Olds compared delivery of his intensive home visiting programme by nurses or para-professionals. Results from the professionals were far better in terms of both effectiveness and cost-effectiveness.⁴¹ The relevance of these findings in the UK is not clear, given the very different approaches to nurse training in the two countries. In the English pilot of this programme, 44 of the 47 home visitors were qualified health visitors,⁴² despite being all labelled 'family nurses', whereas those employed in this role in the US were mainly baccalaureate-educated nurses. Additional, programme-specific training is provided in both countries. Part of the success of US experiment was attributed to the acceptability of nurses as advisers to new parents,⁴¹ whereas UK consumers prefer health visitors in this role.³⁵

The Scottish Starting Well programme explored the use of lay health support workers and community nursery nurses within a team led by health visitors, and showed the importance of strong organisational and managerial support in order to implement the team approach.⁴³ Survey evidence suggests that the presence of community nursery nurses in a health visitor-led team is associated with more group work, and that having sufficient administrative support is associated with delivery of a more comprehensive, multi-faceted health visiting service.⁴⁴ Specifically, community mothers have proved helpful,⁴⁵ and a skill-mix team can support community development work,⁴⁶ but as in the Starting Well experience,⁴³ training, support and supervision by the health visiting team leaders were considered essential.

Concluding comments

Overall, there is a great deal of evidence from RCTs that is relevant to the purpose of a health visiting service, which is to

contribute to a reduction in health inequalities and improvements in public health, by supporting and promoting the health and wellbeing of all families and parents from pregnancy until the child starts school, and possibly beyond. There are limitations, however. Most of the reviews identified above include a comment that the quality of the studies is variable and much of the research was carried out overseas, particularly in the US. Apart from the different cultures that pertain in the two countries, the forms of welfare, accessibility and organisation of health services, occupational groups and professional education are all very different, so considerable caution is needed in generalising results of US RCTs directly to the UK.

While some service commissioners and managers have been happy to accept forms of evidence other than RCTs in the past, this form of research is increasingly required in order to justify service costs. A number of programmes have been developed within the UK but not evaluated through RCT, perhaps because of a limited research capacity within health visiting, low availability of research funding, or the need to develop the theory base of approaches used as a necessary precursor to testing their effectiveness. Over the last 15 to 20 years, there has been a great deal of qualitative research, which could provide the theoretical foundation for exploratory and feasibility trials of UK-based programmes and approaches introduced into health visiting practice.

The review of reviews that was commissioned to inform the CHPP¹³ provides a solid base upon which to build, but far more information is needed still, and in a format that is helpful to service commissioners, managers and practitioners in this field. There is a need for much further UK research of all kinds, not only about the interventions carried out as part of the service, but also to inform the education, ▶

organisation and delivery of health visiting. In particular, there is a shortage of robust research about the impact, effectiveness and acceptability of various forms of team and corporate working, and about substituting less expensive or differently trained workers in the place of qualified health visitors. The existence and value of the universal health visiting service is increasingly under threat, yet by its nature, this cannot be evaluated through RCT. Some of the research questions involved are remarkably complex, and they are better answered by studies drawing upon methods that are able to adjust to changing circumstances.

Strong, statistical evidence alone cannot provide a basis for determining which programmes or interventions should be provided, or which occupational groups should continue to be educated and employed. A range of information is required to inform such decisions, which are political and moral, and based in social justice as much as in science.

Acknowledgment

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