

Accepted Manuscript

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Author: Sarah Cowley Karen Whittaker Mary Malone Sara Donetto Astrida Grigulis Jill Maben



PII: S0020-7489(14)00199-0
DOI: <http://dx.doi.org/doi:10.1016/j.ijnurstu.2014.07.013>
Reference: NS 2427

To appear in:

Received date: 4-5-2014
Revised date: 15-7-2014
Accepted date: 19-7-2014

Please cite this article as: Cowley, S., Whittaker, K., Malone, M., Donetto, S., Grigulis, A., Maben, J., Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: a narrative review of the literature., *International Journal of Nursing Studies* (2014), <http://dx.doi.org/10.1016/j.ijnurstu.2014.07.013>

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Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: a narrative review of the literature.

Sarah Cowley (*corresponding author*)¹

Karen Whittaker

Mary Malone

Sara Donetto

Astrida Grigulis

Jill Maben

¹ Emeritus Professor Dame Sarah Cowley, National Nursing Research Unit,
Florence Nightingale School of Nursing and Midwifery, King's College London
sarah.cowley@kcl.ac.uk

Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: a narrative review of the literature.

Abstract

Introduction

There is increasing international interest in universal, health promoting services for pregnancy and the first three years of life and the concept of proportionate universalism. Drawing on a narrative review of literature, this paper explores mechanisms by which such services might contribute to health improvement and reducing health inequalities.

Objectives

Through a narrative review of empirical literature, to identify:

- (1) What are the key components of health visiting practice?
- (2) How are they reflected in implementing the universal service/provision envisaged in the English Health Visitor Implementation Plan (HVIP)?

Design

The paper draws upon a scoping study and narrative review.

Review Methods.

We used three complementary approaches to search the widely dispersed literature:

- (1) broad, general search,

(2) structured search, using topic-specific search terms

(3) seminal paper search.

Our key inclusion criterion was information about health visiting practice. We included empirical papers from United Kingdom (UK) from 2004 to February 2012 and older seminal papers identified in search (3), identifying a total of 348 papers for inclusion. A thematic content analysis compared the older (up to 2003) with more recent research (2004 onwards).

Results

The analysis revealed health visiting practice as potentially characterized by a particular 'orientation to practice.' This embodied the values, skills and attitudes needed to deliver universal health visiting services through salutogenesis (health creation), person-centredness (human valuing) and viewing the person in situation (human ecology). Research about health visiting actions focuses on home visiting, needs assessment and parent-health visitor relationships. The detailed description of health visitors' skills, attitudes, values, and their application in practice, provides an explanation of how universal provision can potentially help to promote health and shift the social gradient of health inequalities.

Conclusions

Identification of needs across an undifferentiated, universal caseload, combined with an outreach style that enhances uptake of needed services and appropriate health or parenting information, creates opportunities for parents who may otherwise have remained unaware of, or unwilling to engage with such provision.

There is a lack of evaluative research about health visiting practice, service organization or universal health visiting as potential mechanisms for promoting health and reducing health inequalities. This paper offers a potential foundation for such research in future.

Key words

Health inequalities; health visiting practice; human ecology; narrative review; salutogenesis; person-centredness; public health nursing; universal service

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Introduction

The last decade has seen increasing international interest in developing universal, health promoting services for pregnancy and the first three years of life. This paper draws upon a scoping study and narrative review of health visiting practice commissioned to support the English Health Visitor Implementation Plan (HVIP) (Department of Health 2011), which aimed to identify 'the key components of health visitor interventions and relationships between the current health visiting service, its processes and outcomes for children and families' (Cowley et al 2013a, p.9), focusing particularly upon information about health visiting practice within universal services. There is a gap in the literature about how universal services are supposed to help (mechanisms), so the paper concludes by offering some potential explanations about how such provision might promote health and reduce health inequalities, with a view to encouraging further research in this field.

Background

The focus of this paper and context for the literature review is introduced in three sections. The scientific reasons for policy interest in proportionate universalism in the early years are explained first, before second, identifying a range of preventive nursing roles from around the world, including universal health visiting in England. Third, the HVIP is outlined, to set the context for the scoping study and narrative review of health visiting described in this paper.

Health inequalities and early years

The World Health Organization's (WHO) Commission on the Social Determinants of Health (CSDH) (2008 p26) points to the 'dramatically different life chances' of children born in the poorest parts of the world compared with the richest. The CSDH showed

that differences occur along a continuum from the least to the most wealthy, so that when health inequalities are charted, the result is a gradient, which applies both between and within countries, and throughout societies. The differences are particularly significant between the top and the bottom of the gradient, but they run through the whole population, so each socioeconomic step, up or down and from the highest to the lowest, affects the child's life chances. Health inequity is caused by the unequal distribution of income, goods and services and of the consequently unequal chance of leading a flourishing life – which the CSDH (2008, p.39) called the 'social gradient in health.' The term 'inequity' is generally associated with injustice, where health inequalities are preventable by reasonable means and 'putting them right is a matter of social justice' (Marmot et al 2010 p37). The CSDH emphasised that targeting the most needy and deprived populations was necessary but not sufficient to change the graded relationship between socio-economic position and health. Instead, a focus on health improvement through the whole population, and to shift the curve of the gradient, was needed. Further, drawing on a specially commissioned report that described early child development as a 'powerful equalizer' and social determinant of health (Irwin et al 2007 p3), the CSDH stressed the importance of a policy focus on the early years as a means of reducing health inequities.

This policy emphasis has developed in part because of an exponential increase in scientific understanding about how children develop both before birth and in the first two years of life, and the significance of this early period for public health and health inequalities. This new knowledge includes developmental neurophysiology, the interplay of genetic inheritance and environment (Shonkoff and Phillips, 2000; Center on the Developing Child at Harvard University, 2010) and evidence confirming the crucial influence that pregnancy and the early years have on establishing the child's future life course. This is a critical period for setting up the neurophysiological, psychological and behavioural aspects of development that lead to health inequalities (Irwin et al 2007;

Shonkoff et al 2009; Marmot et al 2010). In turn, this knowledge has laid the foundation for a parallel increase in understanding about which health promotion and preventive activities are most likely to help, and where the strongest evidence lies (Center on the Developing Child at Harvard University, 2007a, 2007b, Shonkoff 2014).

The expansion in evidence has persuaded many researchers to promote policies of delivering preventive programmes with proven effectiveness (Allen 2010), until recently targeting only the most deprived or highly vulnerable populations. In England, for example, the Family Nurse Partnership programme (Olds 2006) has been expanded to cover much of the country, but it is offered only to first-time teenage parents (Family Nurse Partnership Unit, 2012). In the United States of America (USA), the Maternal, Infant and Early Childhood Home Visiting (MIECHV) programme, established as part of the Affordable Care Act 2010, will provide funding to states and territories for evidence-based home visiting services, specifically for at-risk communities (Adirim and Supplee 2013). The ability to bring about measurable change amongst such obviously needy populations is a strong political driver for the spread of discrete programmes, targeted at particular groups of parents who are deemed to be in need of support. Such programmes lend themselves to randomisation and robust evaluation, leading to convincing evidence to support their effectiveness (Karoly et al, 2005, Allen 2010), so policy-makers and service commissioners can be reasonably assured that they will get 'value for money.'

However, it is increasingly being realised that such targeted programmes, alone, are insufficient to shift the gradient that occurs in health inequalities. Accordingly, Shonkoff et al (2012 p8) indicate that 'Targeted interventions should be framed within larger systems that are robust, appropriately financed, and universal so that individual programs are not isolated.' In a similar vein, Marmot et al (2010 p23), who chaired the CSDH, called for a 'second revolution' in the early years in his follow-up review, which

focused on health inequalities in England. The 'first revolution' occurred when policy-makers understood the need to deliver well-researched, well-targeted programmes to the poorest and most needy families. Stressing evidence about the long-term impact of pregnancy and the early years on the social gradient in health, Marmot et al (2010 p20) made 'giving every child the best start in life' the highest priority for policy makers wishing to reduce health inequalities. Increased expenditure should be allocated to this priority, he said, then distributed proportionately according to need (called 'proportionate universalism'): that is the 'second revolution.' Despite the firmness of these recommendations, there is less clarity about the mechanisms through which universal services are supposed to help. This paper aims to reduce that deficit, by drawing upon selected findings from a large literature review to clarify some potential processes through which a universal health visiting service might promote health and help reduce health inequalities.

Universal services

The idea of a universal, preventive and health promoting service that is proportionate to need creates questions about how such services are to be set up and who should deliver them, not only in England, but in many other countries. Debates about the relative effectiveness of universal or targeted approaches have been reflected in changing priorities for the health visiting service over time (Elkan et al 2001; Greenaway et al 2008; Peckover 2013), leading to a different shape of provision in each of the four United Kingdom (UK) countries following devolution (Hoskins 2009). Such variation is common, reflecting different national and within-country policies and environments.

A universal child and family health nursing service is provided free of charge to all children from birth to five and their families across Australia, although coverage varies in the different states and territories (Schmied et al 2011). Likewise, public health early child

home visiting programmes have been delivered for many years throughout Canada, with coverage varying from one province or territory to another (National Collaborating Centre for Determinants of Health 2009). In USA, there is a tendency to focus on targeted programmes, but a trial of a newly developed universal home visiting service showed reduced use of emergency services (Dodge et al, 2013). Several Northern European countries have health visitors or community or public health nurses delivering universal services (Winkler 2011). Others are considering developing them (UNICEF Regional Office for Central and Eastern Europe, Commonwealth of Independent States 2012), sometimes looking for ideas and guidance from countries like the UK, which have more long-established services (Winkler 2011, Whittaker and Browne 2014).

In the UK, health visitors are the professional group charged with supporting early child development, by delivering a universal service designed to promote the healthy development of pre-school children, whilst improving public health and reducing health inequalities. The initiative described in this paper refers only to England, where a newly elected Coalition government (in 2010) committed to redressing an earlier fall in staff numbers by employing 4,200 more health visitors by 2015, as detailed in the HVIP (Department of Health 2011).

Health Visitor Implementation Plan

The HVIP (Department of Health 2011) had three key aims: to increase the size of workforce, to mobilise the profession and to align delivery systems with the new NHS architecture and local government children's services. The HVIP explains that the new health visiting service should include leading the pre-existing Healthy Child Programme (HCP) (Department of Health 2009), which prescribes the number and purpose of specific contacts (such as antenatal or new birth contacts and immunization schedules), and integrate with other services for children, families, mental health and public health. Health visitors are supposed to work

collaboratively to develop local services and ensure families know about them (Department of Health, 2010, 2011). A key part of this involves health visitors helping families find out about services, whilst working to build community strengths and capacity to generate action from local people on the health issues that matter to them.

The HVIP included a 'new service vision' (Department of Health 2010), with a layered structure reflecting Marmot et al's (2010) description of proportionate universalism – that is, provision for all, distributed according to need. It provides a series of five service descriptors: Community (as explained above); Universal service (for all families); Universal Plus (specific care packages, interventions or support for some families, according to need) and Universal Partnership Plus (intensive, multi-agency support for the most needy families); with safeguarding/child protection as a cross-cutting theme. Collectively, the descriptors are known as 'service levels,' with a tailored 'offer' to families, emphasizing that the service is universally available and free but voluntary, in that families have a choice about whether to accept it or not. Thus, the service is layered to match the social gradient and intended to operate across a continuum of need, connecting the health visitor with whole communities, small groups, families and individuals.

There is no overt, underpinning theory in the HVIP to explain the mechanism by which a universal service helps to reduce health inequalities. However, the model is predicated on the desire to address the negative social gradient in health, working through the principle described by Marmot et al (2010) as proportionate universalism. The idea is that capacity within communities will be developed and all pre-school children and their families will be in touch with the universal health visiting service. Then, those families who need more support can be readily identified and connected with sources of additional help (including evidence-based

interventions and programmes) as required. Once in place, it is anticipated that such a comprehensive service should enable every family to receive health-promoting messages and obtain any help they need.

Study Aims

The review (Cowley et al 2013) focused on health visiting practice rather than interventions and programmes, which had been reviewed already, by Barlow et al (2008) to inform the HCP. Given the importance attached to enabling every child to have the best start in life (as explained above), we were interested in uncovering what health visitors bring to the 'table' of early years provision. We wanted to understand how health visiting services fit with the wider community public health and about the craft of practice – in short, about which forms of practice are central to ensuring that provision by health visitors could be effective at promoting health and reducing health inequalities. Given the arguments for proportionate universalism (Marmot et al 2010), this paper focuses particularly on two research questions, adapted from those in the full report, to relate to the universal layer of provision:

- What are the key components of health visiting practice?
- How are they reflected in implementing the universal service/provision envisaged in the Health Visitor Implementation Plan?

Methods

We carried out a scoping study (Poth and Ross 2009, Valaitis et al 2010), which also incorporated a narrative review of the literature (Arksey and O'Malley 2005, Levac et al 2010). It included the following feature of a scoping study, as described by Poth and Ross (2009):

- Criteria for exclusion and inclusion are not based on the quality of studies, but on relevance (i.e., studies that included information about health visiting practice).

- The aims are exploratory, so results from all studies on a topic are included.
- Data from the included studies are charted; themes and key issues are identified.
- Themes are discussed with experts and stakeholders in the topic area, to give context to the findings. (There were expert health visitors in the research team and advisory group, which included other stakeholders, such as service/consumer groups and mental health experts).

The narrative review included clarification of working definitions and conceptual boundaries of a topic area, developed in the form of systematic overview of the literature, but specifically excluding a traditional systematic review (Levac et al, 2010). Our study broadly followed the five steps set out by Arksey and O'Malley (2005), which are:

1. identifying the research question;
2. identifying relevant studies;
3. study selection;
4. charting the data, collating, summarizing and
5. reporting the results.

However, along with Levac et al (2010) and Valaitis (2012), we found the process was far more iterative and collaborative than linear (see Figure 1). The literature was extremely widely dispersed and the task seemed particularly broad and unwieldy, so we developed three different search approaches to manage it.

First, we searched several databases using generic terms, for example home visit* and health visit* and including (where relevant to

the database) Medical Subject Headings (MeSH) such as 'public health nursing', 'community health nursing' and 'home visiting'. The databases searched were: Medline, Embase, British Nursing Index and Archive, and Psychinfo; Cumulative Index to Nursing and Allied Health Literature (CINAHL); Applied Social Sciences Index and Abstracts (ASSIA); and Web of Science. We checked search results from different databases for duplicates. The overlap in search results proved minimal, so we continued searching all the databases to enhance comprehensiveness.

This first broad general search (Search 1) revealed several thousand papers, so we focused on publications after 2004, noting the significance of *Every Child Matters* (HM Treasury 2003) and related policies, which transformed children's services in England at this time. This reduced the number to 593 empirical and non-empirical papers that included information about health visiting. After examining a number of international papers, we decided to concentrate on the UK only, given the varying policy contexts influencing service delivery, organization and different nursing/professional education across countries. Also, after reading all the abstracts, we decided to focus on empirical work only, identifying 49 such papers since 2004, which were read and reviewed in full.

Second, using the same databases, we undertook a series of more structured searches focusing on key topics of interest to health visitors and derived from activities recommended in the HCP (Search 2). These searches generated more than 3000 papers, which were screened and 318 abstracts read in full, before finally including another 218 empirical papers published since 2004.

Finally (Search 3), to ensure we captured arguments from seminal work on health visiting published prior to 2004, the health visitors on our team each re-reviewed a list of 272 papers generated from the initial results of the first broad search (that is, empirical papers identified before concentrating on the post-2004 papers, as described above, under Search 1), along with additions identified from secondary references and existing health visitor programme curricula. Each team member worked independently to identify

influential or seminal publications considered crucial to any serious examination of health visiting issues, then compared and discussed their separate recommendations before agreeing a further 81 papers, bringing the overall total to 348 for our review (see Table 1).

We read all 348 included papers in full and, whilst we formed judgements about the quality of the research, study quality *per se* was not an inclusion or exclusion criterion. Rather, the amount and quality of the information about health visiting practice was our main reason for inclusion, which was often unrelated to the quality of the research. Detailed tables of all included papers, and all those read but excluded, were collated into appendices, to serve as a resource for future research (Cowley et al, 2013b). Each of our team members took the lead in reading and analysing key areas, working with at least one other team member to discuss and cross-check impressions, analyses and writing.

Much of the available research refers to a time when more staff had been in post, possibly within a different culture of practice – for example, team working and skillmix are far more common within health visiting now than 10-15 years ago. To explore whether these temporal differences substantially affected practice and research findings, we completed a thematic content analysis comparing older (mainly qualitative and descriptive evidence, up to 2003) studies, and research from 2004 onwards, which included more evaluative (intervention or outcomes-focused) papers (see Table 2). This exercise revealed considerable continuity in the basic values and skills for practice, which gave us confidence that older literature is still relevant to current practice, although different service contexts need to be taken into account. Overarching threads were discussed across the team at regular intervals before pulling together the final report (Cowley et al 2013a), which was jointly authored by all team members.

This paper concentrates on reporting findings relating to health visiting practice within a universal service, as our analysis of the literature showed the importance of the universal layer in underpinning the remainder of the service. The research identifies that it

provides an essential base from which to identify and reach out to families in need of more intensive programmes (designated 'universal partnership plus' in the HVIP) or more short-term, specific interventions (designated 'universal plus' in the HVIP). Also, compared to the amount of attention given to preventive programmes and circumscribed interventions, there is relatively little written about how universal services help to promote health and reduce inequalities.

Key Findings

The new service vision (Department of Health 2010) was developed through consensus discussions between policy makers, health visitors and service managers and was acknowledged as aspirational and developmental, since it needs a full staff complement (i.e., the promised additional 4200 health visitors) to adequately implement it. Similarly, we discovered that many of the papers we reviewed described a form of provision that could work in theory, but which might not currently be in place. Even so, health visitors need a range of skills, values and approaches to practice, which were identified from the thematic analysis described above.

Health visitors' orientation to practice

Our analysis identified a clear 'orientation to practice,' which appears to guide delivery of health visiting across the whole service spectrum. Table 2 illustrates how the different concepts are dispersed throughout the older and more recent literature. This analysis suggests that successful health visiting practice needs to be salutogenic (health-creating), to demonstrate a person-centred approach (human valuing) and to recognize the person-in-situation (human ecology). The concepts and wider theory base embedded within this health visiting 'orientation to practice' help to delineate the underlying professional values, attitudes and attributes that need to be preserved or promoted as services are transformed. They can be used to guide education or service organization, as explained below. They do not confirm the forms of practice that exist in reality, but offer a conceptual description of

how health visitors aim to reach out to parents, promote service uptake according to need and foster responsiveness proportional to the changing needs of individuals, families and population groups.

The orientation to practice explains how, when working optimally, health visitors can use specific skills and actions to support and facilitate parents' potential 'journey' through services, from the time expectant mothers become pregnant and aware of a raft of services they have not used before and may not have known about. It offers a way of explaining how responsive and proportionate services can enable these families to negotiate different forms of provision and health visitors to vary the intensity of the 'service offer' as families' needs change with time and circumstance.

Promoting use of the service

Health visitors need to actively encourage use of their service, particularly when parents (or expectant parents) first become eligible for them, but may know nothing about them. Use of the health visiting service occurs over time, which can be described as a 'service journey.' It commences as an unsolicited experience where the health visitor, proactively and uninvited, makes contact with someone who is either about to be or has recently become a parent (Luker and Chalmers, 1990; Chalmers, 1992; Cowley, 1995a; Collinson and Cowley, 1998a). It is unlikely that they have formed a relationship at this stage, unless the health visitor has engaged in activities in the wider community, when they may have met before. Alternatively, others - like friends or neighbours - may have passed on information about the health visitor's reputation (Luker and Chalmers, 1990; Forester, 2004), or parents may have obtained prior information at the 'pre-contactual phase' of engagement (i.e., before contact is made between health visitor and parent) (Hanafin and Cowley, 2006).

The initial stages of this 'service journey' are concerned with each becoming known to the other, with the health visitor seeking

entry into the parents' situation (physical and personal) and the parents determining how far to allow access to their life. They need to engage in a reciprocal exchange (Chalmers, 1992) to share information and thereby achieve a collaborative interaction (de la Cuesta, 1994a) about how best to tailor (the health visitor) and use (the parent) the service, whilst forming a relationship to help guide them through the 'service journey' ahead. Bidmead (2013) identifies stages of relationship formation (introduction, putting at ease, eliciting expectations, giving information about role, establishing ground rules) and relationship working (explanation, establishing understanding and clarification, negotiating aims and goals, planning a strategy, implementing and reviewing), with each stage potentially contributing to a therapeutic health visiting interaction. The 'orientation to practice' is operationalized through such relational activities, along with home visiting and needs assessment. Together, these constitute three inter-connected, core forms of health visiting practice.

Home visiting

Parents do not necessarily ask for their first home visit by a health visitor, but rather receive it as part of the universal programme provided for all families (Cowley et al 2004, Bidmead 2013). Some parents may be ambivalent, at least initially, about the health promoting interventions offered by the health visitor, especially interventions that call into question health beliefs and practices. In those circumstances, the health visitor may choose to market the service and her/himself in a relationship-building way (de la Cuesta, 1994b; Collinson and Cowley 1998b), perhaps by negotiating or participating in 'fringe work' (de la Cuesta, 1993). This includes activities like negotiating and advocating for the parent (McIntosh and Shute, 2007), which may be peripheral to mandated contacts (Hanafin and Cowley 2006), such as those prescribed by the HCP (Department of Health 2009). By explicitly recognizing the parent's felt need, the health visitor is investing in relationship-building, attempting to demonstrate its longer term value to the parent (de la Cuesta, 1993; Collinson and Cowley, 1998a). This form of flexibility is considered important in ensuring service uptake

across the social spectrum, especially for families who find services hard to access.

Repeated contacts can help health visitors to develop a deeper understanding of the parent's situation (Chalmers, 1994; McIntosh and Shute, 2007; Pettit, 2008; Wilson et al, 2008a) and changing needs as the family develops (Pearson, 1991). The home environment was identified in much of the research as the optimum place for relationship formation and where identification of needs could happen (Cowley 1995a; Bryans 2005; Plews et al 2005). Parents seem more likely to 'open up' in their home, perhaps disclosing longstanding problems, such as family histories of child abuse, domestic violence or mental health concerns (Chalmers and Luker 1991, Dixon et al 2005).

Needs assessment

In an ideal 'service journey,' relationship-building activities would be a core feature running alongside the interwoven actions of assessing and intervening (Appleton and Cowley, 2008a), which should start at the first contact and occur on a repeated basis. Research about approaches to health visitor needs assessment describes it as a continuing process, rather than occurring as a single event (Williams 1997; Cowley and Houston 2003; Appleton and Cowley 2008b). Repeated iterations are made possible by the ongoing availability of a universal service from pregnancy to five years. Parent-health visitor relationships (Chalmers and Luker 1991, de la Cuesta 1994a, Bidmead 2013) are mentioned in much of the research as a key mechanism or way of working, being considered especially important in enabling uptake by families who sometimes find services hard to access.

Sensitive communication, used within visits, allows the health visitor to attune to the parent's situation and to be ready to shift the focus of the visit to match pressing needs (Cowley, 1991, Chalmers, 1992; Cowley 1995a, Appleton and Cowley, 2008a). Health

visitors' use of listening, observing and talking skills are intended to help the parents engage with the service, making it possible to open up the discussion to expose issues that may be troubling (Chalmers, 1992; Long and Johnson, 2001; Pritchard, 2005; McIntosh and Shute, 2007; Appleton and Cowley, 2008b). A relationship based on trust and respect helps parents to feel valued (Collinson and Cowley, 1998a), and Bidmead (2013) points to the importance of that trust being mutual. The process of communication is intended to both assess and respond to need, helping the parent develop a new awareness and understanding of their own situation (Cowley, 1991; Chalmers, 1993; Appleton and Cowley, 2008a). Where necessary, it can prepare the ground for making a referral to another service (for example, social care), which the parent may otherwise have rejected (Luker and Chalmers, 1989; Cowley, 1991; Kirkpatrick, et al., 2007).

If the health visitor is unsuccessful in opening up discussion about an issue that is considered important (such as in child protection or domestic violence), it may be necessary to directly confront and 'bring face-to-face' an issue that the parent has been avoiding (Chalmers, 1994, p175). In working towards confronting an issue, health visitors may need to adjust the frequency and intensity of contacts carefully, to ensure they act at the right moment to achieve a successful result, such as the parent changing behaviour or accepting additional support (Chalmers, 1994; McIntosh and Shute, 2007; Appleton and Cowley, 2008b).

Purposeful Practice

The idea is that health visitors' professional knowledge, ability and autonomy, along with the skillful relationship-building, home visiting and needs assessments described above, should come together to enable parents to understand and feel confident about using the health visitor whenever needed, to promote early and appropriate service use. Ideally, where required, the parent will also be introduced to local community activities that may have been developed in conjunction with local Children's Centres (which

are local service hubs), including support groups, such as for breastfeeding support (Hoddinott et al 2007; Clarkson and de Plessis 2011), parenting programmes (Harrison et al 2005; Patterson et al 2005), sleep and behaviour clinic (Merrifield 2005) and other focused activities.

The enduring consequence of an effective parent-health visitor relationship formed over earlier repeated contacts is that, if new difficulties arise at a later time, parents seem more likely to initiate contact themselves and request help (Pearson, 1991; Hanafin and Cowley, 2006). During contacts, the health visitor may offer praise or encouragement to help the parent recognize their own existing expertise and feel more confident about their actions and future abilities (Collinson and Cowley, 1998a; Plews et al, 2005; McIntosh and Shute, 2007). Once mutual confidence is established, the two can negotiate a change in pattern of contact or prepare for ending the journey through health visiting services (Chalmers, 1992), including transfer to other services, such as school health as the child reaches school age.

The development of health visitors' orientation to practice and their way of working, therefore, appears to be purposeful, with the intent of enabling parents and children to navigate their way through the available service provision and to benefit from it. Universal contact with all families provides the opportunity for relationship-building and needs assessment in the home or elsewhere, which should translate into equitable provision and health promoting activities to families who most need them.

Also, notions of 'health visiting as therapy' (Cody 1999), 'therapeutic relationships' (Bidmead 2013) 'therapeutic prevention,' (Cowley 1995b) and using a 'therapeutic gaze' as part of their disciplinary practice (Peckover 2002) permeate the literature.

Therapeutic terminology may initially seem contradictory, given health visitors' usual focus upon primary prevention in the absence of existing disease. However, the descriptions outline an approach designed to psychologically hold and support individuals who are experiencing non-specific forms of distress, perhaps whilst identifying hidden difficulties or awaiting diagnosis or specialist intervention. Preventing an escalation of distress may reduce risk or increase the likely take-up of services, which are particularly important for parents who may otherwise find referrals daunting. It may also support disclosure, for example of domestic violence or previous adverse experiences in childhood, possibly revealing hidden health needs that potentially inhibit positive parenting and perpetuate health inequalities. However, services need to be organized in a manner that optimizes this uptake and delivery of appropriately skilled practice.

Services that promote uptake

Not all parents find it easy to access health promoting/community services (including health visiting), either because they do not know about them or because the services seem daunting or unappealing, or may be organized in a way that inhibits access. Therefore, several papers describe how health visitors may operate at the community level to influence the appeal and availability of local resources by developing new ones (de la Cuesta, 1994b; Cowley, 1995b). Research examples included developing new youth facilities to meet needs identified in a community survey (Grant, 2005a, b), promoting accessible forms of health care to combat social exclusion in people with learning difficulties (Harrison et al, 2005; Harrison and Berry, 2006), encouraging people to develop their own capacities and support systems as resources for health (Cowley and Billings, 1999), specialist work with asylum seekers and refugees (Drennan and Joseph 2005, Burchill 2011), co-facilitating parent education/support programmes (Hutchings et al, 2007; Clarkson and de Plessis, 2011; Roberts, 2012), community development in a declining, socially deprived area (Stuteley, 2002) and developing peer educators to promote accident prevention (Carr 2005).

Long waiting lists or limited specialist help may mean that health visitors step in to help, perhaps continuing to hold the case after referral (Wilson et al, 2008b), or offering listening visits whilst waiting for availability of additional expertise or community resource (Cody, 1999). In some instances, the health visitor may mediate between the parent and a third party (Bryans et al, 2009) and, when the parent accepts referral, the health visitor can support introductions to another source of help (Luker and Chalmers, 1989; Kirkpatrick et al, 2007). After identifying needs and resources, offering some follow-up can help the parent feel that they are valued and being kept in mind (Hanafin and Cowley, 2006; Worth and Hogg, 2000). To achieve a quality service, health visitors need the professional autonomy to reprioritise their workload to offer additional help at times when parents experience greatest need (Hanafin and Cowley, 2006; Appleton and Cowley, 2008a).

Also, health visitors may work towards increasing service uptake by parents that traditionally find it hard, for whatever reason, to engage with formal provision when needed, which perpetuates health inequalities. This may include helping parents identify and use the most appropriate provision for them, drawing on health visitors' local knowledge of resources (Brassett-Harknett et al 2006) to provide information. This knowledge enables them to make links with local resources and the parent's existing community networks when seeking to raise awareness and facilitate health-enhancing activities (Luker and Chalmers, 1989; Cowley, 1991, 1995b; Cowley and Billings, 1999; Appleton and Cowley, 2008b; Bryans, et al, 2009).

Shortcomings in practice

Research detailing the various components of practice that enable parents to navigate their own personal 'service journey' helps to delineate the characteristics of good health visiting across the service. Other evidence illustrates the tension between support and

surveillance (Peckover 2002) and flaws in practice when health visitors are inadequately skilled, perhaps missing cues, being poorly attuned to parents' needs, or failing to demonstrate helpful communication (Pearson, 1991; Kendall, 1993; Cowley and Houston, 2003; Mitcheson and Cowley, 2003). Some research described deficiencies in advice-giving style (Pearson, 1991) and hasty communication where the health visitor moves swiftly to advice-giving before exploring the parent's perspective (Foster and Mayall, 1990; Kendall, 1993; Cowley et al 2004). Whilst there may be some common thinking about the difficult things in parenting, the importance and priority of these difficulties can differ between health visitors and parents (Foster and Mayall, 1990; Bloomfield et al, 2005). Failure to read cues, or to purposively seek clarification of parents' understanding, risks damaging future opportunities for health promotion, as parents may feel they are being dictated to and misunderstood when presented with unsolicited advice (Bloor and McIntosh, 1990; Foster and Mayall, 1990; Kirkpatrick et al, 2007; McIntosh and Shute, 2007). This may be perceived as being judgemental (Roche, et al, 2005) or as 'negative verbal persuasion' (Bandura, 1982), which has the potential to undermine self-efficacy, whereas 'positive verbal persuasion' (praise, encouragement, support) can help it to develop.

The literature points to some particularly marked deficits in practice when it comes to working with the very groups who most need support, if health inequalities are to be successfully addressed. Barlow et al's (2005) study showed the importance of health visitors having the skills and willingness to work collaboratively with women who feel unheard, unable or unwilling to trust service providers, along with the service flexibility required to meet different sets of expectations. Peckover (2003) showed that health visitors often lacked understanding or knowledge of available services for domestic violence, so women did not always disclose their experiences. Health visitors have tried to understand needs of families living in areas of deprivation (e.g. Grant 2005a, Price 2007), or to maintain relationships despite barriers, such as frequent house moves by refugee families (Drennan and Joseph 2005). However, failure to

fully grasp different cultural perspectives or needs was a recurring theme in the research about seldom-heard populations, particularly around post-natal depression (Hanley 2007; Baldwin and Griffiths, 2009; Edge, 2010, 2011; Almond and Lathlean 2011, Wittkowski et al 2011), with health visitors acknowledging a need for more education for these, and many other, areas of practice.

Discussion

The new service vision (Department of Health 2010, 2011) described an idealized form of provision that would not be in place until the additional staff and service transformation had happened. The proportionate nature of the provision is intended to ensure families who are most in need, or have most difficulty accessing services, will be helped, so the service can contribute to reducing health inequalities and ensuring each child has the best start in life.

This paper focused on the key components of health visiting practice within the universal health visiting service, identified in a narrative literature review. This revealed the importance of an underlying 'orientation to practice' in which practitioners adopt a salutogenic (proactive, strengths-based, health creating) approach, demonstrating person-centred/human valuing for all parents and families, recognizing health needs regardless of their background, ethnicity, culture or community and within their own situation (human ecology). These concepts and underpinning theories are given expression through three intertwined and key approaches to practice (relationship-development, home visiting and assessment of individual/family needs), within an undifferentiated, universal caseload. Together, these various elements make up the key components of health visiting practice, demonstrating how the 'new service vision' would ideally be implemented. The literature showing deficits in practice in particular, demonstrated that these underlying professional values, attitudes and attributes are not always present, yet the research suggests they are always needed.

Sensitive relationship-building and responsive skills are central to some trials of parenting/home visiting programmes delivered by health visitors (e.g., Wiggins et al 2004; Davis et al 2005; Barlow et al 2007; Christie and Bunting 2011), suggesting that such approaches can help to promote more relaxed mothering and better use of services, both valuable elements in reducing health inequalities. Whilst these trial results lend support to the health visiting orientation and forms of practice described in this review, home visiting was more frequent and intensive in the experimental programmes than is usual for universal provision. This draws attention to the importance of skilled assessments and an ability (within the service) to offer more intensive support to families who need more – the aim of ‘proportionate universalism.’

The ‘service journey’ narrative identified by the review sheds some light on the question of how universal provision might meet its overarching goals of promoting health and reducing health inequalities. Throughout, the research describes the importance, through health visitors’ abilities and attitudes, of a welcoming availability of services that reach out to all parents. A major element of this involves promoting use of services that could provide timely advice and support where needed, including enabling those who might find such services daunting to feel comfortable about them, and identifying early or warning signs that some change in parental approach may be needed. Sensitivity and skill are required to avoid appearing authoritarian or judgemental whilst promoting preferred approaches with demonstrable child health benefits, like promoting breast feeding (Gildea, et al. 2009; Clarkson & de Plessis 2011), accident prevention activities (e.g., Woods et al 2004; Carr 2005; Kendrick et al 2009), warm and responsive parenting style (e.g., Davis et al 2005; Barlow et al 2007) and immunization uptake (e.g. Redsell et al 2010). Such promoting/preventive activities are more challenging where parents have had different, potentially difficult, life experiences, or may

be receiving wider family or peer advice that runs counter to the current evidence, or facing additional pressures such as mental health problems, domestic abuse, inadequate housing or poverty.

In summary, the review helps to shed light on some mechanisms through which a universal, health visiting service might help to promote health and reduce health inequalities. The skill to identify needs across an undifferentiated, universal caseload is highlighted in the literature. If this is combined with an outreach style that enhances uptake of needed services and appropriate health or parenting information, it should create opportunities for parents who may otherwise have remained unaware of, or unwilling to engage with such provision. Inequalities are likely to be reduced if services managers and commissioners embrace the need for health visitors' professional skills and a service format that allows referral to embedded, proven programmes where more intensive provision is indicated.

Conclusions and research directions

This paper draws upon a larger scoping study and narrative review about the key components of health visitor interventions and relationships between the current health visiting service, its processes and outcomes for children and families (Cowley et al 2013). The literature was widely dispersed and difficult to identify, so we included only those papers that directly linked results to services or interventions delivered or facilitated by health visitors, including descriptions of their practice, which was our key focus. We managed by focusing closely on the current policy in England, and acknowledge that other researchers may have made different choices and therefore identified different research. However, the analysis reported in this paper shows consistent themes and processes running through older and more recent literature, providing some clarity about the skills and attributes needed and used by health visitors. We hope this will help with designing health visitor education and enhancing skills development. It also clarifies

the specific contribution made by health visitors to community, public health and children's services, which can be used to guide service organization, and we would particularly highlight the need for these professionals to have the autonomy to respond flexibly to parents' different circumstances and needs.

This paper drew on an analysis of research to explain how universal health visiting offers the potential for health promotion and early identification for treatment or referral to needed services and proven programmes. These are clear mechanisms for reducing health inequalities, but one other question remains. Might a health visiting service that fully incorporates the sensitive, relational, supportive and informative elements identified in this review, offer some form of non-specific, yet helpful means to promote health and reduce health inequalities as a result of this engagement?

This question touches upon the overall purpose of the programme of research from which this paper emanates, which was to determine what health visitors, in particular, bring to early years preventive services. Some papers (e.g., Cowley 1995b, Cody, 1999, Peckover 2002, Bidmead 2013) claim the specific approaches they identify as particular, or distinctive, to health visiting practice. Individual elements of practice described in this paper (advice giving, needs assessment etc.) are generic, in that other workers may provide them. However, the overall approach described above seems central and particular to the forms of practice and service provided by health visitors. We did not identify any comparative studies, either across disciplines (e.g., health visitors compared to children's social care), or evaluating whether different forms of service organization support or inhibit interventions proven to enhance health or help reduce inequalities. Such research seems to be the next step. It would be fruitful to explore literature from other disciplines, such as organizational theory, psychology or sociology as a basis for such work. Also, the theoretical base and

descriptions of practice in this paper would provide a foundation for such research in future, perhaps even to directly evaluate the impact of universal health visiting as a potential mechanism for promoting health and reducing health inequalities.

Acknowledgement

This Paper was drawn from a study that was commissioned and supported by the Department of Health in England as part of the work of the Policy Research Programme (Health Visitor programme of research ref: 0160058). The views expressed are those of the authors and not necessarily those of the Department of Health.

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Figures and Tables

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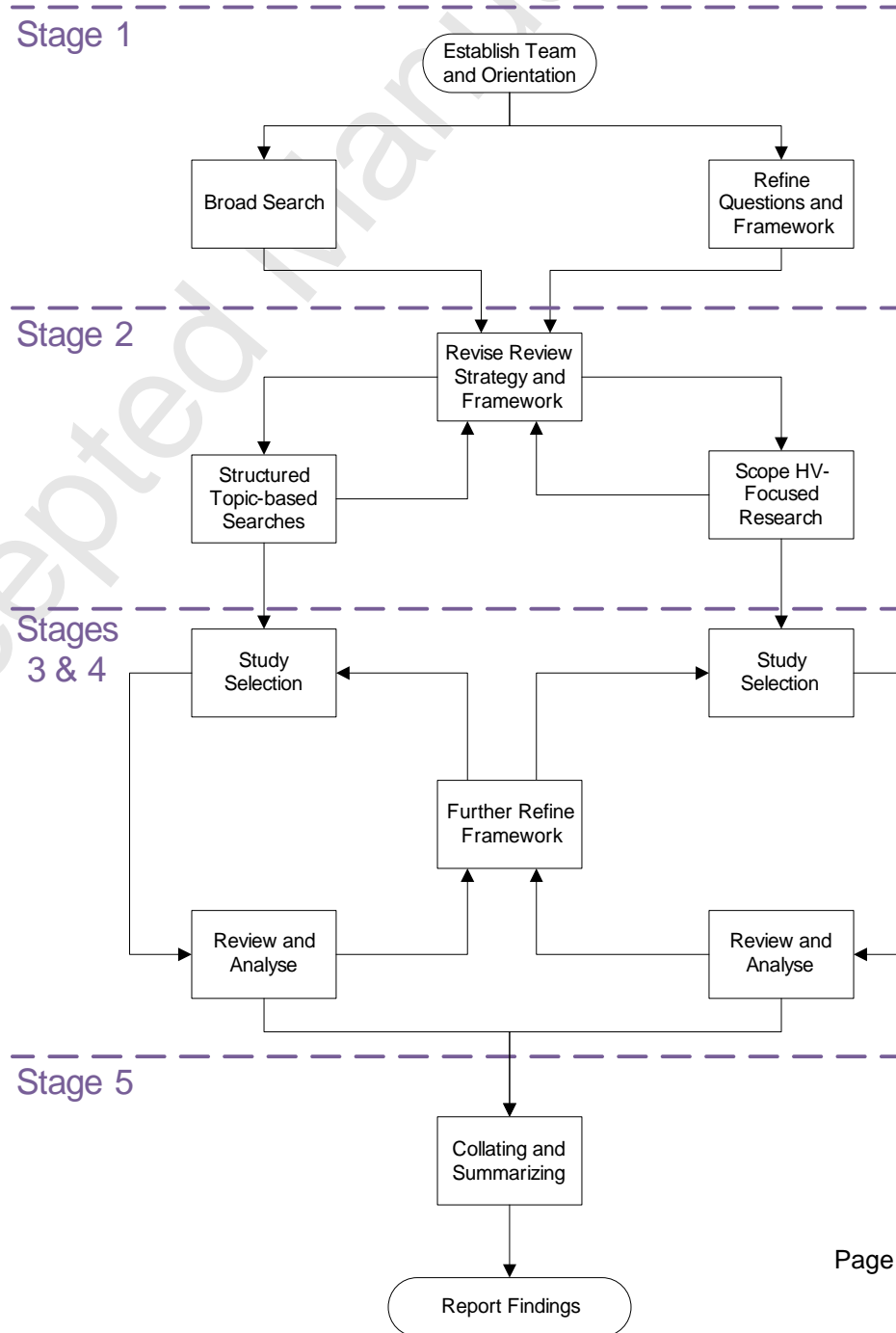


Figure 1: Stages of Review, after Arksey and O'Malley (2005) and Levac et al (2010)

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Search	Stage of study Type and dates	Abstracts reviewed N	Full papers reviewed N
1	Stage 1 Broad searches, empirical papers 2004 – March 2012	593	49
2	Stage 2a Structured, topic-based searches empirical papers, 2004 – March 2012	318	218
3	Stage 2b Influential and seminal papers empirical and non-empirical no date restriction	272	81
	Total	1183	348

Table 1: Three search strategies

<u>Relevant theory</u>	<u>Health visitor activity</u>	<u>Older evidence (≤2003)</u>	<u>Newer evidence (≥ 2004)</u>
	Pro-active	<ul style="list-style-type: none"> → Seek out (Cowley, 1991; Luker and Chalmers, 1990; Chalmers, 1992) → Providing information for health education purposes (Chalmers, 1992; Foster and Mayall, 1990; Plews, 1998) → Offer follow-up (Collinson and Cowley, 1998b) → Confronting client to bring an issue 'face-to-face' (Chalmers, 1994) → Understanding the fine balance between seeking to educate about health and respect client choice (Cowley, 1991) 	<ul style="list-style-type: none"> → Provide information/advice without obligation to accept (McIntosh and Shute, 2007) → Professional honesty to prompt health action (Kirkpatrick <i>et al.</i>, 2007; Brocklehurst <i>et al.</i>, 2004) → Able to act on concerns to instigate earlier action to safeguard the interest of children – as following training and intensive visiting more sensitised to recognising abuse (Barlow <i>et al.</i>, 2007)

Creating health: salutogenic approach (Antonovsky, 1987)	Identify resources (personal and situational)	<ul style="list-style-type: none"> → Build on strengths – check out existing expertise (Collinson and Cowley, 1998b) → Negotiating an important feature of getting to know and becoming known to help understand the resources available to client (Cowley, 1991) → Assesses needs by treating health as a process that draws on personal and situational resources (Cowley, 1995b; Cowley and Billings, 1999) → Delivers community parenting programme, with access to regular clinical supervision, to provide resource for parental learning and skills development (Sonuga-Barke <i>et al.</i>, 2001) 	<ul style="list-style-type: none"> → When children are vulnerable to poor psycho-social development use interactions to develop personal resources, such as parental confidence, (McIntosh and Shute, 2006), sense of being listened to, encouraged and faith in services (Davis <i>et al.</i>, 2005) and situational resource for child in the form of improved parent-child interaction (Puura <i>et al.</i>, 2005b). → Delivers parenting programme, with access to regular clinical supervision, to provide resource for parental learning and skills development (Hutchings <i>et al.</i>, 2007; Stewart-Brown <i>et al.</i>, 2004) → Linking clients to one another (Hanafin and Cowley, 2006) or to community services (Byrne <i>et al.</i>, 2010; Drennan and Joseph, 2005; Chakrabarti and Fombonne, 2005)
	Solution focused	<ul style="list-style-type: none"> → In the absence of available resources, effort goes towards creating new resources specific to needs (de la Cuesta, 1994b; Cowley, 1995b) → Identifies those who can benefit from referral to expert help (Godfrey, 1995) → Work with others to support availability and delivery of additional: parenting support (Whittaker and Cornthwaite, 2000); community development initiatives (Stuteley, 2002). 	<ul style="list-style-type: none"> → Work with others to support availability and delivery of additional community resources; parenting programmes (Hillen, 2004; Bateson <i>et al.</i>, 2008; Stewart-Brown <i>et al.</i>, 2004; Whittaker and Cowley, 2012); sleep behaviour clinic (Merrifield, 2005); obesity prevention (Barlow <i>et al.</i>, 2010); breastfeeding education (Clarkson and de Plessis, 2011); supporting families with addiction problems (Orford <i>et al.</i>, 2007); community development initiatives (Forester, 2004; Drennan <i>et al.</i>, 2007); child mental health expertise (Craig and Power, 2010); outreach to marginalised families (Jenkins and Parylo, 2011; Drennan and Joseph, 2005) → Relationship working to identify needs and goals then develop strategy to achieve and review (Bidmead 2013)
Value the person: person-centred (Rogers, 1980)	Shift focus to align with client	<ul style="list-style-type: none"> → Respecting client priorities to achieve consonance (Cowley, 1991) and focus on what is important to client (Chalmers, 1992) → Waiting for right time – growing trust (de la Cuesta, 1994a) → Need to consider the child development trajectory (Pearson, 1991) 	<ul style="list-style-type: none"> → Reflexive practitioner pursues issues raised by client & checks their perspective (Bryans, 2005) → Gauging what, how and when to say something to pitch information at the right moment when the client is ready (Appleton and Cowley, 2008b) → Listening to offer support specific to client need (Turner <i>et al.</i>, 2010)
	Recognises potential for unmet need	<ul style="list-style-type: none"> → Offering everyone a certain level of service (Cowley, 1991) → Hidden/unacknowledged need (Collinson and Cowley, 1998a) → Keep trying - not giving up on families (Chalmers and Luker, 1991; Luker and Chalmers, 1990; Chalmers, 1994) → Providing advice/information as reassurance to support ongoing parenting (Plews, 1998) → Providing support and recognising increased needs during transition period such as new parenting and managing infant crying (Long and Johnson, 2001) 	<ul style="list-style-type: none"> → Concern that judgements made too early may misdirect care (Appleton and Cowley, 2008a) and miss later developing needs (Wilson <i>et al.</i>, 2012; Wright <i>et al.</i>, 2009) → Assessment requires time investment for cumulative picture of the person to be developed (Wilson <i>et al.</i>, 2008a; McIntosh and Shute, 2007) → Providing support and recognising needs during transition (Plews <i>et al.</i>, 2005) → Increased support offering better service satisfaction and less reliance on emergency care (Christie and Bunting, 2011)
	Seeking out potential strengths – maintain hope	<ul style="list-style-type: none"> → Holding, being there for, whilst exploring problems (Cody 1999) → Respect and value client expertise (Collinson and Cowley, 1998b) → Communication skills that emphasise partnership (Chalmers, 1992) → Dialogue/partnership style (Foster and Mayall, 1990) → Refer and retain - continuing relationship even when referred to additional service (Collinson and Cowley, 1998b) 	<ul style="list-style-type: none"> → Demonstrating partnership communication techniques to support growth in the client behaviours (Puura <i>et al.</i>, 2005a; Kirkpatrick <i>et al.</i>, 2007; Orford <i>et al.</i>, 2007; Patterson <i>et al.</i>, 2005) → Refer and retain - continuing relationship even when referred to additional service (Halpin and Nugent, 2006)

Person-in-situation: human ecology (Bronfenbrenner, 1986)	Assessing and acting (intervening) constant feature, taking account of the individual and their personal and situational circumstances.	Acting in the client's space: → Home visiting (de la Cuesta, 1994a) → Observing to improve real knowledge of client's situation (Cowley, 1991) → attunement to client situation – intuition (Chalmers, 1992; Ling and Luker, 2000) recognising when situation 'not quite right' – acknowledges this (Chalmers, 1993) → Hold/offer continuing support/care for distress/suffering (even if no clear reason) whilst unravelling complexities and assessing risk to seek explanation – 'therapeutic prevention' (Cowley, 1995a)	→ Additionally trained health visitors can more accurately determine need for intensive parenting home support (Papadopoulou <i>et al.</i> , 2005) → Intensive home support has assisted mothers in feeling less anxious about their child's development and has impacted on their reliance on health services (Wiggins <i>et al.</i> , 2004; Knapp <i>et al.</i> , 2005) → Reflexive approach balances maternal and infant needs – keeps mother in mind (Bryans, 2005) → Reading the whole situation to gauge what is happening to know what to say, how and when (Appleton and Cowley, 2008a; Plews <i>et al.</i> , 2005), tuning in to client (Plews <i>et al.</i> , 2005) and their situation (Wilson <i>et al.</i> , 2008b) → health visitors additionally trained in listening and with ongoing access to psychologist's expertise, helped stimulate awareness and 'unlock issues' for women with postnatal depression, assisting their sense of ability to manage their condition (Turner <i>et al.</i> , 2010)
		Acting in the community to: → facilitate groups, liaise with other groups/agencies marketing service. Making best use of 3 rd parties to help 'pave the way' (Luker and Chalmers, 1990) → know the community to be able to make appropriate referral (Luker and Chalmers, 1989) → mediate between client and agency, described as 'working up the agency' (Luker and Chalmers, 1989; Chalmers, 1993)	→ Mediate between client and agency (Brocklehurst <i>et al.</i> , 2004) → With appropriate training improved clarity of public health role and connection between family and community work (Parker and Kirk, 2006) → Enabling client to access service that they would otherwise have resisted (Kirkpatrick <i>et al.</i> , 2007; Shute and Judge, 2005) → Ability to keep community resources in mind when working in role combining caseload and community development work (Forester, 2004) → Desire to deliver public health practice in wider community if have sufficient support from managers and organisation (Goodman-Brown and Appleton, 2004; Smith, 2004; Hogg and Hanley, 2008)
		Acting in the workplace to: → manage workload, working within limits to safeguard self and client (Pearson, 1991; Mitcheson and Cowley, 2003) → keep trying, using organisational system to legitimise contact renewal and open fresh opportunity for searching for needs, stimulate awareness (Chalmers, 1992) and influence policy (Stuteley, 2002). → work around the official system of prescribed visiting/core programme to deliver service fitting client needs (Cowley, 1995a; Sonuga-Barke <i>et al.</i> , 2001)	→ Use personal autonomy in workplace, drawing on own expertise to assess and make referrals or deliver interventions when organisational system permits (Chakrabarti and Fombonne, 2005; Wilson <i>et al.</i> , 2012; Hutchings <i>et al.</i> , 2007; Condon, 2011) → Access workplace clinical supervision to safeguard practice and quality of care when working intensively with families (Barlow <i>et al.</i> , 2003; Turner <i>et al.</i> , 2010)

Table 2: Thematic content analysis of literature: the orientation to practice

Why health visiting? Examining the potential public health benefits from health visiting practice within a universal service: a narrative review of the literature.

What is already known?

Pregnancy and the first three years of life are crucial in determining the infant's future life chances, health and health inequalities.

Early years programmes, often delivered through home visiting, have shown demonstrable benefits to mother and infants, when targeted to the most needy populations.

Strictly targeted programmes do not shift the 'social gradient' of health inequalities, so attention has turned to provision of universal services, such as the British health visiting service.

Enhancing uptake of needed services and appropriate health or parenting information can reduce health inequalities, but there is limited research knowledge about how universal services achieve these outcomes, or about the 'craft' of practice involved in delivering them.

What this paper adds

- A detailed analysis of health visitors' skills, attitudes, values and their application in practice, which offers a potential explanation of how universal provision could help to shift the social gradient of health inequalities.
- Details of the 'craft' of health visiting practice needed to deliver universal health visiting services, predominantly through home visiting, needs assessment and parent-health visitor relationships.
- An understanding about how the health visitor outreach style and practice within a universal service creates opportunities for parents who may otherwise have remained unaware of, or unwilling to engage with services.
- An explanation of the components required in a universal health visiting service that enhances the potential for health promotion, early identification for intervention or referral to needed services and proven programmes.