

National Nursing RESEARCH UNIT



Health visiting: the voice of service users
Learning from service users' experiences to
inform the development of UK health visiting
practice and services
(Department of Health Policy Research
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¹ Membership of the advisory group is listed in Appendix 1.

Glossary of terms/abbreviations

BME: Black and Minority Ethnic

EISs: Early Implementer Sites

NNRU: National Nursing Research Unit

NRES: National Research Ethics Service

TAC: Team Around the Child

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Executive summary

Introduction

In 2011, with *The Health Visitor Implementation Plan 2011-15: A Call to Action* (Department of Health, 2011) the Coalition Government set out a new vision for the future of health visiting in England. To inform and support the implementation of the new service organisation proposed in the Health Visitor Implementation Plan 2011-15 (Department of Health, 2011) and to provide useful input for further development in health visiting policy and practice, the Department of Health Policy Research Programme commissioned a programme of research which has been carried out by a dedicated team at the National Nursing Research Unit, King's College London. The present report presents the findings and potential implications of the study - part of the health visiting research programme - investigating the views of parents on their experiences of engaging with the health visiting service in England. More specifically, we discuss our findings from a narrative review of the published literature on service users' views of health visiting and from the analysis of semi-structured interviews with 44 parents undertaken in two Early Implementer Sites (EISs) of the Health Visitor Implementation Plan 2011-2015 (Department of Health, 2011) in England.

Background

In 2011 the Government committed to expanding, rejuvenating and re-energising the health visiting services in England (Department of Health, 2011). The strategy presented in the *Health Visitor Implementation Plan 2011-2015: A call to action* (ibid.) envisages: a strengthening of the workforce with 4,200 new health visitors in post by 2015; a new vision for the organisation of services articulated through four levels of 'family offer'; and a fast-paced progressive implementation of the new service. Implementation of the new service vision started immediately after publication of the policy directive, with selected NHS Trusts – EISs – leading the path to innovation. The new service vision is grounded in the revised edition of the Healthy Child Programme (Department of Health & Department for Children Schools and Families, 2009; Shribman & Billingham, 2009), which sets the standard and objectives for the delivery of a universal preventive programme for child and family health. At the 'Community' level, the 'family offer' provides access to community services for all families, and at the 'Universal' level, it provides essential health visiting advice and support for all families. Focused additional support for vulnerable children and families at the 'Universal Plus' and 'Universal Partnership Plus' levels of the family offer provide, the former, additional support for families who need extra health visiting input for a limited amount of time, and the latter, additional support for families who need ongoing help with more complex issues. The transformation of health visiting is located within a broader context of changes in NHS trajectories for development, of which the growing emphasis in national policy on the value of involving service users in decisions around care and embedding analyses of service user experience in accountability structures and quality improvement strategies are only two examples.

The health visiting research programme at the National Nursing Research Unit aims to produce evidence that is directly relevant to current thinking and future developments in policy as well as in professional practice. In addition to the study described in this report, the programme also comprises a scoping review of the literature on health visiting and another empirical study exploring issues of recruitment and retention of the health visitor workforce. We undertook the scoping review of the health visiting literature in 2011-2012, and the report from that project was published early in 2013 (Cowley et al., 2013). There we discussed the forms of practice that are particularly well suited to this unsolicited, proactive and health promoting focus of health. Drawing on some classic studies of health visiting as well as more recent research, we emphasised the value of an 'orientation to practice' grounded in salutogenic (health creating), person-centred (human valuing), and context-sensitive (human ecology-based) approaches to help parents to have a better experience of their 'journey' through this service. We also paid attention to evaluative work on specific areas of health visiting practice such as breastfeeding support and the diagnosis of and support for postnatal depression, to mention only two. In this report, we draw upon our scoping review and outline the ways in which the findings from our research on service users' views connect to broader themes in health visiting research and practice.

Aims

The aims of this study are to briefly review the academic literature on service users' views of health visiting and to provide an in-depth analysis of service users' accounts of their experiences of engaging with health visiting services, with a particular focus on the 'Universal Plus' level of the family offer. We included health visitors and the wider health visiting teams in the light of current service configurations and an expanding literature that shows contemporary health visitors rarely work in isolation. We do not define these terms but use them colloquially, taking our cue for terminology from the parents themselves.

The study aims to address the following research questions:

- 1) What is already known, from existing research, about service users' experiences of health visiting?
- 2) What aspects of health visitors' practices do service users find valuable and enabling?
- 3) What services would parents like to see available (and how do these match the new service vision)?
- 4) What combinations of professionals and forms of teamworking do parents find most helpful?

Our analysis provides insights into some of the strengths and weaknesses of health visiting at a time of transformation that will prove useful to policymakers, service managers, and practitioners, and will inform the ongoing implementation and further development of the new service vision.

Methods

This study comprises two main components: a review of the academic literature on service users' experience of health visiting and a qualitative empirical study based on interview data gathered at two EISs in England.

The literature review draws together background information about what is already known about service users' views and experiences of health visiting using a narrative approach. We focused on publications that: i) related to UK health visiting context; ii) directly reported on service users' views; iii) directly related to health visiting services, interventions or care delivered by health visitors, health visitors working as part of primary care teams, or contribution to education programmes; iv) were – for the most part – published relatively recently (2004 onwards), in view of the changes in approaches to child care initiated by *Every Child Matters* (Department for Education and Skills, 2004). We searched both specific and general databases (Medline, Embase, British Nursing Index, Web of Knowledge, and GoogleScholar), including both qualitative and quantitative studies on the basis of their relevance to the overall study questions and of the four inclusion criteria outlined above. We also drew upon our broader scoping review of the health visiting literature (Cowley, et al., 2013).

Our empirical study was based on individual semi-structured interviews with parents who had experienced health visiting services provided by health visiting teams at two EISs in England, in particular at the “Universal Plus” level of the family offer. The sites were selected to provide some overlap with the other empirical component of the Research Programme (the Start & Stay study, exploring issues of recruitment and retention for the health visiting workforce) and a degree of variation in population demographics, although practical considerations (e.g. feasibility of access, availability of local support from health visiting teams and team leaders) were also taken into account. We interviewed a total of 44 parents, 42 of whom were mothers. Potential participants matching our criteria for taking part in the study – parent or carer of child aged between 0 and 5 years; over 18 years of age; with experience of sustained contact² with the health visiting team, in particular as per ‘Universal Plus’ level of the family offer – were contacted and provided with information on the study by their health visiting team. Further information and arrangements for interview varied in accordance to local circumstances. We gained ethical approval for this study through the Proportionate Review Sub-committee of the relevant NRES Committee. Data analysis was informed by grounded theory approaches to qualitative research (Charmaz, 2006; Glaser & Strauss, 1967). The themes to include in the report were selected in view of their relevance to health visiting policy and practice. In order to protect the anonymity of participants, throughout the report we use pseudonyms to refer to participating parents, their family members, and the health and social care professionals involved in their care.

² By ‘sustained’ contact we mean contact with members of the health visiting team beyond the first health visitor’s first visit, occasional attendance at child health clinics, and the routine scheduled meetings of the Universal level of family offer.

Findings

Narrative review of the literature on service users' views of health visiting

From our broader scoping review (Cowley, et al., 2013) and from the review we carried out for this study, we identified five areas of health visiting practice that appear central to effective family support: support, relationships, service user involvement, information, and coordination. We used these five dimensions of health visiting to organise our narrative review of the literature.

Support: Parents value health visitors' knowledge of parenting and child care issues, their capacity to offer reassurance and support with specific issues such as postnatal depression. Parents report that health visiting services can contribute to improved wellbeing and self-confidence and reduce feelings of anxiety and social isolation. However, experiences vary widely and depend on many factors, including geographical location, staffing levels, and types of services offered locally. Overall, fathers engage little with health visiting services. Documented reasons for this include poor awareness of service offer, timing of clinics and groups, mother-oriented materials, mother-dominated environments. Studies with different sectors of the community and minority ethnic groups consistently show that health visiting needs to work in partnership with community organisations and representatives to develop a service that the community finds valuable.

Relationships: Building and nurturing the parent-health visitor relationship is important for underpinning the delivery of functional aspects of care, including for example, providing information and advice. In particular, non-directive partnership-based approaches to health visiting are helpful in supporting mothers' self-confidence whilst space for listening, reflective dialogue and therapeutic touch contribute to the development of trusting relationships with health visitors.

Service user involvement: Service user involvement in health visiting can range from individual participation in health-related decision making to participation in service evaluation and at community level. Person-centred approaches to health visiting require enabling opportunities for more active parent participation in their encounters with members of the health visiting team. This participation is facilitated by non-judgemental and encouraging approaches on the part of professionals and it is particularly important to support women who have suffered domestic violence. There is very little evidence about service users' views on their involvement in decisions about the care or support they receive from health visitors and mothers who have taken part in research have tended to see health visiting as providing unidirectional support rather than a reciprocal relationship. We found few examples of direct service user involvement in decision making about health visiting services and practices or health visitor education.

Information: Many parents are unaware of the services that are available to them and more effective dissemination of information about health visiting could be beneficial. Innovative services (e.g. health vans, play buses, health advocates) can help to boost the profile of health visiting. When accessing health visiting, parents value both evidence-based factual information and advice that is tailored to suit their needs. Relatively little research has been undertaken about the potential benefits of the

Internet for supporting parents with their information needs, although websites such as Netmums, Babycentre, and Mumsnet are very popular with parents of young children.

Coordination: Service users value health visitors as a point of contact with and referral to other health professionals, for their links to social care, referral to specialist services and for a sense of continuity and being known personally by a health visitor. New parents also value the coordination and support role provided by health visitors to parent groups as for many parents establishing new social networks is an important way to learn childrearing skills, overcome feelings of social isolation, gain self-confidence and emotional support.

Empirical study

The majority of participants in our study had had positive experiences with the health visiting services they were still engaging with. Only a few parents had some specific criticism or concern that they wished to express. Our findings represent the views and experiences of a self-selecting group of parents and there are therefore limitations on their generalisability and on the aspects of health visiting they shed light on. These limitations, however, do not detract from the value of our findings for supporting the development and consolidation of more effective, sensitive, and engaging health visiting practices.

Supportive and enabling relationships

Parents who had engaged with health visiting services for advice beyond the routine appointments of the Universal level of service valued some continuity of contact with the same health visiting team member. They appreciated feeling 'known' and listened to, and expressed in detail what practices and approaches made them feel this way. Being known to the health professional or to the team of professionals meant that advice was better tailored and better accepted. The perception of being given time and dedicated attention by a member of a busy health visiting team helped to develop relationships characterised by trust and reliance. Expressions of praise and reassurance from health visitors and health visiting team members helped parents to build their self-confidence and trust in their judgement as parents. Awareness of the health visiting services and of their reliability enabled parents to feel they had a safety net, thus helping them to manage some of their parental anxieties. Negative experiences with health visitors or health visiting teams – in this study they were typically previous experiences with other health visitors or teams – often had profound and/or long-lasting effects. When parents felt judged for their parenting approaches or lifestyle choices, when they perceived the advice to be 'by the book' and not tailored to their family's circumstances, they became sceptical about the usefulness of engaging with health visiting that could affect subsequent encounters.

Organisational features characterising supportive health visiting services

Parents in our study said they felt disappointed and confused when they experienced disruption or disorganisation in their care. This was the case for only a very small number of participants but it

contrasted with other accounts of how health visiting contributed to preventing or remedying disruption in care by improving coordination between professionals and providers.

We found that there were at least three ways in which health visiting teams, and health visitors in particular, contributed to effective coordination of care and of the information that went with it: 1) by operating as a point of referral and contact with other professionals and services (e.g. general practitioners, hospital specialist, speech therapists, etc); 2) by acting as key reference points to relay information, thus mediating and facilitating interaction and communication in the context of complex care; and 3) by responding reliably and promptly to parent-initiated contact and tailoring practical arrangements to parents' needs.

Parents are sensitive to failings in these mechanisms of health visiting support and these may undermine their confidence in the reliability of the service. Another strong theme in our participants' narratives was how little they knew about the health visiting service when they came home with their first child. Few first-time mothers in this study had met their health visitor before their baby's birth; most mothers were briefly told about the health visiting service by a midwife. Many mothers said they were not clear when the health visitor would call and what help she could offer, and some held misconceptions about health visiting that made them apprehensive about the visit. Initial lack of information did not seem to impede development of trusting relationships with health visitors or inhibit mothers' use of services. However, meeting the health visitor before the baby's birth and being told about the service at this point was valued by those who had experienced it, and identified as a potential improvement by many of those who had not.

Finally, most mothers in our study took up their health visitor's invitation to use the local child health clinic, which seemed to act as a stepping stone to engagement with other groups and activities, such as breastfeeding groups and mother and baby groups of various kinds, that offer different forms of interaction from one-to-one conversation with a professional. Where these groups took place in Children's Centres, parents who used them were also likely to meet others working with families and children and take up the more extensive range of advice and support that the centres offer (e.g. skills training, employment advice, finance and education) and opportunities to meet other parents with children of similar age. Drop-in clinics and support groups offered forms of support that were complementary to home visits, and provided opportunities to cement existing relationships or to form new relationships with members of the health visiting team. The latter possibility proved particularly important for parents who were not entirely comfortable or in tune with the particular health visitor or health visiting team member they had been seeing.

Fathers' involvement with health visiting

The accounts from mothers and fathers in our study painted a picture of paternal engagement with health visiting as a complex process with many contributory aspects: the opportunity for contact with the health visitor, the dynamics and division of labour within the couple, the father's inclination to make contact with health services, the health visitor's approach to involving 'dad' during home visits,

and the perceived accessibility of Children's Centres all emerged as significant from our analysis. From the accounts of participants in our study, the involvement of fathers with health visiting services varied across a broad range: from impossible contact due to work commitments, to back seat presence, to active interaction with the services. Some mothers ascribed their partner's reluctance to proactively engage in communication with the health visiting team to their personality, others to the habitual dynamics in the couple. Across the range of possibilities we encountered, health visitors were skilful at assessing the mother's preferences and, especially at the first visit, actively sought to involve fathers in the conversation where this was appropriate. However it often proved difficult to maintain contact over time due – mostly – to the timing of home visits and activities at the Children's Centre.

Discussion

We organised our discussion around the research questions that the study sought to address.

- 1) What is already known about service users' experiences of health visiting?

In exploring the evidence from research on service users' experiences of health visiting under the headings of support, relationships, service user involvement, information, and coordination, we found that the published literature explores in some depth the value of health visitor-parent relationships for effective family support. Successful relationships between parents and health visiting team members allow the service to offer the best support possible to families, and parents to perceive and appreciate this support. The literature on service users' experiences of health visiting also shows that despite the collaborative foundations of health visiting work, research efforts to examine the language and practices of collaborative approaches to family support and service development are scarce. We also confirmed our finding from the scoping review that available evidence on fathers' engagement with health visiting services is scarce, thus making our commitment to exploring parents' views on this matter particularly relevant to the current health visiting context.

- 2) What aspects of health visitors' practices do service users find valuable and enabling?

and

- 3) What service would parents like to see available (and how do these match the new service vision)?

Our findings confirm the health visiting literature's emphasis on the role of trusting and enabling relationships in family and child care support. They also offer richer understandings of the dimensions of relationships that parents found most helpful. Parents appreciated and valued feeling 'known' to the professionals in the team and perceiving that professionals cared about them and their family circumstances, were willing to listen to their concerns, and could address their questions respectfully and sensitively. Our analysis also points to the effects that unsatisfactory encounters can have in parents' preferences on whether or not to engage with health visiting in the future.

Effective coordination of care (e.g. appropriate referrals to other forms of healthcare and/or social support, coordination of health visiting team transfers, etc.) contributed significantly to creating a good experience of the service for parents. We also found that certain transitions in family support, and in particular that from antenatal care to health visiting support, are central to parents' perceptions of health visiting and their engagement with the service.

Child health clinics and group activities at the Children's Centres had at least three very important roles in parents' successful engagement with, and perceptions of receiving support from, the service: 1) child health clinics supervised by a health visitor represented an important point of contact when queries and doubts that did not require immediate attention arose; 2) regular child health clinics and group activities facilitated ready access to a health visitor and opportunities for social interaction with other parents; and 3) the availability of different professionals at Children's and health centres facilitated parents' choice. These findings highlight the importance of consolidating a health visiting service that combines home visiting with opportunities for support and advice outside the home. We suggest that support outside the home can be seen to represent a fourth core practice of health visiting that complements and supports the existing 'triad' (identified in our earlier review of the literature) of: 1) health visitor-client relationship; 2) health visitor home visiting; and 3) health visitor needs assessment (Cowley, et al., 2013).

Our analysis highlights the potential that engaging more with parents and making use of their experiences and feedback would have to inform local service providers' strategies for service improvement. It also illuminates the barriers to, and complexities of, providing adequate support to fathers and the role that more structured involvement of parents in the design, delivery, and evaluation of services could have in contributing to devising more effective strategies for fathers' engagement with sources of advice and support.

4) What combinations of professionals and forms of teamworking do parents find most helpful?

Roles and responsibilities in health visiting can be unclear – if not completely obscure – to first-time parents until their first routine postnatal visit. Indeed, roles and responsibilities often remained unclear also to parents who had experienced only minimal contact with the service with previous children. Our recommendations reflect our suggestion that it would be useful for health visiting and family support services to consider whether action is required to promote better understanding of the role and function of health visiting among the general public.

In addition to exploring the relevance of our findings in relation to our research questions, we also highlight some of the most obvious connections between our analysis and academic research in the wider healthcare literature in order to contextualise our study - and health visiting research more generally - within broader healthcare issues and debates. In particular we discuss the relevance of covenantal conceptualisations of care and relationship-based approaches to practice in the exploration of the value and role of relationships in health visiting. We suggest that the literature on 'emotional touchpoints' and on experience-based co-design approaches to service improvement can

be helpful in developing more participative practices of user involvement in the design, delivery and evaluation of health visiting services. We outline the connections between the emphasis on continuity of contact and coordination of care in health visiting in our analysis and theoretically informed research on continuity and coordination of care in the broader healthcare literature. Finally, we point to the relevance of broader explorations of user involvement and shared decision making as a means for reflecting on the collaborative aspects of health visiting support.

Strengths and limitations

The research questions were developed and refined in view of policy concerns and service improvement requirements at a time of fast-paced policy developments. In the future we would consider carrying out further research on health visiting practice in which service users had the opportunity to contribute to shaping the design and focus of empirical work. We worked in collaboration with health visiting teams to identify potential participants for our empirical study and interviewed a self-selecting sample of participants across two EISs. Our design and sampling strategies have limitations as to the aspects of health visiting they shed light on. Whilst not being generalisable, our findings provide in-depth understanding of some of the aspects of health visitors that prove essential to effective family support and prompt useful reflections and suggestions for policy, research and practice.

Implications for policy, practice and research

In view of the findings and discussion above, we make the following policy and practice recommendations:

- 1) Structures and systems³ to be put in place or consolidated to ensure that health visitors and health visiting teams have the space and resources to critically examine how their practices and behaviours influence their relationships with parents and to develop corrective measures in sensitive and constructive ways.
- 2) Stronger links between midwifery care and health visiting support to be cultivated and parents' contact with the health visiting team to be facilitated in the antenatal period.
- 3) NHS trusts to support current policy and practice developments aiming at facilitating contact with health visiting services during the antenatal period.
- 4) Health visiting support to continue to be organised in a way that ensures rich and flexible combinations of support at home and support outside the home.⁴

³ Examples of structures of this kind are (but are not limited to): regular team meetings focused on discussion of interaction with contribution of all members; opportunities for training and development of reflective and reflexive skills; mentoring systems.

⁴ We would list 'support outside the home' as a fourth core practice to be added to the existing triad of practitioners' 'orientation to practice' (see page 86).

- 5) Systems supporting the active involvement of parents and carers in the design, development, and evaluation of health visiting services⁵ to be implemented as a matter of routine practice in a manner that is mindful of local needs and circumstances.
- 6) Health visiting services to work closely with parents to improve the support they can offer fathers and further research to be carried out to explore in depth the ways in which primary care services could support fathers.⁶
- 7) Research to be commissioned to explore participatory practices in health visiting work and policy that will generate more reliable evidence on the support that health visiting can offer to fathers.⁷
- 8) Policymakers and service managers to consider whether action is required to promote better understanding of the role and function of health visiting support amongst the general public.⁸

We also suggest that:

- 1) Children and family services may need to address parents' lack of clarity around roles and responsibilities of members of the health visiting team, if meaningful evaluation of skillmix and teamwork arrangements is to be carried out successfully.
- 2) Health visiting practice and research should strive to promote cross-fertilisation between different disciplinary, theoretical, and methodological approaches to the study of processes and practices in family and child health support.
- 3) Systems based on active consultation processes – e.g. regular group discussions for staff and parents, video diary booths, comments and suggestions boxes, celebrations of success and achievements with planning for improvement – may help to develop health visiting services that are more in tune with, and responsive to, the needs of their local communities.
- 4) More research is required to help illuminate the role of health visitors in the context of TAC meetings and processes for supporting families with complex social and health needs.

Conclusions

In this report we have presented and discussed the findings from our narrative review of the literature on service users' views of health visiting and from our empirical qualitative research on parents' views

⁵ For example: regular group discussions for staff and parents, video-diary booths or suggestion boxes; celebration events for achieved improvements, 'parents' panels' to support and comment on services in general, etc.

⁶ Research in this area should be trans-disciplinary and benefit from the collaboration with existing independent research and support organisations wherever possible

⁷ For example, home visits or activities scheduled outside office hours

⁸ We acknowledge that the move towards routine universal antenatal contacts between prospective parents and health visitors envisaged by the Health Visitor Implementation Plan is a significant step in this direction.

of their experiences of the service in two EISs in England. It provides a rich picture of the dimensions of health visiting practice that parents in our study found useful and enabling, and draws attention to forms of ineffective interaction that can have long-lasting negative effects on parents' engagement with the service. Based on our analysis and discussion of the findings, we make specific recommendations for policy, practice, and research that are intended to contribute to further policy and practice developments in health visiting.

1. Introduction

In 2011, with the *Health Visitor Implementation Plan 2011-15: A Call to Action* (Department of Health, 2011) the Coalition Government⁹ set out a new vision for the future of health visiting in England. The new health visiting service is currently expanding its workforce and will continue to provide support to parents and carers of children aged between 0 and 5 years through a restructured service providing 4 different levels of ‘family offer.’ Within this re-organised service, health visitors will coordinate and contribute to providing ‘Community’ and ‘Universal’ levels of service to all families, whilst tailoring additional support for those who need it through the ‘Universal Plus’ and ‘Universal Partnership Plus’ offer.

To inform and support the implementation of the new service organisation proposed in the *Health Visitor Implementation Plan 2011-15* (Department of Health, 2011) and to provide useful input for further development in health visiting policy and practice, in 2011 the Department of Health also commissioned, through their Policy Research Programme, a broad programme of research to be carried out by a dedicated team at the National Nursing Research Unit, King’s College London. This programme consists of three main strands of research: a scoping review of the literature on health visiting, which was recently published (Cowley, et al., 2013); an empirical study focusing on issues of recruitment and retention in health visiting (Whittaker, Grigulis, Hughes, et al., 2013); and a second empirical study, reported here, exploring service users’ views on their experience of engaging with the health visiting services.

The present report aims to summarise the aims and background to the study exploring service users’ views on health visiting and to illustrate and discuss the findings and suggestions derived from our analysis of interviews with 44 parents across two Early Implementer Sites (EIS)¹⁰ of the Health Visitor Implementation Plan 2011-2015 in England. More specifically, in the first section of this report we discuss our findings from a review of the academic literature on service users’ views of health visiting. In Section 2, we summarise the broader policy context of the Health Visitor Implementation Plan and the findings from our scoping review of the literature (Cowley, et al., 2013). In Section 3, we state the specific aims of the study and the research questions it aims to address. Section 4 provides details of the methodological approaches we adopted for this study, including a broad¹¹ characterisation of the research sites and study participants and our notes on the ethical and reflexive issues that the study raised. Section 5 looks at the existing academic literature on service users’ views on health visiting practice by organising it under headings that reflect some of the most important areas of family support to which health visiting contributes. Section 6 draws upon our empirical data – semi-

⁹ Conservative-Liberal Democrats coalition, under the leadership of Prime Minister David Cameron and Deputy Prime Minister Nick Clegg.

¹⁰ EISs are a selected number of NHS Trusts identified as leaders in implementing the new health visiting service and acting as pilots and demonstration sites.

¹¹ We provide only a broad description of participating sites in order to preserve anonymity. Further details on the measures we took to ensure anonymity of participants are provided in Section 4.

structured interviews with 44 parents across two EISs in England - in order to illustrate the core features of health visiting that parents described as particularly enabling or, in some cases, rather disempowering and amenable to improvement. In Section 7, we discuss how the findings from our analysis help us to address our original research questions (listed on page 22). We also establish some useful links between our research and relevant work in broader healthcare research with a view to encouraging cross-fertilisation in health visiting scholarship. Finally, in Section 8 we outline our suggestions for policymakers and for future research developments that would strengthen health visiting theory and practice.

2. Background

2.1 Policy context

With the *Health Visitor Implementation Plan 2011-2015: A call to action* (Department of Health, 2011), published in 2011 by the Department of Health, the Coalition Government committed to expanding, rejuvenating and re-energising health visiting services in England. The strategy detailed in the document envisages, in particular: a strengthening of the workforce with 4,200 new health visitors in post by 2015; a new vision for the organisation of services articulated through four levels of ‘family offer’ – *Community* (community services available to all families), *Universal* (essential advice and information from the health visiting team for all families), *Universal Plus* (additional support for families who need extra health visiting input for a limited amount of time), and *Universal Partnership Plus* (additional support for families who need ongoing help with more complex issues). A fast-paced progressive implementation of the new service is operating through three main mechanisms: growing the workforce; professional mobilisation; and alignment of delivery systems. The Plan also sets the implementation in the context of broader transformations in healthcare governance and accountability (as proposed in the White Paper *Equity and Excellence: Liberating the NHS*, Department of Health, 2010), and enshrined in law in the Health and Social Care Act, (Health and Social Care Act, 2012) and outlines the monitoring processes that will accompany the implementation of the new service vision. The new organisation of health visiting has, at its core, the effective delivery of the *Healthy Child Programme* (Department of Health & Department for Children Schools and Families, 2009; Shribman & Billingham, 2009). Its implementation started immediately after the publication of the *Health Visitor Implementation Plan 2011-2015* with selected NHS Trusts – EISs - leading the path to innovation (see the *Celebrating Early Implementer Achievements – One Year On* report by the Department of Health (2012a) for an overview of the implementation experiences at these Trusts). Also, a newly developed dataset about Children and Young People’s Services was recently put in place by the NHS Information Centre for Health and Social Care to begin measuring outcomes from services delivered by health visitors (Kausch, 2012).

The *Healthy Child Programme* (Shribman & Billingham, 2009) sets the standards and objectives for the delivery – at the level of local health and social care services for children and families – of a universal preventive programme and of focused additional support for vulnerable children and families. It builds upon the *National Service Framework for Children, Young People and Maternity Services* published by the Department of Health in 2004 (Department of Health, 2004a) and on the evidence base provided by key guidance and research (Barlow, Schrader McMillan, Kirkpatrick, et al., 2008; Hall & Elliman, 2006; NICE National Institute for Health and Clinical Excellence, 2006, 2007) and promotes an integrated approach to supporting children and families.

The rapidly evolving policy landscape of health visiting is also connected to other changes in NHS trajectories for development. In particular, we highlight the growing emphasis in national policy on the value of involving service users in decisions around care and embedding analyses of service user

experience in accountability structures and quality improvement strategies (Department of Health, 2004b, 2005, 2007). In particular, the *NHS Outcomes Framework 2013/2014* (Department of Health, 2012b), which sets the desired outcomes for the NHS in the forthcoming years, promotes a conceptualization of quality of care as comprising three main components: effectiveness, patient experience and safety (as proposed by Lord Darzi in his *NHS Next Stage Review* - Department of Health, 2008).

The programme of research on health visiting at the National Nursing Research Unit at King's College London is located within this broader policy context and it aims to produce evidence that is directly relevant to current thinking and future developments in policy, as well as in professional practice. In the following section, we describe the programme in a little more detail so as to provide a more complete backdrop to the study this report describes.

2.2 Earlier insights from the health visiting research programme at the NNRU: the “*Why health visiting?*” report

As mentioned above, in 2011-2012 we undertook a review of the health visiting literature (Cowley, et al., 2013) to support the Health Visitor Implementation Plan (Department of Health, 2011). This was an extensive scoping review which brought together key seminal literature from health visiting research, as well as more recent work exploring the health visiting contribution to different areas of intervention outlined in the Healthy Child Programme. Our review organised the literature analysed under the headings provided by the levels of the ‘family offer’ set out in the Implementation Plan. On the basis of the picture we drew from this extensive review, we argued for the importance of preserving and consolidating certain core dimensions of health visiting practice and also made clear recommendations for research, practice, education and policy.

In particular, in our *Why health visiting?* report (Cowley, et al., 2013) we suggested that some forms of practice are particularly well-suited to the unsolicited, proactive and health promoting focus of health visiting, which means that in the early phases of pregnancy and having a new baby, services need to reach out to parents who have not initially requested a service. Our analysis revealed an ‘orientation to practice’ grounded in salutogenic (health creating), person-centred (human valuing), and context-sensitive (human ecology-based) approaches, which could enable parents to have a better experience of their ‘journey’ through this service. We drew on some classic studies as well as more recent research to describe how this operates.

To get to know the parent, the health visitor needs to first gain access to family, by attuning, listening and observing the situation, which in turn allows the parent to get to know the health visitor (Chalmers, 1992a; Collinson & Cowley, 1998a; Luker & Chalmers, 1990). An ideal ‘service journey’ allows reciprocal exchange and opportunities for the health visitor and parent to get to know each other, developing a relationship based on trust and respect, which helps clients feel valued (Collinson & Cowley, 1998a). Listening, observing and talking skills help the parent to engage with the service and open up the discussion, perhaps exposing issues that may be troubling, sometimes after initiating

discussion about surface or 'safe' topics (Collinson & Cowley, 1998b). This approach appears to be more effective and acceptable as a means of assessing health needs than using structured lists of questions (Appleton & Cowley, 2008b; Chalmers, 1992a; Houston & Cowley, 2002; McIntosh & Shute, 2007). As parents get to know the health visitor and health visiting service, they develop a new awareness and understanding of their own situation and of how best to use the service (Appleton & Cowley, 2008a; Chalmers, 1993; Cowley, 1991).

Health visitors also draw on their local and professional knowledge to provide information, making links with local resources and community networks when seeking to raise awareness and facilitate health enhancing activities (Appleton & Cowley, 2008b; Bryans, Cornish, & McIntosh, 2009; Cowley, 1991, 1995; Luker & Chalmers, 1989). Ideally, a range of activities including assessing and intervening, on-going availability, reciprocal exchange and collaborative interaction leads to a situation in which the parent understands and has confidence in the service, is able to express needs and accept referrals or initiate further contact as required.

The above description explains how the service journey can be facilitated through health visitors' 'orientation to practice,' which finds expression through the fostering of health visitor-parent relationships, health visitor home visiting and health visitor needs assessments. The research showed that these three forms of practice, which we dubbed 'a triad of core practices,' are interconnected and all operate together as a single process, forming the basis of the health visiting service. We also paid particular attention to more evaluative work on specific areas of health visiting practice such as breastfeeding support, diagnosis of and support for postnatal depression, assistance and help for domestic violence and abuse, etc. Although there was no strong research evidence for any particular intervention or programme, our review allowed us to outline some of the main issues and unanswered questions in health visiting practice for each level of service provision. Furthermore, implementing proven approaches and programmes into a service organised and delivered in a way that is known to enhance uptake and use of provision would increase the likelihood of positive health outcomes.

The ideal is not always the reality, however, and we also identified studies indicating difficulties and barriers that might arise. If resources are inadequate, this might cause health visitors to limit health awareness-raising action to avoid creating client demands that cannot be met (Chalmers, 1993; Pearson, 1991). Health visitors may miss cues or communicate in unhelpful or insensitive ways (Cowley & Houston, 2003; Kendall, 1993; Mitcheson & Cowley, 2003) such as inadequate (Pearson, 1991) or hasty advice-giving, before exploring the parent's perspective (Foster & Mayall, 1990; Kendall, 1993) or priorities (Bloomfield et al., 2005), or appear judgemental and not open to partnership working (Roche et al., 2005), or services may be organised in ways that inhibit relationship-formation (Bidmead, 2013). Much of the evidence that we identified offered professional perspectives only, there was a paucity of work about the effect of skill mix or team-based provision on parents, and very limited research about child health clinics or other centre-based provision delivered by health visitors alone or in conjunction with other colleagues (such as in Children's Centres) in the community.

In our recommendations, we suggested – amongst other things – that health visiting research should proceed through greater interdisciplinary collaboration (in particular with scholars in the social sciences and the broader healthcare research landscape) as well as seek to evaluate the safety, quality and acceptability to service users of different skill mix models and ways of working (for a summary of recommendations, see executive summary, in Cowley et al., 2013). We also argued for more structured continuing professional development and policy and service developments geared towards enhancing flexibility and responsiveness of the service. We found that sound research on health visiting work with groups that are less engaged with the service – ‘seldom heard’ groups and fathers – was scarce; we agreed with the authors who had explored these topics (e.g. Baldwin & Griffiths, 2009; Bayley, Wallace, & Choudhry, 2009; Edge, 2007, 2008, 2010, 2011; FI, 2008, 2011; Greening, 2006; Salway, Chowbey, & Clarke, 2009; Williams & Hewison, 2009; Williams, Hewison, Stewart, Liles, & Wildman, 2012; Wittkowski, Zumla, Glendenning, & Fox, 2011) that health visitors need to develop strategies to engage more effectively with various groups in the community and with fathers in particular.

We draw attention to these findings and suggestions from our earlier work as we return to them later in the report, when we discuss how findings from our study add to our scoping review and contribute to health visiting and healthcare scholarship.

3. Aims

The aims of this study are to briefly review the academic literature on service users' views of health visiting and to provide an in-depth analysis of service users' accounts of their experiences of engaging with health visiting services. Our focus is on users of the service at the 'Universal Plus' level of the family offer, although we include input from proactive users of Universal services. At a time of radical transformation of health visiting services, and at these early stages of implementation of the new service model, it is crucial to give voice to the views and experiences of service users so that these views can inform policymaking and service development throughout the process. In discussion with the Department of Health's Policy Research Programme representatives, who commissioned our programme of research, we explored the most pressing areas for further research on service user experiences of health visiting, which inform the research questions we developed to guide our study.

Through a focused narrative review of published academic literature on service users' views of health visiting and the analysis of data from interviews with parents at two EISs, we set out to address the following research questions:

- 1) What is already known, from existing research, about service users' experiences of health visiting?
- 2) What aspects of health visitors' practices do service users find valuable and enabling?
- 3) What services would parents like to see available (and how do these match the new service vision)?
- 4) What combinations of professionals and forms of teamworking do parent find most helpful?

Our analysis aimed to generate useful insights into some of the strengths and weaknesses of health visiting at a time of active transformation. We hope these insights will prove useful to policymakers, service managers, and practitioners and inform the ongoing implementation and further trajectories of development of the new service vision.

4. Methodology and methods

This study comprises two main components: a review of the academic literature on service users' experience of health visiting and a qualitative empirical study based on interview data gathered at two EISs in England. The literature review aims to summarise the main aspects of existing research on service users' views of health visiting. It provides context for our empirical work but did not frame or constrain our analysis. Details of our methodological approach to each of these components are provided below.

4.1 Literature review

The literature review presented in Section 5 draws together background information about what is already known about service users' views and experiences of health visiting. Using a narrative approach we examine the health visiting literature and set the scene for our empirical research (Pope, Mays, & Popay, 2006). The review informs our overall aim of gaining in-depth understanding of service users' experiences of health visitors and health visiting teams. Aware of the problems inherent in a narrative approach - which include generating an unmanageable number of records that would become a research enterprise in its own right (Mays, Pope, & Popay, 2005) – we limited the scope of our review by the following criteria:

- i) related to UK health visiting context, because of a lack of transferability of both service situation (e.g., publicly funded universal service, different preparation for practitioners) and our wish to stay close to the particular experience of service users in this country;
- ii) directly reported on service users' views (rather than professional's perceptions or proxy);
- iii) directly related to health visiting services, interventions or care delivered by health visitors, (e.g. early intervention programmes, parenting courses), health visitors working as part of primary care teams, or contribution to education programmes;
- iv) focused primarily (although not exclusively) on literature published from 2004 onwards, in view of the changes in approaches to children's services initiated by *Every Child Matters* (Department for Education and Skills, 2004). Some papers published prior to 2004 were identified by reference tracking of papers returned by the searches. These earlier papers were included in the narrative review if they were highly relevant to the review question.

We began the search process by drawing together references on service user experience identified by our earlier scoping review (Cowley, et al., 2013) which detailed the strengths and weaknesses of our approach. In particular, our focus on papers reporting health visitors' practice, rather than outcomes from specific interventions or programmes, which has been well covered elsewhere, convinced us to focus upon UK health visiting literature. Whilst taking into account some of the wider literature in our conclusions, we retained a UK focus in the present study, to ensure (as far as

possible) that the picture we gained did represent direct views of parents using health visiting services. Having said that, we are aware that including older literature (despite a primary focus on papers published post-2004), risks inclusion of views about services delivered within a very different context to contemporary provision. A comparison of older and more recent literature about health visiting practice showed much continuity in the way the work was conceptualised (Cowley, et al., 2013), which encouraged us to examine the literature over a longer time scale again, when searching specifically for service users views. We searched both specific and general databases (Medline, Embase, British Nursing Index, Web of Knowledge, and GoogleScholar) and used keywords in combination (e.g. service user/client/parent in combination with health visiting/health visitor) to search the titles and abstracts of papers, tracking references of key papers and reports. We aimed to identify key sources including both qualitative and quantitative research studies relating to service user experiences of health visiting services. Our quality assessment (following Mays, et al., 2005) was based on the relevance to the overall study questions and the four inclusion criteria outlined above.

4.2 Empirical study

Our empirical study was based on individual semi-structured interviews with parents who had experienced some sustained contact with the health visiting teams at two EISs in England. We included health visitors and health visiting teams in the light of current service configurations and an expanding literature that shows contemporary health visitors rarely work in isolation. However, the terminology of 'health visiting team' is used in a variety of ways. Houston and Clifton (2001) trace 'team work' in health visiting back to the early 1990s, when the traditional model of 'one health visitor, one caseload' began to be challenged. Three key forms of team have developed since then:

- the corporate caseload model, where a team of two or more health visitors share responsibility and accountability for a wider caseload of families (see examples described by Brocklehurst & Adams, 2004; Houston & Clifton, 2001)
- the skillmix model, in which health visitors delegate specific activities to members of the team with lower-level qualifications (such as community nursery nurses, community staff nurses or health visitor assistants), whilst retaining overall accountability for their actions (explored in depth by Carr and Pearson's (2005) qualitative study) and
- the collaborative model, where health visitors engage actively with local authority or third sector staff, possibly sharing premises and staff in joint activities, exemplified by the Scottish Starting Well demonstration project (Ross, Caestecker, Sinclair, & Lakey, 2005) where support staff working with health visitors were employed by the local council in the area.

Particular forms of working and service organisation usually combine some elements of each of these models, rather than embracing one model exclusively. Each local area devises its own configuration to suit micro-political, organisational, population and geographical circumstances, often including different variations even with a single authority. We did not, therefore, attempt to define precisely what

our informants understood by the term 'health visiting team,' but use it colloquially as they did, to mean health visitors and the various colleagues with whom they hold a formal relationship to enable them to deliver the service. In this report we refer to health visiting teams to include health visitors and all the other team members that parents identified as providing health visiting support, looking through the parents' eyes rather than through a description of the team provided by the professionals in the participating EISs.

We chose an interview-based approach as this was appropriate for exploring parents' perspectives and feasible in the timeframe and with the resources available to us. The aims of our empirical research were discussed with our policy commissioners and advisory group prior to the start of the project, so that they could be refined by taking into account the input of experienced researchers and practitioners in the field of public and child health and with the needs of policymakers in mind. We also discussed ongoing progress with our policy colleagues during and towards the end of the analytical stages, with a view to ensuring that policy priorities would be borne in mind in the process of developing and finalising the structure of the study report. The interview guides were designed by a member of the study team (SD) with research aims and questions in mind. They were discussed and approved by the team as well as reviewed by the ethics committee prior to fieldwork. Question guides were also discussed again and refined by SD and Principal Investigator JM following early interviews. We selected the participating EISs by inviting expressions of interest at a national meeting of team leaders from across England. Our proposed project was warmly welcomed, and from the several Trusts which volunteered to contribute to the study, we selected two. The number of participating sites was decided in view of the resources and time constraints of the project, and the sites were selected to provide some overlap with the other empirical component of the Research Programme (the Start & Stay study, exploring issues of recruitment and retention for the health visiting workforce¹²) and a degree of variation in population demographics. Practical considerations such as feasibility of access from the researchers' base and availability of local support from health visiting teams and team leaders were also taken into account. We collaborated with two health visiting teams at one site (Site 1), and three at the other site (Site 2). The selected EISs were not informed about the identity of the other participating site for the duration of the study. We interviewed a total of 44 parents, 42 of whom were mothers. Details of study participants are provided later in this section.

We regret not having been able to directly involve parents in designing and carrying out the study. This was not possible due to the time constraints which we faced in view of the policy relevance of the health visiting programme of work. We did, however, ensure that service user representation was provided within the advisory group (see Appendix 1) and that user representatives were involved in the initial study design when the proposal was drawn up.

¹² See King's website at <http://www.kcl.ac.uk/nursing/research/nru/research-programme/Nursingandhealthcareworkforce/health-visitor-implementation-plan.aspx>

4.2.1 Study sites

We interviewed parents living and using services in two socio-economically mixed geographical areas. Site 1 was part of a trust that covered a large geographical area with urban, suburban and rural areas, some of which were relatively affluent. The two health visiting teams from this site were located one in a suburban area and the other in a rural area. Site 2 was in a trust that covered an area comprising areas of deprivation and pockets of affluence. The specific characteristics of the local area served by each health visiting team seemed to have more impact on the daily functioning of services than the demographic characteristics of the trust as a whole.

At Site 1 we worked with two health visiting teams. One team was based in a Children's Centre in a predominantly residential suburban area, through which other services – e.g. early education and midwifery support to mention only two examples – were also provided to the local community. At the time of the study the Children's Centre team comprised health visitors and health visiting students, family support workers, community nursery nurses, speech and language therapists, project workers, coordinators and administrative support. The centre hosted a number of groups and activities on different days of the week, organised by child's age and/or theme – e.g. baby group, baby massage classes, cooking classes. Child health clinics were held weekly at the centre and at other locations in the catchment area. The second team covered four different centres in more rural areas served by the same Trust. Different centres offered different services in addition to the regular weekly child health clinics – for example, weekly breastfeeding support groups, weekly groups for young parents, baby massage classes and fortnightly advice sessions (with appointment).

At Site 2 we collaborated with three health visiting teams. Their catchment areas included some rather deprived neighbourhoods as well as less disadvantaged districts. Teams at Site 2 provided different services at different centres. In addition to the traditional home visits by health visitors and other members of the teams, services were provided in health centres (for example, some child health clinics) and/or Children's Centres (for example, age-specific parent and baby groups and breastfeeding support groups). The frequency of clinics and groups varied according to the resources and requirements of the individual team and of the families they would engage with. For example in one centre child health clinics were held regularly more than once a week, whilst in another they rotated across different community locations resulting in one weekly 2-hour clinic in each location. All Children's Centres offered a variety of regular activities which included parent and baby groups organised according to the baby's age, scheduled baby massage classes, and breastfeeding support groups in some cases. Children's Centres usually also offered access to education courses, sensory rooms, smoking cessation support, and some engaged in 'outreach' activities.

4.2.2 Recruitment

Potential participants matching our criteria for taking part in the study – parent or carer of child aged between 0 and 5 years; over 18 years of age; with experience of sustained contact¹³ with the health visiting team, in particular as per 'Universal Plus' level of the family offer – were contacted and provided information on the study by their health visiting team. At Site 1, teams provided all the relevant information (invitation letter; participant information sheet; guide to the interview questions; sample consent form; and study advert) to potential participants and arranged provisional interview dates with parents. Depending on individual preferences, parents would hear more about the study from the researcher over the telephone, prior to their interview appointment, or on the day of the interview appointment.

At Site 2, health visiting teams handed out project information to parents matching the recruitment criteria and compiled lists of potential participants who were willing to be contacted by telephone by the researchers. Further details about the study were provided by the research team over the telephone and interview appointments arranged according to parents' preferences. At one site we were able to present details of the study to a group of mothers - who were attending a breastfeeding group at a Children's Centre - with three of these mothers then volunteering to take part in an interview. Consent was sought in writing for interviews carried out in person; item-by-item verbal consent was obtained for telephone interviews and this was followed by posting of a blank consent form with a self-addressed stamped envelope. Interviews were carried out at Children's Centres and Health Centres, which provided quiet and relatively familiar settings for informal conversations. Participants were welcome to invite a friend or relative to the interview if they so wished, and could be accompanied by their children. Participants who agreed for their interview to be audio-recorded were advised that they could interrupt the audio-recording at any point. Only one interviewee preferred not to be recorded. The interview 'guide', providing information on the main aspects of the experience of the service that we would seek to discuss and examples of questions that we might want to ask, was summarised over the telephone to the potential participants we contacted directly, included in the information packs, and made available to any parent who wished to have a copy. A copy of this interview guide is available in Appendix 1.

4.2.3 Ethics

We gained ethical approval for this study through the Proportionate Review Sub-committee of the relevant NRES Committee (Reference No. 12/NE/0067). We ensured we had systems in place in the event of distress caused by the interview process but were also careful to outline our duty of care towards the children, ensuring parents were aware that any concern over the safety and/or wellbeing of a child arising from the interview would require disclosure to the relevant health visiting team leader (see Appendix 2: Participant information sheet). In order to protect the anonymity of the participating

¹³ By 'sustained' contact we mean contact with members of the health visiting team beyond the first health visitor's first visit, occasional attendance at child health clinics, and the routine scheduled meetings of the Universal level of family offer.

sites, and to ensure that any health visiting team members from the participating Trusts reading this report would not be able to identify the parents in the study, in this report we purposely provide very little organisational detail about the teams, the particular services they provide and any identifiable aspects of parents' experiences. Throughout the report, we use pseudonyms to refer to participating parents, their family members, and the health and social care professionals involved in their care. These names have no socioeconomic or other reference purpose. We have also taken all necessary measures – e.g. altering details of medical conditions – to disguise the identity of participants.

4.2.4 Study participants

Across the two participating sites we carried out individual interviews (only in one case two mothers were interviewed together, as a woman who had originally come only to accompany her friend volunteered to share her views) with a total of 44 parents (two fathers and 42 mothers; age range 19-43; age groups: 9 participants aged ≤ 24 ; 25 aged 25-34; 10 aged ≥ 35). Interview length ranged from 14 to 66 minutes, for a total of 27.5 hours of audio-recorded material (only one interview was not audio-recorded). 36 participants were interviewed in person and 8 over the telephone. SD and MM carried out the interviews for this study. Their reflexive considerations on the process can be found later in this section. The vast majority of participants (41) described themselves as being of 'White British' ethnic background, with two parents being of other 'White' (we do not specify which 'other' background here for confidentiality reasons) and one of 'Mixed' background. The local health visiting teams confirmed these samples were representative of the population they served at the 'Universal Plus' level of the family offer. Characteristics of participants in the study are summarised in Table 1.

Characteristics of participants in the study			
Distribution			
	<u>Site 1</u>		<u>Site 2</u>
	19		25
Gender			
	42 F		2 M
(Site 1)	(18 F)		(1 M)
(Site 2)	(24 F)		(1 M)
Ethnic origin			
	<u>White British</u>	<u>White</u>	<u>Mixed</u>
	41	2	1
(Site 1)	(17)	(2)	(-)
(Site 2)	(24)	(-)	(1)
Age			
	<u><24yo</u>	<u>25-35yo</u>	<u>≥35yo</u>
	9	25	10
(Site 1)	(5)	(12)	(2)
(Site 2)	(4)	(13)	(8)
Number of children (ongoing pregnancies not included)			
	<u>1 child</u>	<u>2 children</u>	<u>3 or more children</u>
	18	15	11
(Site 1)	(6)	(6)	(7)
(Site 2)	(12)	(9)	(4)
Living with partner			
	<u>Yes</u>	<u>No</u>	<u>Not known</u>
	34	8	1
(Site 1)	(14)	(4)	-
(Site 2)	(20)	(8)	(1)

Table 1

4.2.5 Reflexivity

The relative lack of negative views on health visiting in our data is most likely due to the self-selecting nature of the sample. It is also possible that holding the interviews on service premises (Children's Centres and clinics) - even though privacy was ensured and confidentiality assured and protected - had an influence on the extent to which parents chose to discuss their dissatisfaction with services. Where parents expressed dissatisfaction or commented on negative experiences, we reported on these, trying to identify the relationship between these negative experiences and more positive ones.

The nursing research team included researchers who do not have a nursing or health visiting background. All members of the research team, and especially those directly involved in the generation of data, adopted a reflexive approach to their work, exploring personal views and assumptions and reflecting on the impact these may have on conversations with parents and the analytical process. Alternative perspectives within the team (e.g. practice, research, service user perspectives) were explored during team meetings (these took place at regular intervals which varied according to the stage of the project, from monthly during data generation to fortnightly and then weekly during data analysis and report drafting) and were brought into the analysis and interpretation of the data. SD has a background in medicine and medical anthropology and experience of qualitative research within social science-based approaches to the study of health care practices. She joined the Health Visiting Research Programme's team with relatively limited knowledge of the health visiting context and developed a more grounded understanding of the main discourses in health visiting policy, practice, and research through her collaboration with the scoping review of the literature on health visiting. MM is a health visitor by background and the leader of the Post Graduate Diploma, Advanced Practice (Health Visiting) at King's College London. She has a background in history and health promotion and a keen interest in the history of the profession and the current climate in which practitioners work. These different viewpoints were important for producing rich notes and discussions in the analysis of the interview transcripts. Further analytical lenses were provided by JH's experience in health services research and evaluation, EM's insights in to the wider policy and research literature on patient experience and patient involvement in health care, and JM's expertise in user experience research examining quality of care issues and policy-focused analysis.

4.2.6 Analysis of interview data

All audio-recorded interviews were transcribed through a transcription service bound by a confidentiality agreement and working with encrypted files. We carried out spot-checks on transcripts to ensure the quality of the transcription was accurate. Our analysis proceeded alongside the drafting of our emerging thoughts and ideas. We used a mixture of manual and software-assisted coding (using N-Vivo software package, version 9) based on coding procedures informed by grounded theory approaches (Charmaz, 2006; Glaser & Strauss, 1967; Strauss & Corbin, 1990). More specifically, we had a preliminary open coding phase, during which three researchers (SD, MM, and JH) read a set of six transcripts each, discussed extracts from the transcripts (with JM, who had read a sample of the

same transcripts), explored themes and issues and early impressions of the data to generate an early coding scheme (see Appendix 4). This coding scheme was then used to code in a more organised fashion the transcripts already examined and to orient further coding. In the process, new codes were developed and existing codes were refined, merged, and further qualified (Pope, Ziebland, & Mays, 2000). Each interview transcript was read more than once and a summary of the whole interview was made available to the team. Codes and categories were recorded either in MS-Word tables or in N-Vivo alongside the relative quotes or sections of the transcript. This strategy ensured easy sharing, retrieval, and cross-comparison of analytical notes, which all enhanced the rigour of the analysis. The summary and analytical notes were shared and discussed with the team in regular meetings to gain an overall understanding of the data and emerging analytical themes. Prominent themes and those that had specific relevance to policy questions were identified and further analysis proceeded through the writing, drafting, and redrafting of sections of the report and alongside discussion of the wider research literature by team members. The analytical process also benefitted from insights from the parallel empirical study examining recruitment and retention issues in health visiting, which JH and JM also worked on simultaneously. Finally, Prof Dame Sarah Cowley, who has extensive experience in health visiting research and also led the Project 1 scoping review (Cowley, et al., 2013) offered critique, comment and insights on draft versions of this report.

During the early stages of analysis we were concerned about the risk of fragmenting the data, or focusing too narrowly on themes risking not 'seeing' the bigger picture and the wider implications of the study. What helped with this was ensuring we 'kept an eye on' issues and perspectives of particular relevance to policy questions whilst undertaking more detailed coding of the transcripts to capture the variety of parents' experiences. Some of these particular issues – for example the tensions between dispositions of individual professionals and opportunities and styles of work allowed by the structure of services, or between experiencing the service through an individual professional versus experiencing the service through interaction with a team – informed, and helped us to clarify, the final structure of the report. More specifically, in Section 6 we organise our analysis along the lines of these tensions, examining first the interpersonal aspects of parents' interactions with members of the health visiting team and then the organisational dimensions of the service that have a bearing on these interactions. These two levels overlap extensively. Individual professionals and managers and service users make up the service, and structural characteristics of the service, in turn shape the practices and perceptions of individuals. We focus on these two dimensions separately, partly for practical reasons and ease of presentation, and partly because some dimensions of health visiting pertain more significantly to the sphere of interpersonal exchanges and some more clearly to the sphere of organisational characteristics, policies, and wider institutional context. However, we invite the reader to bear in mind that the structure of our analysis aims to encourage shifts of focus, from the micro to the macro and back to the micro, in an attempt to establish links, connections, and relationships between different dimensions of family support. We also explore in some detail (Section 6.3) parents' views and reflections on the parenting support available to fathers, with a view to offering some insights into this often neglected field of inquiry. We suggest further work is however required in

this area, as our work sheds light on the complexity of fathers involvement with the health visiting service and needs as parents.

4.2.7 Dissemination of research findings

The present report, providing a detailed account of our findings, is primarily intended for an audience of policymakers and practitioners in the field of health visiting and family support. We plan, however, to produce more focused and theoretically-minded articles for publication in peer-reviewed journals, which we expect to be able to publish by 2014/15. In 2012, we presented methodological papers from both empirical studies from the NNRU health visiting research programme at the Community Practitioners and Health Visitors Association (CPHVA) annual conference. We plan to present the final findings at this year's CPHVA annual conference in October 2013.

At the time of writing, we have concrete plans to present our findings to health visiting teams at both participating sites. One dissemination event has been organised at each site with the help of local health visiting managers and both should take place by the end of June 2013. We do not plan to present our findings orally to parents at the two sites. During the analytical stage of the study, we organised short feedback meetings to share our thoughts and ideas from the analysis with participating parents from Site 2. Due to the extremely poor attendance – three meetings were arranged, two had no participants and one was attended by one parent – we decided not to pursue similar arrangements at Site 1 and revised our plans to organise dissemination meetings for parents at the end of the study. Instead, we will produce a plain English lay summary of our findings aimed at a general public audience and make this available in printed form to all participating health visiting teams for distribution to families in their area.

5. Service user experience of health visiting: what we know from existing research

In this section of the report we present findings from the narrative review of the healthcare literature on service user experiences of health visitors and health visiting. The findings are organised according to five key themes that were informed by a range of theoretical perspectives, including analyses of the 'multi-dimensional' aspects of service user experience (Cornwell & Foote, 2010), of the individual aspects of service users' physical and emotional needs (Institute of Medicine, 2001), of compassion, empathy and responsiveness in health care (Coulter, et al., 2009, Firth-Cozens & Cornwell, 2009), and of the relationships between service user experience and organisational factors (Leatherman & Sutherland, 2007). These five key themes - Support, Relationships, Service user involvement, Information, and Coordination – also resonated with the themes emerging from the analysis of the empirical data and with our earlier scoping review of the health visiting literature (Cowley, et al., 2013). We therefore used them as useful headings under which to group what would otherwise amount to a rather disjointed body of published work. Although these headings are, of course, not exhaustive and overlap to varying degrees, they help to organise the literature coherently and to help us to provide context for, and useful links with, the discussion of our empirical findings in Section 7.

5.1 Support

5.1.1 Parents' experiences of health visitor support

When asked about parenting support, parents generally want support and advice on child health and development from a trained health visitor with up-to-date knowledge (Clark, 1984; FPI, 2007) (fewer say they want this support from a nurse, a volunteer with children of their own or a child care worker/nursery nurse). Most parents want support to be given in the home or at a Children's Centre (FPI, 2007). Research with both mothers and fathers indicates that they value time with health visitors to understand their needs, particularly emotional needs in the early stages of parenthood (Clark, 1984; FPI, 2007). However variations in the number of health visitors across the country (Steel, Reading, & Allen, 2001) and differences in types of health visiting services that parents can access (FPI, 2009) lead to varying levels of satisfaction with the frequency and patterns of health visitor contacts (Bailey, 2010).

Service users' positive views about health visiting services are frequently based on their satisfaction with the knowledge regarding parenting and child care offered to them, with the information, support and reassurance they received, and/or with the support through the diagnosis and management of postnatal depression they experienced (Machen, 1996; Russell & Drennan, 2007; Wiseman & Wakeman, 2004). Parents also value health visitors' empathy and caring, having 'someone to turn to' should the need arise to 'lift a weight' by sharing relevant knowledge, advice or information (Machen,

1996). Parents who have received health visiting support say they feel tangible benefits to their wellbeing and their ability to cope with various challenges, but perceptions of support vary according to the service users' personal situation (Plews, Bryar, & Closs, 2005). Parents who have attended health visitor-led parenting programmes express increased confidence in infant care, reduced anxiety regarding infant care needs, increases in knowledge and sense of personal competence in parenting practices, reduced isolation, and advocacy for those experiencing problems (McIntosh & Shute, 2007).

Sources of dissatisfaction with health visiting support include: a perception of services to be worsening in terms of the type of service offered; insufficient health visitor time; and high turnover of health visitors. High proportions of mothers (60 per cent in one study) report putting off calling the health visitor or dropping in because of a concern that they would be too busy to help (Wiseman & Wakeman, 2004). Some service users express fears and negative perceptions in relation to home visiting (Elkan, Blair, & Robinson, 2000; Elkan et al., 2000). The relationship with the health visitor and continuity of contact are two critical factors in determining whether a successful service can be provided (Russell, 2008). It may be that current services are not always providing parents with the opportunities to address their concerns fully in the early months; leading to feelings of abandonment (Russell, 2008). New parents in particular would welcome more time and advice from health visitors (Deave, 2003). Specifically, some parents would like more help from their health visitor on issues such as healthy family eating, relationships and accident prevention (Russell, 2008).

5.1.2 Lack of support for fathers

Research with fathers indicates that many are not aware of health visiting services, that fathers are intimidated by a woman-dominated care environment, mother-oriented materials, and timetabling of services (Bayley, et al., 2009; Greening, 2006). Fathers of Black and Minority Ethnic (BME) background recognise the importance of health visiting services, for mothers, but indicate that they may have had little contact with health visitors and also anticipate cultural insensitivity, communication difficulties and discrimination (Williams, Hewison, Stewart, et al., 2012; Williams, Hewison, Wagstaff, & Randall, 2012; Williams, 1999) Although these barriers are at the institutional level, it may be that individual health visitors are failing to recognise the support needs of fathers including dealing with traumatic experiences and emotional distress (Harvey & Pattison, 2012). Some fathers welcome the opportunity to express their feelings and emotions about fatherhood (Williams & Hewison, 2009) on becoming a parent (Greening, 2006), but do not always have the encouragement or opportunity to do so (Salway, et al., 2009). It has been suggested that health visitors' work with men is influenced by both their conceptualisation of men within family-focused health visiting practice and contextual factors in the actual client-health visitor situation which enhance or restrict involvement of men (Chalmers, 1992b).

5.1.3 Issues of equity between different service user groups

Studies with parents from different sectors of the community and minority ethnic groups consistently suggest that health visiting needs to work in partnership with community organisations and representatives to develop a service that the community finds valuable rather than applying population targets or ideals to their individual situations (Abbott, 2004; Barlow & Stewart-Brown, 2000; Hoddinott, Craig, Britten, & McInnes, 2012; Naish, 1995; Scott et al., 2010; Shakespeare, Blake, & Garcia, 2004). Some health visitors may not have sufficient knowledge and skills to assess and treat women in minority ethnic groups (Almond & Lathlean, 2011; Jayaweera, D'Souza, & Garcia, 2005); particularly in relation to the sensitivities of discussing and meeting maternal mental health needs (Cinnirella & Loewenthal, 1999; Edge, 2007, 2008) and offering collaborative, community-based models of care (Edge, 2011). Issues of equity are also identified in the literature relating to refugees (Drennan & Joseph, 2005) and homeless families living in temporary accommodation (Haynes & Parsons, 2009), who value support to access health care services, including advice about how to contact providers and access to same-day appointments (Jenkins & Parylo, 2011). There is an argument that deprived areas and communities could benefit from an additional dedicated member of staff working in a public health role working alongside traditional health visiting, and significant improvements to the health status of deprived areas have been reported following this model in Nottingham (Boyd & Chubb, 1994).

Health visiting services could also do more to enable parents from ethnic minority groups to make the most of family support opportunities available to them, for example by keying into cultural dimensions of parenting and childrearing (Dobson, 1989; Harding & Pandya, 1995; Jackson, 2007). Some mothers from Black and minority ethnic groups are reluctant to discuss private issues with a stranger, or to seek health visiting support for mental health problems (Edge, 2008; Hanley, 2007). Women can experience 'cultural clashes', somatisation and isolation, poor input from services, and barriers to and from primary care services (Wachtler, Brorsson, & Troein, 2006; Wittkowski, et al., 2011). Very little is known about the use of different languages in interactions between service users and health visitors. Some individual health visitors are willing to promote bilingualism with parents and parents feel this can have positive benefits however other health visitors do not perceive this to be part of their role or a priority for them (Tranter, Irvine, Roberts, & Jones, 2011).

5.2 Relationships

5.2.1 Nurturing trust

Under the health visiting 'gaze' women may feel they need to present themselves as good mothers and resist offers of support (Peckover, 2002). Parents therefore value knowing who their health visitor is, building relationships with them over time, and establishing trust (Russell & Drennan, 2007). For women with postnatal depression in particular, having a good relationship with the health visitor has been identified as a contributing factor to accepting support and having a positive experience of care (Shakespeare, Blake, & Garcia, 2006). Seeking help for depression and accepting support depends on women's perspectives of their health visitor as an individual and whether they feel they can relate to them on personal matters (Slade et al., 2010). Trust and reciprocity also feature in Bidmead's (2013) research, which shows parents valuing a non-judgemental approach to the difficulties of family life, along with reliability, the ability to give sound advice and willingness to 'reach out' to parents. Getting to know their health visitor appears to help parents to understand the service (Collinson & Cowley, 1998a), which in turn increases their use and appreciation of it.

In interactions between health visitors and service users, both parties control the interactions by regulating what they offer and accept from each other. Each party both selectively 'gives' and 'receives' in order to manage the health visitor-client encounters. What gets offered and how the offer is received and acted on is a complex process involving many factors related to the personal skills and attitudes of the health visitor, the client, and the context in which the interaction takes place (Chalmers, 1992a). Any one question, purpose or topic selected by health visitor or client as a specific focus, forms only a relatively small part of the whole (Cowley, 1991). Building and nurturing the parent-health visitor relationship is therefore important for underpinning the delivery of functional aspects of care, including for example, providing information and advice (Plews, et al., 2005).

5.2.2 Therapeutic non-directive approaches

Mothers report that non-directive partnership-based approaches to health visiting are helpful in supporting their self-confidence (Kirkpatrick, Barlow, Stewart-Brown, & Davis, 2007). For example, some parents emphasise the importance of therapeutic aspects of health visitor support (Warner & Forryan, 1988) - such as space for listening (Reed-Purvis & Dakin, 1993; Shakespeare, et al., 2006), reflective dialogue (Scholes & Freeman, 1994), or therapeutic touch (Sayre-Adams, 1994) - in the development of trusting relationships with health visitors (Bryans, 2005; de la Cuesta, 1994b). Use of helping styles and holding relationships provide a 'listening to' opportunity for parents, a sense of the health visitor being there for them and an exploration of their problems (Cody, 1999). Trusting relationships may not as easily be achieved if health visitors' primary focus is on applying formal structured assessments or tools (Cowley & Houston, 2003; Cowley, Mitcheson, & Houston, 2004). Treating health as a relational process has the potential to allow multiple competing views and ideas

about health and health promotion to be integrated into a manageable form, thus allowing positive health to be promoted within a broad, acceptable socio-cultural context (Cowley, 1995).

5.3 Service user involvement

5.3.1 Enabling parents' active participation in encounters with health visiting teams

Service user involvement in health visiting can range from individual participation in health-related decision-making to participation in service evaluation and at community level. Person-centred approaches to health visiting require enabling opportunities for more active parent participation in their encounters with members of the health visiting team. This entails overcoming contextual barriers to providing individualised care such as task-orientated practice and time constraints (Bolster & Manias, 2010), or the use of structured needs assessment tools (Houston & Cowley, 2002, 2003). Service users say they want health visitors to be non-judgemental – e.g. socially and culturally accepting - (Muntz, 1988), encouraging, and to use approaches that aim to enable them as parents to manage their health and wellbeing during the antenatal and postnatal period (Price, 2007; Raleigh, Hussey, Seccombe, & Hallt, 2010; Shakespeare, Blake, & Garcia, 2004). Single mothers perceive some health visitors as being judgemental in attitude and not necessarily interested in them as individuals, rather than being friendly, interested and able to promote their confidence, and offer individualised advice (Knott & Latter, 1999).

Health visitor skills to enable participation in care are particularly important for supporting women who have suffered domestic violence or rape. Although referring to health care practitioners in general rather than health visitors in particular, the study by Campbell, Adams, Wasco, Ahrens, & Sefl, (2009) highlights the important point that women survivors want professionals to show warmth and compassion and allow them to exercise choice and control about how they discuss their experiences and emotions.

5.3.2 Involvement in decisions about care and support

There is very little evidence about service users' views on their involvement in decisions about the care or support they receive from health visitors or the types of client relationships different service users expect or would prefer (Almond, 2001). Health visitor support often involves helping families to make decisions; however, there is little research from parents' perspectives exploring the mechanisms through which decision-making processes take place and are shared in health visiting. Roche, et al. (2005) pointed out that, whilst official guidance about child health surveillance emphasised the importance of working in partnership with parents, there was little evidence that parents had been engaged in developing the guidance. This remains the case for the current guidance, the *Healthy Child Programme* (Department of Health & Department for Children Schools and Families, 2009; Shribman & Billingham, 2009). Further, parents in Roche, et al.'s (2005) study were unaware of the 'partnership message' and, whilst those living with overt health needs experienced the health visiting service as positive, parents seeking reassurance from the universal

provision felt judged and rejected. Bidmead and Cowley (2008) set out the complex background to decision-making across health visiting, suggesting that tensions about universal versus targeted service provision (e.g. the extent to which health visiting services should be delivered to all (universal) or only to those experiencing identified problems (targeted)) affect health visitors' approaches to partnership working to engage parents. Where health visitors expect, or are expected, to limit the amount of time offered to parents regarded as generally at 'low risk,' the approaches used to assess health needs may reduce the extent to which parents are engaged in decisions about future provision (Cowley, et al., 2004; Houston & Cowley, 2003), with parents potentially being unaware that the needs assessment process is taking place or that decisions are being made about their future provision at that stage. Mothers who have taken part in research, have tended to see health visiting as providing unidirectional support rather than a reciprocal relationship (Plews, et al., 2005). It remains unclear whether this is because they do not expect or do not wish to be 'involved' (see also Bidmead & Cowley, 2008) on partnership working and Roche, et al. (2005) on parents' being unaware of their potential role as partners in care.

5.3.3 Involvement in health visiting services, policy, and practice

For health visiting practice and services to evolve towards increased responsiveness and effectiveness, parents' views need to be taken into account in the design and the delivery of services. At a community level, there is general consensus between policymakers, primary care service managers, general practitioners, community nurses and members of the public that all community nurses must work more closely with members of the public to overcome lack of public understanding of professional roles (McKenna & Keeney, 2004) and to find ways to engage with seldom-heard groups (Pfeil & Howe, 2004). The literature reveals few examples of direct service user involvement in the education of nurses (Price, 2004) and parents perspectives have been largely absent from discussions about local child health surveillance, health promotion programmes (Roche, et al., 2005), or guidelines development (Renfrew, Dyson, Herbert, et al., 2008).

5.3.4 Involvement in community health development

Building community capacity is a key component of the Health Visitor Implementation Plan (2011), although relatively little is known about service users' experiences and expectations for health visiting to contribute to community health development work (Dalziel, 1994; Price, 2007). Community development, social capital and capacity building are recognised elements of community empowerment approaches with a 'bottom-up' agenda driven by community members (Piper, 2011). These perspectives concern micro-population health gain, where the process, the quality of the healthcare provider-community relationship, is as important as outcome (Carr, 2005; Grant, 2005a).

5.4 Information

5.4.1 Information about available services

Many parents are unaware of the services that are available to them and more effective dissemination of information about health visiting could be beneficial (Wiseman & Wakeman, 2004). Mothers' prior knowledge of the service and the extent to which the service meets their expectations appear to influence the value women place on health visiting and their subsequent use of it (Collinson & Cowley, 1998a). People who have the greatest need for health information are often reluctant to seek it out. Innovative services such as health shops (Malin & May, 1992), health vans (Edgerley, El-Sayed, Druzin, Kiernan, & Daniels, 2007) and play buses (Edwards & Ramsey, 1992) and the involvement of health advocates (Harding & Pandya, 1995) can help to bring health education to communities and boost the health visiting profile. For families who do not access health visiting services written information may not be sufficient (Appleton, 1996). Although health visitors are generally aware of, and make use of, interpreting services compared to other health care professionals (Gerrish, Chau, Sobowale, & Birks, 2004) overcoming language barriers is only one part of the issue.

5.4.2 The type of information that service users' value

Service users value both evidence-based factual information and advice that is tailored to suit their needs (Russell, 2008; Russell & Drennan, 2007; Brassett-Harknett, Joshi, N., et al., 2006). Effective communication from primary care professionals is important for women with postnatal depression generally, and a perceived lack of information is a major cause of dissatisfaction (Boath, Bradley, & Anthony, 2004). Mothers participating in the *First Parent Health Visitor Scheme* (Deave, 2003) reported that quality parenting advice and practical advice shared within parenting groups were all important aspects of health visiting. Relatively little research has been undertaken about the potential benefits of the Internet for supporting parents with their information needs, or why people go online for health and parenting information (Powell, Inglis, Ronnie, & Large, 2011), although sites such as Netmums, Babycentre, and Mumsnet are very popular with parents of young children.

5.5 Coordination

5.5.1 Point of contact

Service users value health visitors as a point of contact with, and referral to, other health professionals, for their links to social care, referral to specialist services (Rothman, 2006; Russell & Drennan, 2007), and for a sense of continuity and being known personally by a health visitor (FPI, 2007). For the majority of mothers who are 'low-risk', sources of dissatisfaction with health visiting services can include factors to do with poor coordination; such as a lack of appointment systems for clinics, poor punctuality in home visits, and inappropriate or inadequate advice (Bowns, et al., 2000). Taken together previous studies suggest that service providers need to be both constant in their offer

of help, flexible in terms of the type of support that they are able to provide, and willing to work in a collaborative manner with different types of families. Houston and Clifton (2001) suggested that corporate working in health visiting can provide services that are more equitable, proactive, efficient and accessible to clients compared to individualized health visiting. Corporate working is a form of service organisation whereby two or more health visitors and their team share responsibility for families registered at their base, instead of each individually holding a specified 'caseload' of families. However, little is known about the acceptability of such approaches to service users, who then need to relate to a whole team instead of one health visitor.

5.5.2 Links to community information and support groups

There is good evidence that parents would value greater health visitor coordination of information and access to local/community resources (Russell, 2008; Russell & Drennan, 2007) including information about local statutory initiatives (Brassett-Harknett, Joshi, Butler, & Bryar, 2006). New parents value the coordination and support role provided by health visitors to parent groups (Cowpe, 1994). For many parents establishing new social networks appears to be an important way for them to learn childrearing skills, overcome feelings of social isolation, and gain self-confidence and emotional support (Hogg & Worth, 2009).

The elements of health visiting described in the literature on service users' views and reviewed here appeared repeatedly in our data. In our analysis we did not refer to these elements as an orienting framework. Rather, we aimed to ensure we acknowledged and gave some thought to any resonances and possible links between the findings emerging from our analysis and existing research. This was true for the focused review presented in this section and for the findings from our previous scoping review of the literature on health visiting (Cowley, et al., 2013), which we used to ensure we contextualised our study and our findings within the health visiting research landscape adequately.

6. Empirical findings

As we mentioned earlier, identification of potential participants for the study at two EISs was assisted by the health visiting teams at these sites. Selected parents who agreed to be contacted would then decide whether or not to volunteer to be interviewed. Our findings therefore represent the views and experiences of a self-selecting group of parents. In most cases, these were parents who had found the service very helpful and wished to somehow show their appreciation. Less frequently, parents had some specific criticism or concern that they wished to express or – even less frequently – no specific remarks about the service and the support they had received. Of course, recruiting participants in this way means the study has limitations as to the aspects of health visiting practice on which our study sheds light and those which it necessarily leaves unexplored (e.g. we cannot and did not set out to investigate the views of parents who did not engage with the service or for whom services proved not accessible).

At the two study sites, and even within each site, we found that health visiting teams worked in slightly different ways, particularly in how they organised activities at their community centres (health centres or Children’s Centres). We were aware of local differences, but were unable to spend time with the teams to gather information about service delivery that would have allowed us to contextualise parents’ accounts. Although we were alert to how health visiting teams’ responses to local community needs and working practices can shape parents’ experiences of services, we did not find any systematic or substantial differences in the accounts of parents from the two study sites. It may be that health visitors in the two areas had to overcome different challenges in order to deliver the services they did but these challenges were not identified by the parents to whom we spoke.

However, these limitations do not detract from the value of our findings for supporting the development and consolidation of more effective, sensitive, and engaging health visiting practices, as envisaged in the *Health Visitor Implementation Plan 2011-2015*. The views expressed by parents in our study, and illustrated in this report, form a sound foundation which can inform reflections by policymakers, practitioners and researchers on the existing strengths of the service and on the potential trajectories of further development. In this section we discuss parents’ perspectives on the one-to-one relationships they developed with members of the health visiting team, the organisation of the service, and the issues around the involvement of fathers in health visiting support.

6.1 Supportive and enabling relationships

In this section we explore parents’ accounts of their experiences with the health visitor and/or other members of the health visiting team and draw attention to some of the features of interaction with practitioners that were determinant in making parents’ experience a positive and empowering one, or – on some occasions – a less pleasant and helpful one. We characterise these features in some detail to better understand how interactions between parents and health professionals work and to

encourage approaches to relational aspects of health visiting work that are more grounded in empirical evidence and better characterised.

Before we explore in some detail what, in parents' accounts, appeared to be the components of good relationships with the health visitor and with other members of the health visiting team, we should point out that parents were often unsure about the exact professional role or job title of the team member they were seeing for support or advice. Where possible, we have identified in our interview extracts which health visiting team member parents were referring to in their accounts. However, this was not always possible and in some cases the professional role boundaries between health visitors, nursery nurses and family support workers in parents' accounts were unclear. Although these roles are different and complementary within health visiting teams, to many parents a professional's ability to provide the help and support they feel they need is more important than their job title or specific area of professional competence. Hence, in this section we focus on the aspects of interactions that make support valuable and effective for parents. Later in the report we will discuss how the coordinating role of the health visitor, and a certain flexibility in the organisation of the service, are essential to ensuring that professional competences are matched to family circumstances and enable supportive relationships to develop.

6.1.1 Enabling relationships: feeling 'known' and listened to

In our interviews with parents, we explored what specific forms of interaction and engagement had made parents feel supported and whether they had wished for different or additional support at any point. We asked parents to describe the features of interaction that they had found helpful and enabling in their relationship with one particular health professional and with the wider team. We also discussed with parents the experiences that had made them feel that their needs were not being met.

Parents who had engaged with health visiting services for advice beyond the routine appointments of the Universal level of service generally valued some continuity of contact with the same health visiting team member. In several cases, this was a health visitor, in others it was a nursery nurse or a family support worker, and on occasions it happened to be an allied health professional from a different service involved in the care of a child (e.g. a dietician). Parents valued relationships in which they felt the health visiting team member had established a friendly connection, showed respect for their views and autonomy, helped them develop self-trust in their role as a parent, and demonstrated they genuinely cared about their children and family. Repeated one-to-one contact with the same professional was an important part of feeling supported and satisfied with the service. However, in some instances, it was important for parents to be able to identify and access the professional with whom they felt most comfortable and in tune. This process involved being able to meet different health visiting team members in a clinic setting or in group sessions and special classes (e.g. baby massage, breastfeeding support groups, parent and baby groups) and we come back to this a little later (see Section 6.2.3).

Being known

When we looked more closely at the aspects of this continuity of contact that parents really valued we found that being 'known' to the health professional and, in some instances, to the wider health visiting team, was core to how helpful parents perceived their contacts with the service to be. Parents valued health visiting team members' interest in their life stories, the feeling that professionals really 'cared' about them, their child, or the whole family. Parents also felt that when professionals were familiar with their specific circumstances, they offered advice on specific concerns or arising issues around parental or child's health and behaviours that was more relevant and meaningful to them and that they were more able and ready to accept. For example, Scarlett found it easier to listen to and trust the advice of the health visitor with whom she had established a relationship and who knew her family:

I always listen to good advice, but in a way I only ended up really listening to [my health visitor]'s advice. One, because obviously she was my health visitor, but mainly because she knew us and I was going through stages with her... (Scarlett, mother of three)

On the other hand, Paula found that the advice received at the child health clinic, where she met a different health visitor each time, was not always 'correct' - e.g. appropriate or specific to her situation:

And because when you came to clinic you saw different people who don't necessarily always understand... Not that they don't understand but because they didn't know what the situation was before, they can't give you necessarily the correct advice. (Paula, mother of two)

Parents found it helpful to have confirmation that health visiting team members knew their family stories and showed interest in their circumstances and life events, as Lydia explained:

And it was nice because she [nursery nurse] knew [my daughter] and she knew about what was happening with her [health condition], so when treatment week came she'd remember: 'Oh, how did it go at the hospital?' and the other health visitors, you know, there are that many babies that they didn't particularly know anyone. Obviously they'd call her name but they didn't know her as a person. (Lydia, mother of one)

Not only this form of interest – being known as a person - was welcome as confirmation of professionals' genuine caring for the family's wellbeing, it was also seen to be central to supporting correct health advice, as Nadine's comment suggests.

I rang her two weeks ago when [my son] wasn't well. He hadn't eaten from the Monday at all and it got to Thursday and I was a little bit concerned, and he slept all day Thursday which was not like him. So I rang [the health visitor] and said, 'Look, this is what's happened and I'm not very happy, what do you think I should do?' And she knows [my son]. So she said, 'Right, ring the doctors' and she gave me the support that I needed to be honest. I took him to the doctors that afternoon, and he found out that he had a urine infection. (Nadine, mother of one)

Being given time

Being known to the health professional or to the team of professionals meant that advice was better tailored and better accepted. It also meant that mothers who felt apprehensive about their baby's health would not need to endure the additional disruption of having to describe their situation and their concerns all over again (which some mothers saw as a not very cost-effective use of time). Time was an important dimension of trusting relationships with professionals. On the one hand, mothers' time could be saved (with corresponding reduction in parental anxiety if advice had been sought due to specific health concerns) if they could rely on professionals' knowledge of their circumstances and their child(ren)'s habits and preferences. On the other hand, supportive health professionals were described as being skilful in disguising the time pressures characterising their work and ensuring that these would not bear on their relationships with parents. Helen commented:

...sometimes she [health visitor] was there [visiting the home] for ages and I never felt like she was in a rush, although I guess she must have been at times because there's pressure on everybody's time, isn't there? (Helen, mother of two)

Helen, above, recognised that her health visitor must be really busy with other families, but also appreciated that the pressures were never made known to her during visits. Another mother, Denise, pointed to how –despite a very busy schedule – the professionals who visited her never made her 'feel rushed':

And I always made her [health visiting team member] a cup of coffee, so she always had time to have a cup of coffee and just to sit there and just... I mean, she used to be with me for an hour which I thought was quite a long time. [...] But yes, I suppose you have to remember that they've got lots of other people to see. But she never rushed, no. I never felt rushed. Whether she set aside more time for me or what, I don't know. (Denise, mother one)

Developing confidence

The interactions in which parents felt that professionals had time to dedicate to them and a genuine interest in them and in their family's wellbeing contributed to make mothers acquire confidence and trust in their own judgement as parents. This 'scaffolding'¹⁴ support was framed by parents in our sample as the professionals' ability to listen to their concerns without preconceptions, without making them feel 'silly' or as if they were 'wasting their time.' Being reassured that all questions were worth asking and that health visitors were committed to trying and answering them and dispelling doubts without making a judgement on the nature of the question was described as reassuring by several mothers in our study. Here are two telling examples:

¹⁴ We do not use the term 'scaffolding' with reference to its use and development in socio-cultural theories of learning (for a brief history, see Pea (2004). Rather, we simply refer to the process by which, through the support of a more experienced other (the health visiting team member, in our case), a person (a parent, in our case) learns and becomes competent in tasks that they could not perform initially. Whether socio-cultural theories of learning can provide a useful lens to better understand health visitor-parent interactions is a question that we might want to explore in the future.

It's nice to have someone you can ask questions without feeling silly because at the end of the day they're not going to go and tell anybody. So that is nice. (May, mother of one)

I mean, they're always happy to chat to me no matter how silly it sounds, you know, they're happy to chat to me. And I had a conversation with [name of health visitor] yesterday, I said, 'I feel a bit of an idiot.' She said, 'No, you shouldn't. That's what we're here for is to help you.' So I sort of kind of did feel better after the conversation. (Natalie, mother of one)

Another mother – Roxanne – highlighted in particular that asking questions that might sound ‘stupid’ or to which she thought she should know the answer had the potential to make a parent feel as if they were wasting the health visitor’s time. This mother appreciated that professionals in her health visiting team would reassure her that hers were not ‘stupid questions’:

Like you don't feel stupid or like you're wasting their time about anything. You know, because with some places you can feel as if you're pestering them almost by ringing. But it's not... when you ring, even if you say, 'Oh, this is a stupid question...' they'll go, 'Oh, that's not a stupid question'. I think all mums kind of have them, so I think it's really good that you're able to just ring up and ask questions when you need to. (Roxanne, mother of one)

Several mothers commented on how the health visiting team member they met regularly didn't judge them or didn't make them feel judged – for example in their lifestyle choices, parenting behaviours, health and educational beliefs. We will return to how the perception of being judged proved extremely detrimental to parents' perspectives on the service as a whole (see Section 6.2.1). With the next interview extract we highlight how the health visitors' non-judgemental approach enabled Scarlett, below, to feel that ‘she could be honest’ with her accounts, making it ‘easy’ to talk to the professional:

...she [health visitor] tailored help to us as a family and I could be honest with her. If I said to her, 'Oh, I gave her a bottle last night', she wouldn't judge me, do you know what I mean? I'm not saying that the other health visitors would judge me but I wouldn't tell them if I had given a bottle of formula, I would be little bit more held back. So yes, I think it was just the fact that she was very much on the same wavelength as me in a way, she was just very easy to talk to. (Scarlett, mother of three)

Being able to ask questions and express concerns without worrying about being judged or considered ‘silly’, inappropriate or incapable appeared to contribute to parents' management of their anxieties in relation to their baby and their new or renewed role as parents. Similarly, praise from the health visitor, or another member of the team, seemed to help with self-confidence, reliance on one's own judgement, and sense of direction in parenting. In their one-to-one relationship with a trusted professional, mothers found reassurance in being told that they ‘were doing a good job’ and were not ‘bad mothers’ when accidents happened.

Reassurance and praise

Mothers can find that being a parent is more difficult than they had imagined, and in these cases, for mothers in our study being told that what they are doing is right can prove very reassuring, as for Scarlett, below:

I've probably spoken to [health visitor] some days for no real reason but just to phone and to say, 'Yeah, blah, blah, blah, this is how everything is going'. And it's kind of nice to think, well, probably the reason why I phoned her is to get the support of knowing that she is there and the fact of somebody saying, 'Yes, what you're doing is right, and it's fine' or it's great, you know, and just that extra sort of support saying what you're doing is alright, you know? Because it's so hard being a mum, I never thought that it would be so difficult. (Scarlett, mother of three)

The reassurance that Scarlett refers to can be about very specific aspects of being a mother. Feeding the baby adequately was, in our data, one of the main sources of anxiety for mothers, especially first-time mothers, like May:

When you have to look after the baby and feed it, and make sure it's getting your food from you, it does worry you. Are they getting enough? You don't know, do you? She [health visitor] just gave me the confidence that I was doing a good job. (May, mother of one)

But, in other ways, experienced mothers also felt the reassurance from their health visitor was very useful, especially when such reassurance was unlikely to come from other sources, as was the case for Louise:

I needed more reassurance on, 'Yes, Louise, what you are doing is right. Everything you're doing is fine. Keep going with that.' And I think as well the one thing that I found really good is that she [health visitor] was very, like, giving me loads of praise. She'd always been like, 'Louise, you're doing a really good job. That's really good. That's wonderful.' And often you don't get that. Do you know what I mean? You don't get someone in the house saying, 'Gosh, Louise, you're doing a really good job here. Blimey, you're fantastic.' (Louise, mother of four)

In a way, this kind of praise and reassurance also took the form of normalising mothers' feelings of being unable to cope with their new child. Hillary and Juliet explained how their respective health visitors helped them to approach more constructively their feeling of 'being a bad mum':

Hillary: Sometimes when you sit there and say to your health visitor, 'You know what, I just can't do it. I can't cope. This is happening, that's happening. I feel like a bad mum.' I don't know. Sometimes I feel like when people look at you, whatever, and they give you that little look to say you kind of are. But with a health visitor she says, 'Well, everyone goes through it. You're not a bad mum.'

Juliet: I said that to my health visitor a few times. I can't cope. She said, 'You can.'

Hillary: 'You're not a bad mum, you can't cope, you're tired.' She'll break it down for you and make you realise what's actually wrong with you. It's not being a bad mum. It's just you're tired, you're worn down. You need a bit of help. Send them to a crèche. And they go above and beyond at time, to sort the situation out, that you're feeling at that particular time. It's nice. (Hillary, mother of two, and Juliet, mother of three)

Being listened to

A common denominator of all forms of support that parents identified as helpful and enabling was professionals' abilities to really listen, to be sensitive and responsive to parents' circumstances and concerns. Participants were usually very clear about what it was that made them feel that they were being listened to and their views and specific circumstances being taken into account. 'Good listening' was not an abstract notion, it consisted of very specific behaviours and approaches. For example, when asked about what constitutes 'good listening', Florence, who had experience of learning about listening skills for her professional role, provided a very detailed account:

Interviewer: When do you find that someone is good at listening? What is it that makes them good at listening?

Florence: It's kind of hard that question. I mean, I was trained in listening skills [for my professional role] because if all you do is talk when you do that then you're just going to miss everything and I think it is just about that kind of open body language, exactly what I'm not showing right now. But, you know, a kind of open body language and letting someone get to the end of a sentence before you kind of push in. I'm not... I mean, I don't think advice is the priority. I think letting someone, like letting me be heard rather than jumping straight in with, 'Well, you should do this and you should do that,' because sometimes that's not actually what's needed. And there might be a solution that can be offered at the end of kind of a conversation but it's not something that needs to be offered there. It can wait until here to make sure you've actually got all the information and [my health visitor] is quite good at that because she'll wait until she's got all the information before kind of suggesting something. (Florence, mother of two)

Another mother, Vicky, made the connection between being able to discuss one's own agenda in consultations with professionals and the development of trust in the relationship with them:

For somebody to feel comfortable with you and trust you, yes, you have these guidelines, and yes, that's what you're supposed to stick to or whatever, but I think it's having that there but also letting somebody talk about what they want to talk about and say what they think they want to do and encourage that maybe, as long as they're not doing anything awful. (Vicky, mother of one)

A practical example of this was offered by Lydia's experience of receiving advice about infant feeding. Lydia found that one particular professional in the health visiting team was able to offer her advice and support without making her feel pressured about breastfeeding:

I saw Justeen [health visiting team member] a few times, and she was the only one really who didn't go on and on about breast feeding. Because each time I went to get [my daughter] weighed the others seemed to go on and on about the breast feeding, and she understood how I felt because I was breast feeding and mixed feeding, and the others tended to be like, 'Knock the bottle off and just carry on with the breast feeding.' But this was working for me and Justeen understood that. So I was lucky enough to have Justeen each week when I went to take [my daughter] to get weighed. (Lydia, mother of one)

Lydia found it helpful to feel supported in her choice around infant feeding whether this matched or not professionals' standard advice. Another mother described good listening as professionals' ability to take a parent's concerns seriously and 'act upon them':

If I say, you know, 'My child has problems going to the toilet,' and things like that, you know, doing the referral to the incontinence nurse or to the [name of support group], which we didn't know here in the [name of geographical area]. You know, she [health visiting team member] has done all of that for us so obviously it's a lot of contacts that she has that me, as a parent, I wouldn't know about it. And so that is listening for me because she has listened to my concerns and she actually has acted upon them. So that is the main thing. (Jocelyn, mother of one)

These examples from our data highlight various aspects of health visiting approaches that help parents to feel supported in looking after their new child. They help us to locate relatively abstract notions of 'non-judgemental' and 'empathic' approaches in more concrete notions of day-to-day activities and interactions that health visiting workers engage in with families. We also found that once a positive contact with the service had been established, parents found the very fact of knowing that support was at hand, if needed, very reassuring, as we detail in the next section.

Health visiting as safety net: 'knowing that they're there'

Finally, parents who had had positive early contacts with a health visitor or encouraging previous experiences with the health visiting team found significant reassurance in just being aware of the existence and availability of a trustworthy and reliable source of help. Awareness of and confidence in existing services – usually gained through early contacts with the health visitor and subsequently consolidated through attendance and increasing familiarity with the service – provided a safety net which made parents feel that help was available should things become difficult or worries arise. The perception of a 'safety net' helped some parents' with their anxieties and with the tasks and challenges encountered in looking after their child.

The following two examples illustrate how mothers who had had good experiences with the health visiting team commented on the reassurance they found in 'having them there' if they needed them:

Interviewer: So what did you find helpful about having your health visiting team?

Jennifer: Just kind of having them there if I needed them. It's kind of like reassurance that you're kind of not just left to it, if you like. And if you do need that extra support, like professional

extra support, then they are there and you can just call them up or you can just come in, whichever. But I do tell everybody how great they are. (Jennifer, mother of two)

So we're very lucky, aren't we really, with the level of support that we've had and that we do have? Whether you access it or not it's there; and that's it really, just knowing that they're there, isn't it? (Cynthia, mother of two)

Lorraine, a first time mother, explained that it was helpful to be able to take her child to the baby clinic to check weight and development and to voice any concerns she might have. In particular, she underlined that the health visitors' clinical expertise was important to her as she knew the health visitor would be able to advise her on whether she needed to have her child seen by a GP:

It's just nice to know that there's people close by that you can... if you've got any worries, you can ask. And also they'll say to you, 'Oh no, you need to go and ask the doctor about that.' Sometimes you're not sure whether you need to go to the doctor or not, but they'll always tell you whether you need to or if it's something you can sort out with them. It's just nice to be able to come each week, if you want to, to know you can get them weighed and make sure they're all progressing as they should do. (Lorraine, mother of one)

Heather, who had more sustained contact with the health visitor at home due to postnatal depression, found regular home visits reassuring in that they helped her to contain her anxieties to some degree:

...and the good thing about it that I found particularly useful was that if I had any kind of queries or anything I wasn't quite sure about with regard to [my daughter], or the other two children for that matter, it was handy to know that Annette [health visitor] was coming so, you know, I thought... I didn't let it play on my mind then. Do you understand what I mean? It wasn't, 'Oh, I'm going to have to go and ask someone, I'm going to have to go and ask.' [...] I knew Annette was coming, so I'd just kind of go, 'Oh, I'll ask Annette that on Wednesday.' And I wouldn't let it play on my mind whereas... and I've only just thought of that. Whereas with the other two children, because there were no scheduled appointments like that, I suppose I would worry about, 'Oh, am I feeding them the right thing,' do you know what I mean? (Heather, mother of three)

For Heather, above, the thought of having to 'go and ask' for advice was a source of unease, whereas regular home visits worked best in that they helped her to avoid queries or worries 'playing on her mind'. The mothers in our study expressed very different preferences in terms of the type of contact with the team that worked best for them. We return to this point later in the report (see section.6.2.3), but throughout our findings the effective combination of support at home and support outside the home (e.g. child health clinic, group activities at Children's Centre) appeared to be one of the strengths of the organisation of health visiting at the study sites.

The views and comments discussed in this section highlight the aspects of interaction and communication that parents found central to feeling supported and enabled as first time parents or in their journey with a new baby. These findings strongly resonate with the description of health visiting

relationships and interactions we examined in our scoping review of the literature on health visiting (Cowley, et al., 2013); we return to this in our final discussion (see Section 7). We now move on to examining the cases in which – more often in relation to previous experiences with health visiting services – parents found contact with members of the health visiting team unhelpful and disenfranchising. Although in this report we focus on the aspects of health visiting service that prove effective and enabling, with a view to suggesting that professionals and policy might want to devise strategies to strengthen them and ensure they become everyday practice across the country, it is important to pay attention to less successful forms of health visiting support in order to fully appreciate how these affect further contact with and understanding of the service.

6.1.2 Unsatisfactory relationships and disaffected parents

On some occasions, specific approaches and behaviours on the part of members of the health visiting team had made parents reluctant to continue to engage with health visiting services, or – in some instances – significantly sceptical and negative towards health visiting in subsequent encounters. Here we draw attention to these approaches and behaviours to underline the impact that certain styles of health visiting practice can have on the relationships that professionals establish with parents.

Parents found comments that they perceived as judgemental very unsettling. We do not make any assumptions here about health professionals' behaviour as reported by participants in our study. Our analysis is grounded in parents' comments and accounts from their experiences; our intention in this section is not to evaluate or judge the practices of health visiting teams but to explore in more depth what it is that parents perceive as troubling or off-putting in their exchanges with health visiting team members.

Mothers at times felt judged for their appearance, their age, or their lifestyle choices. May, a single mother in her late 20s, did not find the visit from the first health visitor she met prior to changing team very helpful:

Yeah it's just the way... because she [first health visitor] was saying, 'Oh, you're a young mum, a young single mum.' And she kept emphasising that to me. And I said, 'Well, I'm not that young.' And I don't really want to be looked at that I'm some silly girl that went out and got pregnant at 16. You know, I thought, 'Well, I'm a grown-up.' Stuff just happened. (May, mother of one)

Personal choices around breastfeeding also seemed to have the potential to trigger tensions in interactions with members of the health visiting team, as was the case for the two mothers in the examples below:

And then I said about [my breastfeeding choices in the past] and I got a really, really negative response with her, with a kind of disgusted face and criticism. It's just not what you do to a woman who's just given birth. So, yeah, that wasn't a good start.[...]. And, yeah, that was kind of

the end of the visit because I feel I'd shut her down after that. But, yeah, that wasn't a great start. (Florence, mother of two)

Interviewer: So was it difficult to make the decision to stop? Did anyone help you with that decision to stop breastfeeding?

Susan: Yeah. No, because I knew that I would get... I didn't really... because I knew that they were quite pro-breastfeeding obviously. So I didn't really talk much to her [health visiting team professional] about it because I knew I'd probably get... kind of, just to carry on with it. So I did feel guilty about it. [...] I think people... I think you do because I think it's quite pushed now to breastfeed. (Susan, mother of two)

Parents felt that at times professionals used a 'one size fits all' or 'by the book' approach to queries that required understanding of a family's circumstances and needs. When parents perceived a dissonance between the advice provided and its applicability or relevance to their specific situation, they felt dissatisfied with the lack of a personalised approach. Parents who found professionals unable to 'tune in' to their personal and family biographies identified this disconnect as unhelpful.

The following extract, from the interview with Heather, illustrates well how this mother felt undermined by the health visitor's way of giving her advice on food and nutrition for children:

Last time I went to the clinic to get her [my daughter] weighed where the health visitor was asking what I was feeding her, and because I happened to mention that sometimes I gave her rusk for her breakfast, 'Oh, you mustn't give her rusk. That's full of sugar,' blah-blah-blah, and gave me [a very hard time] for giving her rusk. So it was like, 'Well, it's not the only thing she eats. Just to recap, I do give her baby rice and I give her vegetables and I give her fruit. You know, it's not the only thing that's in her diet.' So she was like, 'Well, you still shouldn't be giving it to her.' [...] And it could be me being overly sensitive to it, but then I think well, sometimes a bit more of a sensitive kind of approach might... [...] This particular person hadn't thought to look back on... well, maybe didn't have the time, but, you know, didn't know our history, didn't know that I had suffered from anxiety in the past. You know, I might have been a nervous wreck and she's going to me, 'Don't give her rusk,' and I could have gone home and cried or... I didn't but... do you know, sometimes that extra bit of understanding might go a long way. (Heather, mother of three)

In her account of her experience of an uneasy interaction with the health visitor, Heather acknowledges that she might have been 'oversensitive' but she also reflects that if the health visitor had known more about her history and her issues with anxiety, the interaction might have proved very different and more pleasant for her. Unpleasant or uncomfortable experience with health visitors, in which mothers feel judged or labelled, can jeopardise future engagement with the service. Florence, below, explained how advice from health visitors that had felt 'set' and rigid had made her sceptical about the support she could have from the service:

But, yeah, so I kind of... I'm not actually massively keen on speaking to health visitors or people like that just because I've had these experiences where people have had their little set thing of what's going to work and I must just be silly if it doesn't work. And just in a really pushy way and I don't like to be pushed because, you know, if you come to someone for kind of advice about something, it doesn't mean that you have to do exactly what they say, especially if their advice, you know, isn't going to work for you, you know? (Florence, mother of two)

A few mothers commented on having had previous experiences with health visitors or other members of the health visiting team who had offered advice in a way that had seemed too inflexible, as if guidelines were 'set in stone'. Roxanne, below, talked about how her enquiry on baby-led weaning had not been really engaged with by a health visitor she consulted. She commented on how she thought the cause for the unsatisfactory response on the part of the health visitor might be 'generational' or related to flaws in their continuing professional development:

...although she [health visitor] was really, really nice, and the information that she gave me was good, when I asked about baby-led weaning she didn't particularly seem to support it that much, and I think personally it's a generational thing, but that may be me being judgemental. But I feel that it probably is more of a generational thing, and that her initial training when she started her job probably didn't include anything about baby-led weaning, and babies are meant to be fed on mashed-up food and this, that and the other. [...] Because I asked about baby-led weaning and then she kind of changed the subject and continued to talk about mashing up food. So that was it really. I didn't get a lot from it. She just started talking about giving mashed-up this, giving mashed-up that, getting a hand blender and a processor. And I said, 'Well, I was thinking about doing the baby-led weaning', and I think she advised me to get a book or something; I think that's what she said. But it wasn't like she was rude or anything at all. I think I'm making it sound worse than it was, but I just don't think that she really thought that that was the right thing to do. I think that they should all have the same training and have it kind of intermittently and make sure that everyone has the same information. (Roxanne, mother of one)

Dorothy had tried her health visitor's suggestions to help her son settle at night. She found that nothing had worked and that health visiting teams might not have much else to offer:

...my point of view was that [my son]'s going to then hate his bed because his bed is the place where he's being put to cry and that's how I was trying to explain myself to the health visitors but they were saying about, 'Don't put him in front of the TV before he goes to bed, try and read him a story, try and take out little bits that you think could scare him and then be in his dreams.' And obviously with the feeding him and everything else, try not to feed him through the night. You know, little bits and pieces that they were trying to help me with, his sleeping and things I was trying. And I have still been trying and nothing's been working, [my son]'s just not sleeping through the night. But I've kind of give up coming here to see a health visitor because I feel like there's no point in me to keep coming to keep doing the same thing over and over again. (Dorothy, mother of one)

In less dramatic cases, mothers were not seriously unhappy about the advice and support they had been offered, but they still felt they would have liked to have more support. These mothers appreciated that health visitors were under pressure and had to prioritise effectively, but they would have also appreciated more help from them. One mother commented that, as a second-time mother, she probably was perceived as less of a concern to the health visiting team:

I guess they probably have some kind of system as to who they worry about more and who they don't worry about more really and probably because I was a second time mum they probably didn't necessarily... they probably thought, 'Oh, she's got... she can just get on with it because she's done it before.' But there's obviously a huge gap between [my first and second child] and you forget. You do forget, and things change as well. (Susan, mother of two)

Scarlett, below, explained that in her experience support seemed more geared towards certain choices and was less forthcoming for others, as in the case of breastfeeding and mixed feeding:

Because I think obviously if you can breast feed it's great, if you struggle I think if you want to do it there will be a lot of help, but if you decide to finish or you don't want to do it anymore, I wouldn't say the support is there. (Scarlett, mother of three)

The examples illustrated above suggest that there is much to learn from the experiences of parents who somehow felt that their needs had not been met or that small adjustments would have made the interaction with professionals significantly more supportive and helpful.

In summary, section 6.1 examines in depth the aspects of health visiting practice that parents find most valuable (in particular feeling known to the health visiting team, being listened to and reassured, being supported to develop confidence in one's parenting abilities, being aware of the availability of support in case of necessity) and those that can have long-lasting negative effects on parents' willingness to engage with the service (such as being offered advice that is 'by the book' rather than tailored to one's circumstances or the feeling of being 'less of a concern' to the health visiting team). We discuss the implications of the data illustrated thus far in Section 7. In the next section, we turn to exploring the organisational features that allowed parents to perceive the service as supportive and helpful.

6.2 Organisational features characterising supportive health visiting services

As we discussed in the previous section, parents felt supported in their transition to parenthood and in looking after their children when they felt 'known' to the health visiting team, listened to by professionals, and when they perceived the help and advice from professionals to be tailored to their specific family needs. We also examined the aspects of interaction that hindered the development of enabling relationships. In this section we take a closer look at some of the ways in which service organisation created the conditions for effective relationships to develop and flourish and for parents to gain confidence in the reliability and trustworthiness of health visiting support. More specifically, we

explore the various ways in which health visiting work helped to coordinate health and social support for families; the particularities of the transition from midwifery care to health visiting support; and the role that engaging with health visiting services outside the home had for parents.

6.2.1 Health visiting contribution to coordinating support for families

Parents in our study said they felt disappointed and confused when they experienced disruption or disorganisation in their care. This was the case for only a very small number of participants. However, other accounts highlighted how health visiting contributed to preventing or remedying disruption in care by improving coordination between professionals and providers. In this section, we briefly discuss examples of parents' dissatisfaction with disruptions in care, then illustrate some of the ways in which health visiting teams operated to facilitate seamless support and communication.

Disruptions and gaps in care

Many families with young children are extensive users of a variety of services provided by different agencies and organisations across the spectrum of health, education, social care, housing and community organisations. Thus it was not surprising to find that a high proportion of parents interviewed for this study talked about their interactions with workers from several organisations and agencies. Communication between professionals and their efforts to ensure services are coordinated around the family are typically 'backstage' activities that are not apparent to service users, because they happen when parents are not present. However, the extent and quality of their communication and coordination can impact on parents' experiences of care. Poor communication and coordination may create confusion, discontinuities and delays that leave service users feeling distressed and abandoned or overwhelmed by having to manage a series of apparently unconnected interactions.

Parents described feeling abandoned, scared or 'lost' when a relationship with a professional whom they trusted and relied on to manage communication with other services ended. This can happen when a professional leaves, or when families move house if these transitions are not well managed. Parents may find themselves solely responsible for maintaining connections or establishing new ones with the professionals and services they need for support. Lizzie, a single parent whose child was frequently in hospital as a baby, had come to rely on the physiotherapist who visited her at home for support and had lost touch with health visitors. When the trusted physiotherapist moved on, their successor decided to close the case. Lizzie felt her main source of support had been taken away and returned to the health visiting service for help:

I think it may have been better if I had a little bit more support when the [physiotherapist] was going to be swapped over because I felt a bit lost at that point, when the [physiotherapist] changed over to somebody else ... who didn't really know me very well. So at that point I felt like I needed someone ... so that's why I got in touch with the health visitor. But I think it would have been nice... [to] have a health visitor there to say, 'Listen, you know, this has come to an end and is there anything there that we can help with?' ... But I just felt like there wasn't. There was like a gap. (Lizzie, mother of two)

In another case of complex care for a child born prematurely, the mother – Nadine – was very pleased with current arrangements for coordination of various support services, but she recalled the time when she felt she had no-one to turn to:

The health visitor... [...] came out to me and she was lovely, she really was lovely, but I can understand why, she said to me that because the neonatal nurses were coming out to me the health visitors' team would take a step back and let the neonatal nurses take over because he was so poorly. She'd let them help me out and be my support. But I knew that if I needed to ring the health visiting team that they would come out to me, which was fine, but then I didn't hear from them ever. And it was only because we go to a nursery that a family support worker comes there and we were talking about something, this is only about eight months ago, and we were talking and she said, 'Who is your health visitor?' and I said, 'Who? I haven't got one', I didn't know. And she set me up with my health visitor now who is a goddess. I can't fault her. (Nadine, mother of one)

Similarly, Maddy, who had taken part in various groups and activities at the Children's Centre, was a little concerned about potential gaps in the service, ascribing them to possible understaffing:

Maddy: ...from here I know they are absolutely chronically under-staffed, but [my daughter] never had anything since six weeks, never had a development check or anything like that. Which isn't a problem, we've not sort of needed one, but I understand you're supposed to have one at sort of a year-ish, and one at two.[...] So yes that's sort of the thing that's missing from here is to have all the routine development checks, and she's not had sort of anything about hearing or anything like that since the newborn hearing screen [...].

Interviewer: And have they mentioned anything about sort of whether that sort of under staffing situation as being addressed in any way? Have they talked about future checks?

Maddy: No, I've never sort of asked for her because well she's fine basically, but I did just bring it up at the baby clinic the other week as [my son] is behind and [he] really could do with something at some point. [...] I think the answer was really if you want one ask us, you probably won't just get one automatically. Which is fine, I will ask for that, it's fine but I guess there might well be children out there that are missing out... (Maddy, mother of three)

Maddy could understand how routine development check appointments could be missed in a situation characterised by lack of resources. However, it is also possible that even in optimal circumstances, administrative errors may result in letters not being sent out. What we highlight here is that parents are sensitive to failings in the system and that these may undermine their confidence in the reliability of the service. Kelly, a single mother of four children, appeared to be rather dissatisfied with the new health visitor assigned to her family. She had found the service very helpful until her trusted health visitor was replaced by a newcomer:

Interviewer: And tell me about [the health visitor]. What are the things that she comes to visit you about mostly? What sort of things does she help you with?

Kelly: Not a lot. [...] To be honest, not much really.

Interviewer: Right. Does she come to your home or do you have to go to the centre?

Kelly: Both, both. I'll go over to her. I'll hassle her.

Interviewer: And you're saying that you don't find it very useful...

Kelly: I don't find that health visitor very useful.

Interviewer: Tell me more about that, if you like. What is it that you would like...?

Kelly: You could ring her maybe Monday, she wouldn't ring you until the following Monday. It's not good. You've got a problem, you need it to be sorted out there and then. She works [in this area] two days a week. It's no good putting [this] health visitor to somebody who's got [four] children. (Kelly, mother of four)

Failure in coordination of care sometimes resulted in parents feeling overwhelmed. This was the case when, for example, service providers operating independently each focused on the service user but failed to communicate with each other and modify their input to the family. Beth had sought and accepted breastfeeding support from various sources, initially finding all of them helpful but, when they continued to contact her regularly, the cumulative effect of having so many people involved became too much:

There's almost a little bit too much for breastfeeding. It's great, you know, I'm glad the support is there but there were certainly some points where I'd got to and just gone, 'Leave me alone.' You have the health visitor and the midwife and [name of support group] and the nursery nurse all going, 'How are you doing with breastfeeding?' And I'm going, 'Fine, leave me to it.' (Beth, mother of one)

These few examples of unsatisfactory engagement with the service highlight how, in other accounts, health visiting teams contributed to the background work that kept support seamless and transitions and coordination as effective as possible. We found that there were at least three ways in which health visiting teams and health visitors in particular contributed to effective coordination of care and of the information that went with it: 1) by operating as a point of referral and contact with other professionals and services (e.g. general practitioners, hospital specialist, speech therapists, etc); 2) by acting as key reference points to relay information, thus mediating and facilitating interaction and communication in the context of complex care; and 3) by responding reliably and promptly to parent-initiated contact and tailoring practical arrangements to parents' needs. We look at each of these in turn below.

Health visiting teams as mediating access to services and support

Some parents drew on health visitors' knowledge and networks across a range of services to access support that met the family's needs. Respondents described how health visitors and sometimes other professionals helped them find and access, or secured for them, appropriate specialist services, appointments, and referrals. Effective communication between health visitors and others resulting in access to services was most apparent in acute situations, as described by Adele, whose health visitor intervened to get an urgent GP appointment for her child:

[My son] went to hospital a few times and we were at the doctors a few times, but my health visitor ...when she came out, she saw he wasn't a hundred per cent, so she actually got on to the doctors to phone me. [...] Obviously because it was the health visitor who got in touch, they phoned me in a matter of half an hour after my health visitor left. Straight back in touch with me, and then [my son] ended up in hospital for a week, so it could have been a lot worse if my health visitor didn't [phone]. (Adele, mother of three)

Similarly, health visitors' assessments and visits were pivotal in identifying symptoms of postnatal depression in mothers and ensuring mothers sought appropriate help from their GPs. Heather, whose second child had needed hospital treatment at the age of three months, reported that it was the health visitor who had helped her to realise that the way she was feeling could indicate an underlying depression and that she might benefit from talking to other professionals:

...I should actually mention this, it actually was a health visitor who had come round, it was only about four days after we'd been home, [my daughter] had been discharged from the hospital, that came round actually to check my daughter's weight primarily and she looked at me and you know when someone says to you, 'Are you okay?' and the natural response as anyone who's busy is to go, 'Oh yeah, I'm fine.' [...] And I went, 'Oh yeah, I'm fine,' and she looked at me with that kind of look as, 'Are you really?' And it was her that made me realise that actually I wasn't. I feel quite emotional thinking about it now. [...] But it was actually her that made me realise that actually I wasn't really coping as well as I would have liked to be and that everything had really taken its toll on me. [...] And then, from that, I went to my GP and said, 'Look, I've been feeling this and thinking that and blah-blah-blah,' and the GP referred me to [the counsellor]. (Heather, mother of three)

Other forms of coordination involved ensuring parents could access and benefit from services they were entitled to, for example help with practical aspects of daily life with their child, such as having safety gates fitted, claiming benefits, and linking with social care services. Juliet and Hillary discussed how valuable they found health visitors' willingness to help them with the paperwork required to obtain funding, for example for beds for their children and safety gates in the home:

Juliet: You don't just see the one person. Where I go, I go to [name of centre], and there's a group of them. So I won't just see the one, I see quite a few.

Hillary: Yeah.

Juliet: And they're all like a team. So I don't feel like I've got to say something to this person and I can't say it to this one or that one. I can just spill to the whole lot. I can sit there and have a brew with the lot of them and just spill. Because it's confidential and they're like your mates. You know you can turn to them about anything, which is nice. And they help you with anything you ask them. Anything. And they will help you with it.

Interviewer: What sort of things did you find that they can help with, other than the ones we talked about earlier?

Juliet: They go and look at fire safety, and things like that. And then you think, 'Oh dear, I've got to do all that,' and they say, 'No, don't worry about it I'll do it,' and you just say, 'Oh right, okay.'

Hillary: Like for your safety gates...

Juliet: And then the funding for [inaudible], I thought 'God, I've got to do all that.' It's quite daunting I think.

Hillary: I didn't know anything about it until I got my health visitor.

Juliet: Well I didn't. You don't know all these things, and then your health visitor comes over and says this that and the other. And you say, 'Oh god, I've got to do all that.' But she says, 'No, it's alright, just sign here, sign here.' And they go off and do it. And you think, 'Isn't that amazing?' (Juliet, mother of three, and Hillary, mother of two)

In other accounts, several health professionals and social care workers had contributed to disseminating information and ensuring that parents were aware of services they might find helpful. Nadine had been supported by her visitor through applying for benefits; she was also directed towards additional services by the family support worker at the nursery:

Nadine: ... she will still provide me with information of other services that we use or like as I said the DLA and the Carer's Allowance and all of that. She doesn't forget. She brings her notebook and writes down a lot. [...]

Interviewer: But then say for example the HomeStart thing, [...] you can have someone playing with him for a couple of hours. That sounds like a good thing. [...] Was it the health visitor who arranged that?

Nadine: No, unfortunately it was this family support worker again. She has put everybody in touch with everybody. She's been brilliant. She was the one who suggested HomeStart, and put the referral in for me. And to be honest with you, [the support worker] was the one that suggested [another national support group] - do you know [them]?

Interviewer: No, sorry.

Nadine: To be honest we haven't started with them yet, but it's [my health visitor] who has put the referral through for me. [The support worker] mentioned it, and I mentioned it to [my health visitor], and [my health visitor] is now doing it for me. (Nadine, mother of one)

In the interview extracts above, health visitors were ultimately responsible for completion of referral procedures and involvement of different professionals and agencies provided parents with multiple opportunities to be directed to appropriate sources of help. In the quote below, although mother and child had no specific health problems, social isolation and unfamiliarity with the locality made the experience of motherhood difficult for Denise. The health visitor ensured that family support workers provided social support to enable her to join activities at the Children's Centre and meet other mothers:

So I went up there for [baby's] 12 week check and it was then that I broke down to [the health visitor] and told her exactly how lonely I was feeling because I didn't have any friends, because I'd only moved up here literally three weeks before he was born. [...] And that's when she helped me, and put me in touch with the [Children's Centre] and got me a [family support worker], and helped me integrate a little bit better. [...] Because I went through a stage where I didn't want to go out of the house. [...] I was nervous to come down here on my own to the [baby class]. [...] [The family support worker] met me at my house and actually walked me down here [...] and she came in with me. [...] Without that I would never have got out and I wouldn't have got the friends that I've got now so... (Denise, mother of one)

Denise noticed that the health visitor, the family support workers, and other members of the team were working together; she also appreciated the health visitor assuming responsibility for coordination and staying in touch with her:

Denise: [The family support workers] they're in contact with the health visitors; so they're working in liaison with each other which is really, really nice. And [my health visitor] did check up that they were doing what they should be doing, so she was on the case very much.

Interviewer: So she was co-ordinating...?

Denise: Yes, she obviously spoke to the girls here and then spoke to me and made sure I was happy and everything. Just because she'd put me in touch with these people here she didn't relinquish the responsibility. It wasn't like, 'I've palmed you over there now, you're okay.' She still kept seeing me. And even though she doesn't come to see me every week now, she occasionally rings me up and makes sure I'm okay. (Denise, mother of one)

These examples illustrate the ability of the health visiting team to make appropriate referrals for care and social support. A continuing relationship with the family enabled the health visitor to assess the effectiveness of the interventions and respond to changing needs. In the following section we explore

a related aspect of the health visitor's coordinating role: managing the flow of information between families and the professionals involved in their care.

Coordination of care for families with complex health needs

Parents in our study talked about how the health visiting team and health visitors in particular represented a central point for relaying information, especially in cases in which care was complex and required contributions from several professionals and services. Parents of children with complex needs and long term involvement of a multiplicity of professionals valued formal arrangements to manage communication, with a named key worker as the focal point. Janet listed the professionals who were currently seeing her four year old son Alfie: consultants at hospitals in two different towns, dietician, physiotherapist, occupational therapist, portage workers, health visitor and nursery nurses. She described how her health visitor becoming key-worker had improved communication:

I mean there was a point that I thought things weren't getting relayed as they should do, but at the meeting when we had it, it was last year... [...] We had this meeting and I brought up my concerns then of things not getting passed on as they should be, and ever since then I've not had a problem with that. [...]

Yeah, [my health visitor] came to the meeting, because we had a big meeting where all of the professionals involved with Alfie all came, and [my health visitor] came to that with us as well so that she could have an input on it. It was decided there for me to choose someone as my key worker and [my health visitor] agreed that she would do it, so if ever I need anything doing, like for all the professionals [...] all the professionals need telling about something, I can call her and say, 'Can you let all these people know?' and she would do that. (Janet, mother of two)

Nadine spoke about how useful she had found Team Around the Child (TAC) meetings for bringing professionals together and establishing good communication practices: seeing all the professionals together in one room made the idea of collaboration tangible. The formality of the meeting, with responsibilities clearly identified, tasks allocated, and deadlines set gave a sense of purpose and direction for the professionals and Nadine herself. Having a named keyworker as a point of contact and continuity helped her to feel more in control. In this case, the TAC team had been suggested and was chaired by the health visitor, and Nadine clearly felt part of the team:

Interviewer: Are [the TAC team meetings] good? How do they help you?

Nadine: It's just to make sure that we're all singing off the same hymn sheet. We have like points of what we're going to do before the next meeting, which is great because things do get done. It sounds daft but I have to keep a diary, and I've never had a diary in my life but I have to keep a diary because we have things every single day. [...] So the fact that we get the minutes and mum is going to do this, this and this for the next TAC meeting, I know that things are going to get done before the next TAC meeting, and they are great because it does help me keep on track with stuff like that. I'm a little bit busy [laughs]. (Nadine, mother of one)

For Hayley, whose daughter had been diagnosed with a physical disability, the health visitor was the professional who provided continuity of support to the family through this difficult time when 'there really wasn't really anybody to talk to'. The health visitor visited the family regularly while they were waiting for treatment and identified groups and activities that might help mother and daughter; when these did not prove suitable she suggested alternatives. This mother's narrative is very rich and we only report some excerpts from it here. These give a sense of how the health visitor involved was able to help the family understand and come to terms with the child's diagnosis, 'holding' this family's doubts and anxieties until further supportive relationships were established:¹⁵

I spoke to [my health visitor] on the phone a few times and she came out and visited me at home, and she was lovely. [...] She found out things for me, but she's the first to say that they didn't know much about [my daughter's condition], because it's more of a specific subject, but they did a lot of things to find out where I needed to go for advice and things like that. And also just come to see and to talk to me, because I was struggling at first to come to terms with it, and she just came around and listened to me and just came and saw [my daughter] Lily and played with Lily.... It was nice to have somebody to talk to who knew me, but also knew Lily as well, and just so we could discuss that kind of thing really. [...] ...from Lily's first diagnosis to her first physio appointment, it was [almost three months] we had to wait, which is quite a long period of time of not knowing what's going on, not really understanding what's going on. So we felt a bit lost, so I was very appreciative of [the health visitor] coming around and speaking to me and things like that. (Hayley, mother of three)

Parents who saw evidence of communication and collaboration between professionals had confidence that the service was working for them. This was the case for Cynthia, whose son had been diagnosed with a psychological difficulty she had not heard of before:

Cynthia: ...we'd not really heard of [this diagnosis] before, and obviously we've tried to do a little bit of research into that now. So this family support worker is aware of that, and she is absolutely excellent. All the stuff that she is trying to work on is exactly what the [specialist] social workers would say as well, and the psychiatrists. She is totally in tune with them: so she is fantastic, absolutely fantastic.

Interviewer: So you've experienced the coordination...?

Cynthia: Yes, brilliant. [...] Absolutely brilliant, it's been brilliant support. (Cynthia, mother of two)

These examples illustrate the value that parents placed on good communication with the professionals and services involved with the family and the confidence they gained from knowing that professionals were collaborating to support them. Health visiting services were well-placed to play a pivotal role in managing information and securing coordination or, if services proved difficult to

¹⁵ Holding relationships provide a 'listening to' opportunity for parents, a sense of the health visitor 'being there for' them and an exploration of their problems. (Cody, 1999)

access, the health visitor was able to step in, 'holding' the family until necessary services were in place. Fulfilling this role effectively depended on establishing relationships of mutual trust with parents, providing continuity of contact, and demonstrating to parents that the service was reliable, which we explore next.

Demonstrating reliability: prompt responses to parents' concerns

We saw earlier that Kelly found it particularly unhelpful when her new health visitor did not respond quickly to her calls about issues she perceived as urgent. This further highlights the backstage work that health visiting teams do to ensure that communication is effective and prompt. As we discussed in the section on 'health visiting as safety net' parents were reassured to know that the service was there when they needed it, and timely responses to their enquiries gave them confidence in its reliability. A theme that ran through many interviews was that parents found it easy to contact the service and were confident their calls would be returned promptly:

They're all friendly... [...] I pretty much know most of the women who work here now, if there's a problem. They say they'll pass the message on. It's quite easy to phone up and say, 'Can I speak to so-and-so,' and they'll phone back. (Paula, mother of two)

Some mothers were also happy to speak to any of the team members if their query was a 'routine' one, as in the case of Helen, below:

She's always been around. I phoned a Friday a few weeks ago and she'd left for the weekend, so I said it was alright for me to speak to anyone, because it wasn't about his condition or anything. It was just about a routine thing that I wanted to speak to them, and I think a nursery nurse phoned me back. She gave me some advice, and I have to say, I've done slightly what she said, but not totally [laughs]. (Helen, mother of two)

Similarly, Vicky was happy to get advice from a different health visitor, if this meant her question would be answered more quickly:

I didn't have her mobile phone number; I'd just phone the service and then I'd get to speak to her if she was there or she'd ring me back. No, I didn't have her mobile. I didn't think. I might have done, but I never rang her mobile. It wasn't often that I had to ring her anyway... [...] There was one time when she wasn't in and she wasn't going to be in until a time when I was going to be out so I spoke to another health visitor and she was helpful. (Vicky, mother of one)

Prompt responses to queries gave parents confidence that the health visiting service itself was well-coordinated and that they could rely on it to provide reassurance, support and help with accessing other services when these were needed. At the beginning of this section we illustrated how poor coordination of care could leave parents feeling confused, distressed and abandoned or, occasionally, overwhelmed. Parents' accounts provided examples of how health visiting work contributed to coordinating the care and support they received, so that it was as seamless as possible. Health visiting services offered parents a point of contact for referral to other professions and services,

enabling families to access appropriate help and a wide range of support. For families with complex needs health visitors often played a pivotal role in managing the flow of information between families and professionals and securing coordination through formal arrangements such as TAC meetings. Parents valued being part of these meetings, which gave them confidence that the family's needs were understood and there was common purpose in providing care. For other parents, who had to wait for diagnosis or treatment, health visitors stepped in to provide continuous and reliable support, 'holding' the family until necessary services were in place. In the next section, we explore parents' experiences of a particularly significant transition, from midwifery care to health visiting support. How this transition is managed determines whether parents, mothers in particular, feel that they know what to expect from health services after the birth of their child; it may also have consequences for families' engagement with health visiting.

6.2.2 A critical transition in care: from midwifery care to health visiting support

The transition to health visitor care traditionally takes place in the first weeks after a child is born, when parents are also making emotional, social and practical adjustments to the birth of a baby. It is a time when there is much to do and take in, and the family may be contacted by a variety of people with unfamiliar roles and responsibilities. Most respondents in this study recalled that this was when they met a health visitor for the first time and began to learn about the health visiting service and the support it could offer them.

A strong theme in mothers' narratives was how little they knew about the health visiting service when they came home with their first child. In this section, we explore how mothers found out about the health visiting service and what they thought could have been done differently to improve the transition from midwife to health visitor care. Getting to know the health visitor before the birth of a baby, and thus knowing what to expect and establishing continuity, was valued by those who had experienced it and identified as a potential improvement by those who had not.

Most mothers in our study perceived midwifery and health visiting services as operating separately, although some mothers had experienced health visitors and midwives adapting their normal routines to work together, and they found it reassuring to see evidence that their midwife and health visitor were collaborating to respond to their needs for extra support. However, when postnatal care was complicated or departed from usual routines, and more professionals were involved, mothers' accounts indicated that health visitors found it more difficult to engage with families and there was a danger that contact was lost.

Knowing what to expect

Few first-time mothers in this study had met their health visitor before their baby's birth; most mothers were briefly told about the health visiting service by a midwife. Many mothers said they were not clear when the health visitor would call and what help she could offer, and some held misconceptions about health visiting that made them apprehensive about the visit. Some mothers were not sure who they had seen in the postnatal period, especially if they had been visited by a number of different

healthcare workers. Most first-time mothers said that they received a full explanation about health visiting only when they met a health visitor for the first time, sometimes several weeks after their baby was born. In contrast, mothers who had previously used the health visiting service knew what to expect and were also more likely to know their health visitor personally, which they particularly valued. Most mothers could recall being informed by their midwife that the health visitor would get in touch with them to arrange a home visit when the midwife's visits ended. Views were mixed on the adequacy of the information they were given by the midwife about the health visitor's role.

... when I had [baby], I mean the first I really knew was [the midwife] saying that your health visitor will come and see you. So you don't really know much before that.' (Janet, mother of two)

I never did any kind of NCT classes or anything beforehand, so ... perhaps if we'd have done that we would have got more information.[...] But no, I didn't really know much about it at all until after I had [the baby]. It would have been the midwives that told us about the health visitors and what to expect. (Lorraine, mother of one)

Other mothers, like Lynda, had no clear recollection of being told that a health visitor would come to their home, or when she would visit:

Lynda: [the health visitor] came to the house and we went through everything and [...]she introduced herself and just told us a little bit about what they do and things, which was quite good because obviously I hadn't got a clue what was to come after [baby] was here really. So, yeah, that was helpful.

Interviewer: Had the midwife explained a little bit about the health visitor before?

Lynda: No.

Interviewer: No. So it was the health visitor who gave you all the information on her first visit?

Lynda: Yeah. (Lynda, mother of two)

Some mothers who lacked accurate information about the health visiting service described being anxious and apprehensive about meeting the health visitor for the first time. Tess and Natalie, quoted below, held common misconceptions about health visitors and their reasons for visiting, believing the health visitor would judge them and their parenting abilities and had the authority to 'take away' their baby.

Interviewer: Did you know about what the health visitors... was it clear when you had your first child what the health visitor was there for and what they did, what their job was?

Tess: I was scared more than anything. For the first child, I think I was more scared than anything.

Interviewer: Why?

Tess: I think it was like first child, thinking, 'What are they going to do? They're going to take my child away from me.' If something was out of place in the house, I think, you know, a wire sticking out of the plug socket, I think I was more worried about things like that, and obviously finding out actually they're not there to take your kids away. They're there to help and support. Obviously I didn't get explained all of that.

Interviewer: Do you remember who explained to you what the health visitors do? [...] How did you find out that...?

Tess: I just found out when she came to visit. (Tess, mother of four)

'I remember the first visit really well. I was apprehensive [...] because you feel like you're under scrutiny, do you know what I mean? You're sort of like being watched and I was worried because I suffer from anxiety and depression [...] But I was really concerned about telling them about [my mental health issues] because I didn't want them to think that I couldn't cope and I was terrified that they were going to take her away from me and that. But I knew I'd have to tell them because they would have found out anyway so there was no point...'
(Natalie, mother of one)

Despite their worries about meeting the health visitor, for Tess and Natalie the first visit went well and their anxieties were allayed. They went on to form good relationships with their health visitors and accessed a variety of help and support from health visiting teams. In general it seemed that although most respondents had no contact with a health visitor before their first child was born and were given limited information about what to expect from the health visiting service, this did not impede developing trusting relationships or inhibit their use of services. However, with hindsight, some mothers would have liked things to have been done differently.

Meeting the health visitor before the baby is born

A number of first-time mothers suggested it would have been beneficial to meet health visitors earlier, either during pregnancy or sooner after birth. Beth, who had formed a strong bond with her midwife, would have liked 'a bit more of an overlap' of visits by the midwife and health visitor, 'so that you started to build up trust with one while things were winding down with the other.' (Beth, mother of one). Other respondents said they would have valued meeting their health visitor in the antenatal period, so that 'it's not a stranger that's coming in' at the new birth visit.

Some mothers, however, were less convinced about the value of antenatal contact with a health visitor: Lucy, for example, a mother of one, asked: 'Why would you see someone before the baby was born?' Seeing a health visitor during pregnancy, a departure from what was perceived as usual practice, raised questions about the purpose of the contact and how it should be interpreted, particularly if a home visit was involved. May, who said several friends had received a prenatal home visit from a health visitor commented:

I don't know why they had them. They [health visitors] checked the house out to make sure if there were any concerns. I never had that. (May, mother of one)

Antenatal classes are one setting in which mothers may meet health visitors, but only two respondents specifically mentioned this, although it is possible that others either did not recall meetings or did not know a professional was a health visitor. A similarly small number of mothers, all living in difficult circumstances, talked about being visited at home by a health visitor during their first pregnancy. Annette appreciated the additional support she had received from her health visitor at this time:

... we had a lot of trouble with [antisocial behaviour in the neighbourhood] and I was getting really down about it and stuff. And the health visitor came out to speak to me and she gave me her little red book ... I think it was about a month or two just before my due date. So that was quite nice that I knew I had the support from the health visitor before [baby] was born... I had the midwife and the health visitor both to talk to ... (Annette, mother of one)

Most mothers who had more than one child knew what to expect from health visiting services because they had already used them. They welcomed the opportunity to continue seeing a health visitor they knew and had confidence in, emphasising the value of the health visitor 'knowing the family'. Some had received an antenatal visit. Hayley saw health visitor Liz about a week before her youngest child was born, 'she came to see me to introduce herself'. Although Liz had not been her older child's health visitor, Hayley knew her from the child health clinic, 'I was quite relaxed with Liz and it was nice to see her again really' (Hayley, mother of three).

While Heather was pregnant, she attended a meeting of all the professionals involved with her family due to her previous experience of postnatal depression ('a bit intimidating [but] reassuring because everyone was there to help me') where she met a specialist health visitor, Judith, for the first time:

... after the meeting she came over to me and she said, 'I'm Judith, I'm going to be your health visitor. Here's my number if you need to speak to me but can we organise a meeting now, before [my baby] is due, for me to come round and meet you and your family.' So I met Judith a few times before [my baby] was born... (Heather, mother of three)

Mothers who had formed a relationship with a health visitor before birth and continued to see the same health visitor after their baby was born valued this and those with difficulties experienced continuity over this period as particularly supportive. As we have already suggested, an important aspect of the support was the regularity and reliability of visits parents received.

Cooperation between midwife and health visitor

Most mothers' accounts conveyed a sense of the separation between midwifery and health visiting services. Those whose postnatal care had been routine saw the services as delivered sequentially and operating independently. Perhaps this is not surprising, since few respondents reported seeing

their midwife and health visitor at the same time and communication between midwife and health visitor was generally not apparent to the mothers:

I can't remember the midwife doing anything about it. ... obviously names and everything had been passed over and then [the health visitors] came in contact with me. (Dorothy, mother of one)

A joint visit by the midwife and health visitor seemed to happen only in exceptional circumstances, but respondents gave some clear examples of midwives and health visitors working together to provide them with additional help and support. Communication between midwife and health visitor was obvious to a mother who had experienced 'a really difficult delivery' and poor hospital care. Vicky described the support she received at home after discharging herself from hospital:

... I had one midwife who I saw afterwards for a while ... and she was amazing She just kept checking up on me, and then ... the health visitors took over. I think there was a slight overlap ... [...]

The first time I met her she'd obviously heard about what had happened to me. I was kind of like the local discussion; wherever they work, everyone had heard.... So, she was lovely. She just came and introduced herself and said, 'Look, I'll check [baby] over and all that, but I really want to make sure that you're okay, because you're the one that has been through the ordeal, and I'm here for you.' She was just brilliant really I've only just stopped seeing her... (Vicky, mother of one)

Two accounts in which health visitor and midwife visited the mother together stood out as different from the usual impersonal 'hand over' that took place. Jocelyn, had been readmitted to hospital as an emergency after her daughter's birth:

... [the midwife] called the hospital saying that I needed to go back I was in hospital for 15 days [...] I was in ICU for a while as well and so was my daughter. ... I came back [home], saw the midwife and she contacted the health visitor. She introduced us and that's how I really came to know the health visitor. (Jocelyn, mother of one)

Jocelyn credited the midwife with saving her life and described the health visitor's input when she was ill and alone with a baby as 'the most amazing help I ever had'.

Louise, who had a child after a gap of a few years, became very anxious during pregnancy about meeting the health visitor after the baby was born. Her experiences with a previous health visitor had led her to disengaging completely from the health visiting service. She told her midwife about her worries, and the midwife arranged to visit with a health visitor, which reassured Louise that she would receive the support she felt she needed when the baby was born:

She [the health visitor] stayed as long as I wanted her to ... everything was in place but I needed to hear her say it I found that really helpful. (Louise, mother of four)

These examples illustrate the value of midwives and health visitors working flexibly and cooperatively to support mothers and the reassurance mothers gained from knowing that the professionals involved in their care were communicating and collaborating to ensure a smooth transition. However, this type of collaboration seemed to be more difficult to achieve if postnatal care was complex and provided by multiple professionals.

Transition in special circumstances

A very small number of mothers reported difficulties in establishing contact with health visiting services. The common factor was that they did not follow the usual pattern of transferring from midwife to health visitor care shortly after birth, usually because their babies were born prematurely or were ill and had to remain in hospital. In these cases, neonatal outreach teams managed the transition from hospital to home and provided specialist support to families, which was highly valued by parents. These mothers' accounts of their babies' first months frame the health visitor's contributions as ill-judged or marginal and illustrate that health visitors risk losing contact altogether with these families if they 'step back' too far when other professionals are taking the lead. Breaks in contact were sometimes repaired by the mothers themselves, but a consequence of disruption at this critical time seems to be that relationships and engagement with health visiting services were subsequently less than optimal.

Maddy's description of the health visitor starting to visit conveys a sense that this was untimely and unwelcome, as well as of little value to the family:

... the health visitor started coming ... it was at Christmas as well so there was a lot of people and it was right over the Christmas period so, obviously we didn't want someone every day. ... we'd had quite a lot of input I suppose already then, so we didn't have anything really specific that we needed to know or ask. We already knew about the services up here ...she came out and weighed [the baby] again ...did your red books and things, introduced herself. (Maddy, mother of three)

Diana, below, was telephoned by a health visitor who did not know her baby was still in hospital after an emergency birth, which she found 'a little bit insensitive... [...] they hadn't checked their records'. The health visitor promised to keep in touch with her but never did, so some months later, after the neonatal outreach team had stopped visiting, Diana phoned the clinic herself and a health visitor came to her home the next day and again after two months. Diana described the visits as somewhat perfunctory, with no opportunity to talk about her birth experience about which she still felt very emotional: 'I haven't really spoken to anyone professionally because I was never offered.' Diana summed up her experience with the health visitor:

... the only thing really that I've spoken to them about is feeding and that's been over the phone. So I don't really feel that them coming into the home has benefited me at all other than just to get [baby] weighed, which I can do at clinic anyway. (Diana, mother of one)

While Diana re-established contact with the health visiting service herself, another mother, Nadine, was so overwhelmed by caring alone for a baby with complex needs that she did not think about doing this. She described how she 'slipped through the paperwork' and did not see a health visitor for a year (see Section 6.2.1, pp.48-49). Nadine was reintroduced to the health visiting service and received help with coordinating care for her son (see page 49), but felt sad about having been left without support for so long:

*The whole time they didn't come to me I wished that somebody did. I can't say it was a health visitor I wished for but I did wish that somebody would come and just talk to me. [...] I know that a lot of people have babies and the health visitor teams are pushed. ...But just that follow-up phone call, that's all that was needed. ...And I might not have had that year of no support.
(Nadine, mother of one)*

These examples illustrate that health visitors' attempts to be flexible and coordinate their contribution with those of other professionals providing postnatal care to families can sometimes misfire, leaving families without adequate support. In this section we have seen that most mothers in the study did not meet a health visitor before their first child was born and had been given limited information about what to expect from the health visiting service. Many first time mothers were not clear when the health visitor would call and what help she could offer; and some held misconceptions about health visiting that made them apprehensive about the first visit. However, this initial lack of information did not seem to impede development of trusting relationships with health visitors or inhibit mothers' use of services. Meeting the health visitor before the baby's birth and being told about the service at this point was valued by those who had experienced it and identified as a potential improvement by those who had not. These findings provide support for current initiatives to introduce antenatal home visits by health visitors and to inform parents earlier and more fully about health visiting in general and how the service will be delivered to them in particular. Most mothers in the study perceived midwifery and health visiting services as operating separately, since they never saw midwife and health visitor at the same time and were not sure they communicated with each other. However, some mothers had experienced health visitors and midwives adapting their normal routines to collaborate and provide them with additional support, and they found this reassuring and helpful. When postnatal care was complicated, and more professionals were involved, mothers' accounts indicated that health visitors had more difficulty engaging with families and sustaining relationships. Although there were only a few examples of this in our study, it is an important finding, since these children and families are likely to be among those with the highest need for support in the early years. Transitions from midwife to health visitor care that do not follow a 'routine' pattern may need special attention to ensure that mothers establish and maintain satisfactory contact with a health visitor.

We turn next to exploring how parents used health visiting services outside the home, in clinics and Children's Centres, which enabled them to meet members of the health visiting team and a wider network of children and family workers, as well as providing opportunities for social contact with other mothers and children.

6.2.3 Engaging with the health visiting service outside the home

Section 6.1 explored relationships and interactions in health visiting and showed that home visits by health visitors are pivotal in establishing relationships with families and offering appropriate help and support. Home visits also help to engage families with the wider network of services for parents and children that are provided outside the home: in clinics, Children's Centres and other community settings, by the health visiting team, social care workers and voluntary agencies. As discussed earlier in this section, our participants identified their health visitor as a source of information and a point of contact for linking with a wide range of groups and activities in the community; and use of such services featured prominently in their narratives. Most mothers took up their health visitor's invitation to use the local child health clinic to have their baby weighed in the first months, which brought them into contact with other professionals in the wider health visiting team and the different types of advice they could offer. Child health clinics also seemed to act as a stepping stone to engagement with other groups and activities, such as breastfeeding groups and mother and baby groups of various kinds, which offer different forms of interaction from one-to-one conversation with a professional. Where these groups took place in Children's Centres, parents who used them were also likely to meet others working with families and children, such as Family Support Workers, and take up the more extensive range of advice and support that the centres offer, for example with skills training, employment, finance and education.

One crucial aspect of health visiting services outside the home is that parents have the choice of how and when they engage with them. While many parents were guided by health visitors towards particular groups and activities suited to the age and stage of their child or intended to meet particular needs, it was parents who decided which groups were right for them. In this section we consider how parents used these services and which aspects they valued, focusing on two themes that emerged in the analysis of the interview data. These were: 1) informal contacts with the health visiting team in clinics and groups offered parents a way of identifying professionals they found particularly helpful or sympathetic; and 2) one of the main reasons parents used groups and activities in clinics and Children's Centres was to meet other parents and children, a form of social support they particularly valued.

Finding alternatives

Attending clinics and taking part in groups and other activities enabled parents to meet the wider health visiting team in an informal setting and talk to professionals in less emotionally-charged circumstances than the home visit:

I think having health visitors around at the baby clinics, they're not actually doing the weighing but they are around so that's great because you can talk to them and you've got the time then, especially with them being weighed, so that's really useful. (Maddy, mother of three)

Most participants in our study were happy with the health visitor who had been allocated to them and the advice and help she provided, and contacts with others in the clinic were a complement to this

main relationship. Occasionally, however, unsatisfactory interactions led parents to seek alternative sources of advice or to form a relationship with another member of the health visiting team. The three examples below illustrate the choices some participants made about who they sought advice and reassurance from and how, in some circumstances, this could lead to the formation of new supportive relationships. Susanne explained that she appreciated the advice of her health visitor, but also liked to seek tips and support from a more experienced health visitor she had met at one of the groups at the centre:

As I said, I felt really supported with the group here and they do seem quite a close-knit group. I think that my health visitor in particular was new, so in that respect I felt possibly that she maybe she wasn't as experienced, but then I think that she is a mum herself so that's all the experience that you need really. And so that is one of the reasons that I quite liked [the other health visitor]. Because, as I said, she is a little bit more experienced, and I just felt that they'd been there before and could give you a little bit more reassurance. But generally the whole system seems... if I wanted it, it was there, as much or as little as I wanted... (Susanne, mother of one)

Susanne had only a slight preference for consulting the other health visitor, but another mother, Florence, was wary of speaking to some health visitors at the centre because she found their advice restrictive. Florence had met a health visitor, Sharon, whose advice she trusted and respected, at one of the groups, and felt that she could approach her about a concern with her daughter:

Well, it's because I talked to my partner about it and I was saying, 'Oh, we could go to the clinic, but then you don't know who you're going to get at the clinic, or I could talk to Sharon because I'd seen her that many times at the group that I knew that she was like a decent person. She wasn't someone who is full of misinformation or that kind of thing, which you do get. I mean, you get that in all jobs though, there's going to be people who don't have as much information as others. I knew she was good so I kind of trusted her enough to mention it to her. (Florence, mother of two)

Lydia, who found the whole team at the clinic very kind and supportive, but perhaps too focused on encouraging breastfeeding, effectively switched allegiance to a professional she had met at the clinic, whose approach she preferred. In the quote below Lydia refers to the professional she bonded with as a health visitor; however, elsewhere in her interview she said that she had recently learnt that Terry was a nursery nurse. This demonstrates the value of mothers accessing the broader team, to maximise opportunities for developing effective relationships:

Lydia: And then I became attached to one particular health visitor who I saw each week. And she was helping me through it all, so the original health visitor who I saw I didn't see any longer because the other one kind of took over; because we'd sort of got a bond together and anything I needed I preferred to see her, which was nice. [...]

Interviewer: Okay, so then you could go for the weigh-in and did you just happen to meet Terry and find that you got on with her?

Lydia: Yes, kind of when I went over to the desk to ask for [my daughter] to be weighed I'd ask if Terry [health visiting team member of choice] was there, because the other ones, they were all lovely but they tended to talk mostly about breast feeding and there were other things that I wanted to talk about. [...]

Interviewer: And once you'd met Terry and you felt that you were happy with Terry, could you see Terry when you went to the clinic for the weighing, could you ask to see Terry?

Lydia: Yes. I mean, sometimes she wasn't there because she was part-time, but any other questions I'd save up and ask when Terry was there because sometimes, depending on who you asked, they'd all give you different answers. And I know that there are no, sort of, set rules and everyone has their own ideas and opinions, don't they, but Terry would tend to go with what she knew that I would like. (Lydia, mother of one)

These accounts re-emphasise the importance of the drop-in clinics and support groups as being different forms of support that are complementary to home visits. They allow parents to select which services they use and who they consult for particular problems, creating the opportunity to cement existing relationships or to form new relationships with other members of the team. Clinics and Children's Centres were also important for parents as places where they could meet other parents and children; we go on to explore how the study participants used groups and activities provided by health visiting teams for social support.

Social support from other mothers

As well as providing easy access to advice and help from the health visiting team, drop-in clinics were seen by parents as a place they could meet other parents with children of a similar age. They also offered a stepping stone to the groups and activities organised in clinics and centres that created further opportunities for parents and children to socialise. Mothers in the study identified social support as an important reason for going to clinics and taking part in groups organised by the health visiting team. For many mothers with small babies 'just getting out of the house' and meeting other people was an aim in itself. The clinic or centre was seen as a meeting place that was accessible, welcoming, informal, familiar and comfortable, and provided a cup of tea, which were the basic requirements that most mothers valued, as the three examples below illustrate:

...these places are like a godsend, because if you are a single parent you don't have loads of money to go and do stuff ... I go to all these things because it gets me out of the house. I'm not just sitting around on my own. You meet other people. (May, mother of one)

Interviewer: What did you find helpful about the groups...?

Lorraine: It's just meeting other people and you can talk about everything and getting out of the house, really, because it was all a bit scary to begin with, knowing what to do and how to do things, and actually getting out of the house. But yeah, so we came here and met our two friends that we do everything with, so if I hadn't have had this facility then we wouldn't have

obviously made them friends. The baby group was just nice because you could see that your baby was the same as everyone else's baby, just a bit louder. (Lorraine, mother of one)

....they have the baby group here after the weighing clinic...[...] And we came to that every week, to the baby group bit, which was really good for the non-mobile babies. It was lovely because obviously lots of mums with newborns. It was a nice people sort of group but that... That was quite a nice environment with a hot cup of tea which is always lovely, yeah and just a chance to be in a nice environment without the house and the phone and things like that. (Maddy, mother of three)

Mothers emphasised how much they enjoyed spending time with other mothers, especially those they felt they had things in common with, suggesting that membership of groups was an important consideration for them, as illustrated by the quotes below. Groups organised around the similarities of participants, such as age of baby, teenage mothers, breastfeeding or weaning, helped parents identify with each other, and so feel less alone, because they were all 'going through the same things'. The interview extracts below illustrate the positive experience of Roxanne, Lynda, and Naomi:

But the Children's Centres I think are really good. When you have a baby it can be sometimes quite a lonely time. Not like in a sad way, but when your partner goes back to work, and if you haven't had any other children and you haven't had a lot of experience you can kind of be like, 'Help, what do I do?' Or if your friends haven't got children as well, it's just nice to have the support and to know that other people are going through the same things that you are, and to have people to answer any questions however silly you might think they are. It's been a big help for us. (Roxanne, mother of one)

....you kind of got a different perspective of everything. Like, you get different tips and different ways of doing things and you're not alone because there are other parents that are out there that do find things a little difficult. (Lynda, mother of two)

It gives you a bit of confidence with regards to breastfeeding to know that if you are having problems, you're not the only one. Some support and advice on a professional level from the health visitors has been useful, but also informally, just meeting other mums and chatting to them and just knowing that you're all going through the same thing, because nobody tells you if you're doing it right or you're doing it wrong, but to know that you're kind of doing it the same way as everybody else... (Naomi, mother of one)

The culture created by the professionals who ran groups also influenced mothers' use and enjoyment of them. Non-judgemental attitudes, inclusivity, and being made to feel welcome were important for many mothers. This is clear in Louise's appraisal of the groups she attended at a local centre, which were very popular with local women:

... a lot of the women I speak to would be on their own and I think it was invaluable for them [...] to have somewhere to go for starters and to know that when they got here they were welcome no

matter who they were, what they do or anything like that, you know, how their lives were, you were all the same in this room. [...] You weren't being judged, nothing like that. You come here, have a natter, have a laugh and you're all welcome, [...] and I think that's important, you know? Because you don't get a lot of people who don't judge you and they don't here. (Louise, mother of four)

Professionals also played a role in supporting mothers who were apprehensive about coming to a group for the first time. Earlier (see page 54) Denise described how a family support worker accompanied her to a group until she gained sufficient confidence to go by herself. Going to a group alone for the first time was also a daunting prospect for Louise, above, whose health visitor personally invited and introduced her to the baby group:

[the health visitor] gave me a leaflet She said that she'd be here so it wasn't going to be daunting because I've met her and all this. And, yeah, and then after I talked to her, I came here the very next week. I had [baby] weighed. I met her here. She brought me into the baby group. (Louise, mother of four)

Unfortunately, not all mothers reported good experiences of being enabled to join groups, and some parents who were regular attenders noted a pattern of mothers not returning after their first time at a group. Like Louise, they thought this was connected with the way professionals ran the groups, and this is something that Cynthia made clear in her account of going to a toddler group that she had been encouraged to join by a worker at a Children's Centre:

She even recommended that we come to the toddler group: 'They'll be lovely. There are two girls that work in that room. When you go you will be new, so they will ask you who you are and they might ask you about your situation, and they'll introduce you to people and help to integrate you into the group.' But unfortunately that didn't happen. I sat on my own for two hours in a toddler group and nobody spoke to me at all. [...] And they never introduced me to a soul and everybody all knew each other and they all sat and played, and [my daughter] covered herself in paint and we left. (Cynthia, mother of two)

Not surprisingly Cynthia did not return to the group or the Children's Centre. Her experience underscores the importance of skilled professionals running groups and facilitating interaction between parents so that they can benefit from peer support and develop their social networks.

Parents in our study appreciated groups and activities in centres because they met their own needs, but they also thought it was beneficial for their children to spend time with other children. Diana, whose baby was just coming up to six months old, thought that being in a mother and baby group would help his development:

Interviewer: What do you find good about the groups?

Diana: It's just the social aspect I think.

Interviewer: Is it the other parents or is there...?

Diana: Yeah, the other parents, the other babies. It's good for him. I mean, he's going to be going to nursery at the end of the year and I think that that will make him so much better because it will teach him to share, it will hopefully help his development, because obviously he's going to be slightly behind his development being prem. So I'm hoping that seeing other children will help him with that. So I like that aspect of things, that he gets to see other children rolling around. It's nice for me to actually say to someone, 'Does your baby do that as well?' So then you don't feel like it's just you. (Diana, mother of one)

Mothers liked groups that offered activities they perceived as appropriate to their children's developmental stage and needs. Some parents, however, found attending groups organised specifically for mothers and babies more difficult if they also had older children with them and a number of parents would have liked more activities for toddlers and pre-school children, or a mix of activities so all age groups could benefit:

Obviously it would be nice to be able to bring [baby] to baby group but I've got [toddler] so I can't. So we've missed out on that a little bit but. Yeah, so you've got older ones, so you can't do the baby bits, so they both come to stay and play didn't you? Which is great for her, but not so good for the little one. (Maddy, mother of three)

This section has explored how health visiting services outside the home, provided in clinics and Children's Centres, enabled parents to selectively access help and support from the wider health visiting team and to meet other parents and children, facilitating the development of supportive social networks. Parents' accounts emphasised the importance of drop-in clinics and groups, and that they offered a form of support that was different from and complementary to home visits. Clinics and Children's Centres offer parents an easy and informal way of accessing help and advice from the health visiting team. They allow parents to select which services to use and who to consult for particular problems, thus creating opportunities to cement existing relationships or to form new relationships with members of the health visiting team. As such, they are a vital way in which the health visiting service remains flexible and responsive to parents' preferences and needs.

Groups and activities in clinics and Children's Centres were also settings where parents could socialise with other parents, something mothers saw as particularly important for them when their baby was young. The culture of groups and the skill of the professionals running them were important factors influencing parents' use of and enjoyment of activities. Being made to feel welcome, professionals facilitating interaction between participants, and an atmosphere that was inclusive and non-judgemental were considered very important by mothers in our study. Mothers also liked groups that offered activities they perceived as appropriate to their children's developmental stage and needs. Some parents, however, found attending groups organised specifically for mothers and babies more difficult if they also had older children with them and a number of parents wanted more activities for toddlers and pre-school children, or a mix of activities so all age groups could benefit.

In Section 6.2 we have examined the organisational aspects of health visiting that contribute to making the service useful and effective for families, in that parents feel supported and enabled in their ability to look after their children. We highlighted the backstage work that health visiting teams carry out to ensure that the support parents receive from different services is as seamless as possible. Our findings indicate that parents are sensitive to failings in the system and that these may undermine their confidence in the reliability of the service. Health visiting teams and health visitors in particular contributed to effective coordination of care and of the information that went with it in three particular ways: 1) operating as a point of referral and contact with other professionals and services; 2) acting as key reference points to relay information; and 3) responding reliably and promptly to parent-initiated contact. Our analysis also shows how little parents knew about the health visiting service with their first child. Getting to know the health visitor before the birth of a baby and knowing what to expect was valued by those who had experienced it and identified as a potential improvement by those who had not, whilst some mothers who lacked accurate information about the health visiting service described being apprehensive about meeting the health visitor for the first time (believing the health visitor would judge their parenting abilities and had the authority to 'take away' their baby). Finally, our findings point to the value of child health clinics and group activities outside the home (at health centres and/or Children's Centres). From our conversations with parents, the possibility of networking with other parents in the community and that of exploring and testing interactions and relationships with various members of the health visiting team were useful in combating social isolation and in fostering supportive relationships that were in tune with parents' lifestyle and communication preferences.

Health visiting services aim to support families by offering help and advice to mothers as well as fathers. In the next section, we explore parents' views on fathers' engagement with health visiting services with the aim to better understand the factors that facilitate or hinder this engagement.

6.3 A service for families

Fathers have a central role in promoting and sustaining child and family health. *The Healthy Child Programme* (Shribman & Billingham, 2009) emphasises the role that health visiting services have in involving fathers in the care of their child and supporting them through early parenthood. Thirty-three of the mothers we interviewed were living with their partner (eight were not in a relationship and one did not share this information). One of the two fathers who took part in the study lived with his partner, whilst the other was solely responsible for his children. In our interviews we asked participants about their views and thoughts on fathers' engagement with the service. In this section we discuss mothers' experiences of their partners' participation in health visiting consultations and activities and give voice to the two fathers who had first-hand experience of being involved with the service.

The accounts from mothers and fathers in our study painted a picture of paternal engagement with health visiting as a complex process with many contributory aspects: the opportunity for contact with the health visitor, the dynamics and division of labour within the couple, the father's inclination to make contact with health services, the health visitor's approach to involving 'dad' during home visits,

and the perceived accessibility of Children's Centres all emerged as significant from our data analysis. Fathers' engagement with health visitors in the home environment presented different challenges compared to their participation in clinics or group activities at the Children's Centre. We look at each context in turn, highlighting the aspects of fathers' involvement – or lack thereof – that recurred in our data.

6.3.1 Engaging with fathers at home

Overall it was difficult for fathers who were in employment to be at home for the health visitor's visits. The most likely opportunity for both parents to meet the health visitor was the 'new birth visit', the first routine visit by a health visitor taking place usually 10-14 days after the birth of the child (unless there are complications at birth that require other professionals to follow up the child in the early days). Fathers normally have two weeks' paternity leave from work for the birth of their child and would therefore be at home at the time of the health visitor's first visit. For the other visits, it was often difficult for fathers to be present, as the examples below illustrate:

Yeah. He's only really off for weekends, so he's not really... I don't think he's actually met any of them. (Jennifer, mother of two)

He saw some midwives but he's not seen the health visitor because he is at work, literally, all the time. [...] He literally likes works probably... well, he's out of the door at half past seven and he's back in the door at seven at night, if that makes sense. (Susan, mother of two)

I think maybe he was there for the initial one because he had the first two weeks off, so he would have been there. I remember him not being there when she was asking about the home environment and the other couple of occasions when she came round, but he was there for one visit and he met her once. But I don't think that he really knew much about her or the team. [...] I think they [the visits] were always mid-week when he was at work. I don't think they do have any at weekends, I'm not sure. (Susanne, mother of one)

One mother - Denise, below - explained that her partner would have probably been in a position to make arrangements to attend the visits, but that this was not really discussed. Denise's comment suggests that there may be confusion or poor clarity around whether fathers' presence at visits is considered desirable by the service:

Well, he [partner] did meet her [health visitor]. They didn't ask for him to be there, so I didn't think about it. I think I had one meeting late one afternoon and he came back in the middle of it and met her, you know, but if she'd asked he would have made himself available but it wasn't something that ever came up really. [...] But no, they didn't sort of like say, 'Oh, could your husband be there?' or anything, but she always asked after him. (Denise, mother of one)

Michael, one of the two fathers in our study raised the issue of the incompatibility of visit times with standard working patterns and alluded to the fact that this did not prove very supporting for him:

They [health visitors] are on a working day, I'm on a working day somewhere else, we're not going to meet. So I'd come back home and say, 'What did the health visitor tell you this time?' So I was getting everything second hand really. So I don't think that she didn't get good support, I don't think she didn't get good advice but I didn't get much. [...] I didn't feel that anybody had desperate desire to, you know, find out how I was doing and whether I was doing the right thing. They were quite sure that if they told [my wife] what to do that I would find out. (Michael, father of two)

Michael also suggested that maybe alternative forms of involvement may prove effective for fathers who cannot take time away from work:

I wondered about whether there's something around being able to phone in... my life is all about phoning in to meetings. So why not do the same with my kids? I mean it's better than not being there. (Michael, father of two)

Home visits have the potential to create the conditions for fathers to learn more about the services and to think about whether and in what way they would consider engaging with the service. This is the case regardless of whether fathers engage actively in the conversation with the health visitor or take a back seat, which was a rather frequent occurrence according to mothers in our study.

Fathers in the 'back seat'

As reported by their partners, some fathers had a fair degree of understanding of what health visitors could help with and what activities were on offer at the Children's Centre. However, they tended to take a back seat in the interaction with services and let their partner lead it, although they might suggest contacting the health visiting team if both parents were in doubt about the child's health or behaviour. Natalie's partner had attended one or two groups at the Children's Centre and found them useful. He would encourage her to contact the health visitor if she was concerned about their child:

He, you know, if I say to him, 'I'm worried about such and such a thing,' he'll say, 'Well, phone the health visitor and she'll tell you.' He's quite good from that point of view. (Natalie, mother of one)

Some mothers ascribed their partner's reluctance to proactively engage in communication with the health visiting team to their personality, others to the habitual dynamics in the couple. Both Jennifer and Helen, below, commented that their partner would not contact the health visitor because he was just 'not that type of person':

I think he's just not that type of person, to be honest; he's quite shy around like people he doesn't know. I think he would rather... like he would probably speak to me and get me to like call them. (Jennifer, mother of two)

I don't reckon he'd ring her, no, but he's not that type of person. He'd tell me to ring her, because he woke in the night last night and we were like, 'Oh God, we shouldn't be doing this anymore.'

He was like, 'Ring the health visitor and ask her.' But he wouldn't ring, but in our relationship he doesn't do that type of thing. (Helen, mother of two)

Vicky explained how the health visitor would try to engage her partner on the few occasions when she met him at a home visit. However, Vicky described her partner as not really the type to get involved:

Interviewer: So was the health visitor trying to involve your husband as well, or did he take an interest...?

Vicky: Generally it was more her. My husband is sort of, well, he's not shy but he's not, it's not that he's not interested either, but he doesn't usually see stuff and he doesn't really get involved, if I'm chatting or whatever. But, no, she did speak to him a little bit and ask him how he was and said to him that we were both entitled to counselling together, and she thought that it would be good if we both went as well; I'm not sure if she said together, I can't remember. So yes, she did make an effort with him definitely. But most of the time he was at work when she came round, but this once she did see him... (Vicky, mother of one)

Some mothers were happy with their partner being less involved, as they felt this division of labour worked for them, as was the case for Florence:

He takes more of a back seat but then that's just, I talk more than he does. He's quite a quiet person. So that's just our whole dynamic is that I tend to do more talking in most experiences, because I talk too much and he doesn't talk enough. [...] I mean, at the ten day thing they [health visitors] have their list of things and they ask him as well, like, 'Do you smoke? Do you do this? Do you drink?' and those kind of questions. He was involved in that because he had to answer those.[...] I mean, I think, for us, it doesn't matter that he wasn't the most involved because it's just how our thing works. He's supportive, I do the main talking because I do the main caring and it works for us but I think the service probably, for most dads, feels like it's not as accessible as it could be but then I don't know how you could really make that different. (Florence, mother of two)

Fathers who were not proactive in interacting with the service might benefit from the opportunities afforded by home contact to hear what the health visitor can offer for their family's health and to begin to explore whether they would consider engaging more with the service. However, if home contact is limited due to the incompatibility of visiting times with fathers' working hours, these opportunities might prove rather limited.

Engaged fathers

In some cases, fathers were more directly engaged in the conversations taking place during the home visits. Lynda described how her partner met the health visitor serendipitously at the new birth visit and how he then took leave from work for further meetings with the health visitor with a view to supporting Lynda through her post-natal depression:

He was around when they first visited and he attended some of the visits I had after [my daughter was born] with my postnatal depression, he was there for some of the visits. He kind of stood up and helped in... because he had a few concerns himself because I lost a lot of appetite, I lost a

lot of weight and he was concerned that my health wasn't how it should have been. He took a lot of time in speaking to them and taking advice on how to help me. So he was very supportive in seeing them. (Lynda, mother of two)

In the case of Hayley, her partner's previous work arrangements (his workplace was very close to their home) made it feasible for him to attend the home visits, which proved helpful to both:

He could kind of flit in and out and he was around more then. So he'd be there when they [health visitors] came and [unclear word - ?children] got weighed and that kind of thing. He's never been to a clinic. He's never brought the children to get them weighed by himself. He's just not like a completely hands-on dad; he's more of a... he's sort of just there, bless him. But he's been there a few times when [the health visitor] has come around to see me with [our youngest daughter].[...] And he has been there and so, yeah, he does understand and know what they're all there for and things.... (Hayley, mother of three)

Mothers who welcomed their partner's involvement in the home meetings with the health visitors, described the health visitor's approach and skills in addressing both parents. In the case of Lorraine, the health visitor was skilful at involving not only her partner but also her mother, when she happened to be present at a home visit:

She [health visitor] actually spoke to both of us. He obviously had had a baby before, so he knew a bit more about what to expect and things, but yeah, she spoke to both of us. And then the second time I think she came and saw us when I was at my mum's and, yeah, she spoke to mum. She was very good with everybody, yeah. [...] He [my partner] was happy to speak to her because he liked to know what to expect and make sure everything was fine with [our daughter]. So yeah, he was pleased. (Lorraine, mother of one)

Louise, below, was very appreciative of her health visitor's efforts to involve her partner – who was not working at the time – during the home visits. She described the health visitor's strategy to alleviate the father's anxiety around 'baby stuff':

...because [my partner] is very much where he's like standing on the sidelines, 'Baby stuff, I don't want to know.' So she [the health visitor] said, 'Oh yeah, you could do the registration form for the Children's Centre and all that. So he filled that in. You know, she was talking to both of us. So that was nice, she involved [my partner] in what conversation... it wasn't just for me... (Louise, mother of four)

Roxanne identified her partner's anxieties around handling the baby; she explained that her partner would ask 'typical dad questions' and mentioned that the health visitor's friendliness was a factor in making the interaction comfortable:

Roxanne: And I think he was asking some other things, like typical 'dad' questions, because he was very scared at the start, you know like of breaking him and things? [...]

Interviewer: So, it was a comfortable enough setting where everyone felt... Because you said that you felt comfortable asking questions, and your partner did as well.

*Roxanne: But she's [health visitor] really friendly though, she's like really, really friendly .
(Roxanne, mother of one)*

On occasion the health visitor sought to involve the father by showing an active interest in him:

And she [health visitor] would ask him [partner] where he worked and how he was doing with his work, and he was saying to me that he felt positive in saying stuff to her because he felt like she cared, if you know what I mean. She was very interested. (Lisa, mother of one)

Michael, one of the two fathers in our study, painted a detailed picture of how during the home visits he had tried to offer practical help – by making tea or entertaining their older child – to his wife, so that she could focus on her conversation with the health visitor. His wife had been very ill after the birth of their second child, and the health visitors were very supportive:

It's very good that we did get a lot of support service from that [hospital admission]. My perspective on it though was that they didn't come to see us, they came to see [my wife]. And I suppose what I'm saying is, is there a missed opportunity there? (Michael, father of two)

In his interview, Michael expressed a careful critique of mainstream perspectives on division of labour within the home and suggested that health visiting services may be unwillingly reinforcing a gender divide in parenting by, for example, scheduling visits during standard working hours or holding group activities for fathers and mothers in which the agenda focused predominantly on mothers. Things were very different for the other father in our study, James. He was a 'full-time dad' and the main carer for his children. He therefore had regular interactions with the service, where he had very good relationships with several members of the health visiting team. He welcomed the health visitor's and support worker's visits at home:

The health visitor that I've got at the moment and the family workers that I work alongside are absolutely fantastic. They come in, see what's going on, ask if there's any problems and I just keep them updated with everything that's going on and they try and support me. (James, father of two)

As the examples above show, the involvement of fathers with health visiting services varied across a broad range, from impossible contact due to work commitments, to back seat presence, to active interaction with the services. Across this range of possibilities, health visitors actively sought to involve fathers in the conversation, especially at the first visit, but it could often prove difficult to maintain contact and encourage further participation in home visits over time. Cynthia highlighted how overall fathers were 'getting a raw deal' with family support services:

Cynthia: I don't think that he ever met her. I actually could probably say he's not met any of the workers that we've had, because he's been at work.

Interviewer: And do you think that there is any advantage in involving fathers? And how could that be done? Have you any thoughts on that?

Cynthia: I don't know how that could be done, but it would be a definite advantage. I think men have it easy to a degree, of course they do. When he's out at work he's just like, 'Yes, whatever, I'll deal with what I do best at work.' [Laughs] But I think they get a raw deal really. They don't get the level of support. When I think that he's [partner] not met any of these people, you know, he's had no support whatsoever at being a new dad and he's not found it easy. You know, it works both ways and he is a parent as well and he has to deal with her [our daughter] and he has to deal with her tantrums and everything else. Yes, it would have been great if she could have spoken to him...[...] But I know my husband, he would never phone somebody and ask for help, never. But if there was like a weekend or a morning or something like that when they did concentrate on just going to see dads that would be absolutely excellent, wouldn't it? Because I think that they get a raw deal. I do think that they get a raw deal. I mean, I know that the old fashioned way is that dad is the bread winner and goes out to work, and I know that's not every family but it is the majority of families and if dad gets no support whatsoever then it's no wonder that some dads may struggle. And I'm sure they do. (Cynthia, mother of two)

Cynthia acknowledged that fathers can also be in need of support and raised the question that services might still be rather mother-oriented. She also suggested a dedicated time outside office hours for home visits to fathers as a potential strategy to enhance the engagement of fathers with family support services. Similar suggestions were voiced by some mothers in our study with reference to the accessibility of clinics and Children's Centres to fathers. We illustrate these shortly but first we take a look at the cases in which it was more appropriate for health visitors not to involve fathers in their conversations with mothers around mother's and child's health.

Difficult couple relationships

Some mothers in our study actually preferred their partner not to be involved in the discussion with the health visitor. Dorothy explained that she had found adjusting to motherhood very difficult and that she welcomed a one-to-one relationship with the health visitor, in which her partner was not necessarily involved:

I think with it all, I felt like I wanted it to be my time for me to speak to somebody. Dorothy, mother of one)

At the same time, Dorothy also appreciated that the health visitor could help her with their strained relationship:

At times I did kind of want the health visitors to kind of explain to [my partner] how I felt. So rather than the case of when I had to explain to [my partner] how I felt it didn't start an argument or I didn't break down in tears or whatever else. (Dorothy, mother of one)

Annette's partner had communication difficulties. She found that the health visitor was able to help her to relate to him and explain herself in a way that worked for him:

So she came round and basically sort of helped me talk to him a bit better, and tried to find out information on his thing that he's got so that was nice that she was sort of there and really supportive. And it was nice that he was able to talk to her as well because it wasn't like she was one sided, she was giving us both information. (Annette, mother of one)

Hillary, below, went through a very difficult time with her partner. Her health visitor tailored her visits to Hillary's expressed need for having one-to-one encounters but was also able to support her in working to improve towards healing her relationships with her partner. Here is how Hillary described this support:

Hillary: I just jumped into a relationship too fast. [...]

Interviewer: And did the health visitor help you to work through things with him or not?

Hillary: Yeah.

Interviewer: And was that good?

Hillary: It was very good, yeah. She said I should start doing more stuff with him. But yeah, it really helped. I said I don't want him here. Because she always used to ask me, 'Do you want him in the room?' And I used to say no, because he'd get in a mood if I talked about him or anything. He's weird like that. [...] She used to say, 'Do you want him in the room? You don't have to have him in the room.' He just used to go upstairs, or he'd just go out. It helped really. I don't know, I just didn't want him in the room at that time. When I used to talk about him he just shrugged his shoulders or he'd say little comments. (Hillary, mother of two)

In the experiences of mothers in our study, health visitors visiting them at home were skilful at assessing the mother's preference and behaving accordingly towards the father. When it was important for mothers to have a one-to-one relationship with the health visitor that did not include their partner, health visitors would accommodate this but they would also try and support mothers through relationship difficulties and contribute to creating a better environment for the child. Child health clinics and group activities at Children's Centres offered additional opportunities for fathers to spend time with their children and ask for help and advice if they had any questions. In the following section we explore the experiences parents in our study had of fathers' engagement with health visiting services outside the home.

6.3.2 Opportunities for fathers' engagement outside the home

Health visiting teams would let parents know that fathers were always welcome to attend the child health clinic and/or group activities at the Children's Centre. Some of the Children's Centres we visited displayed leaflets addressing fathers and pictures of activities at the centre in which fathers

took part. Attending groups and clinics could, however, prove difficult for fathers for different reasons. The two main reasons in our data were the incompatibility of the timing of activities with fathers' working hours, and the fact that services could be perceived by fathers to be mother-focused.

Annette described how welcoming and father-friendly the Children's Centre she attended was:

Oh yeah, definitely they always encourage like for this young parents group they always encourage dads to come along, and before he was working he did actually come to some of the young parents groups. And it's good as well because they do get the dads involved, they do things, they sort of promote it more than sort of the mums because you know that the mums are always there, mums always in the background somewhere. So they sort of encourage and promote the dads to do more stuff with the children and it is nice, it sort of really encourages dads. Even the breastfeeding café, like they do encourage dads to come. There aren't many dads that come, but when they do they really welcome them, they really encourage them to come in because it's such a lovely experience for a dad to be involved. And it's a big step for them as well to come into a room full of breastfeeding mums..., (Annette, mother of one)

However, for both fathers in our study going to clinics and 'groups' had been a less than positive experience, mainly due to the nature of the groups themselves. Michael commented that he felt uncomfortable attending the groups not because of the approach of the health workers but because of the reaction he perceived in mothers:

Michael: It's quite... a mum and baby focused environment. We went along to... I took [the children] up to a messy play thing, and... you see, the odd thing about that was I really struggled to integrate in the group and it wasn't really the healthcare workers that were struggling to integrate with me, it was the other mums. They weren't really quite sure what to make of this bloke.

Interviewer: You were the only dad I take it.

Michael: Yes, yes, and [my wife] tells me that she's seen other dads there and maybe I just had a bad day but... and that's something that's happened in other places, non-healthcare places I've been to. A lot of the other mums are a bit dubious about, 'There's a dad here.' And sometimes you get a couple of dads and they sort of stuck together in the corner and talked about football. [...] I think it comes back to what I was saying at the beginning about culturally people find it a bit strange that you're there doing it, particularly around our sort of area, you always feel that this is sort of, 'Hasn't he even got a job?' [laughs] (Michael, father of two)

The other father, James, who was the main carer for his children, attended the local Children's Centre regularly and described the team as 'a family'; however, he also noted that a mother-dominated environment could be intimidating:

James: It would be nice to see more dads in here, in the centre, because I think it's on a Tuesday, I come in here to talk to [my family support worker] before taking [my son] to nursery and all I see is

mums coming in here and there's like hundreds of mums sitting out in that area waiting to get their child weighed but I don't see no dads about. And that is really annoying.

Interviewer: Why is it annoying?

James: Because I do so much for my kids and I can see the perspective that the female has on bringing up their kids. (James, father of two)

James added that fathers who were in relationships probably did not realise how children were being influenced mostly by their mothers and that he himself had only started noticing after breaking up with his partner. He suggested that a mixed environment – ‘mixed groups where there's some just father groups and then actually couple groups with their kids’ – at the Children’s Centre would encourage fathers to become more involved.

Some mothers appreciated that fathers might find it difficult to be in such numerical minority. Paula, for example, reported her partner’s reaction the only time he attended the child health clinic:

He's not come to clinic. I have said to him, 'Dads do come, you are welcome to come also.' No, I tell a lie, I think he did come once, but on that occasion it was mostly mums and he felt a little bit 'oh'... He knows he's allowed to come, and he's welcome, but he just doesn't. [laughs] (Paula, mother of two)

However, this was not the experience of all fathers. Maddy explained how her partner would be more than willing to take their older daughter to group activities at the Children’s Centre:

He has come to the groups, when he has holiday and things, he has come to the groups with [our daughter] instead of me, once or twice. Obviously he doesn't get much holiday. So he's happy to come in here and join the groups and things had he not really been here before. So he feels comfortable coming here and this environment felt...[...] I think he has enjoyed it when he has been able to come, yeah and when I was in hospital with [my other child] I think he came to the group with [our daughter]. So he's happy to do that... (Maddy, mother of one)

In the case of Maddy it was the opening hours of the Children’s Centre that made it difficult for her partner to take their daughter to group activities. Another mother, Louise, argued the case for father-only activities as an opportunity for fathers to feel less intimidated and spend ‘quality time’ – as she called it – with their children. She commented:

I think dads should be involved and I think a lot of dads feel that they shouldn't come or they can't come, it's just for women or whatever, you know? But I think if there was something where it was more male orientated... it's nice to see mums and dads together, of course, for their children as well to see that, but I think maybe more dads would come if they gave like a little thing where just dads could come, you know? Maybe they would come. They'd like that. (Louise, mother of four)

Louise said that things had changed significantly from when she had had her first child. At that time she would not have expected to see fathers attend child-oriented services. She said that more could

be done but she also commented that in her experience a lot of mothers would welcome fathers' participation in group activities:

I've never noticed any of the other women with... like, say the women who are breastfeeding, I've never felt them feel intimidated. I've never noticed that myself when the men come in. And, you know, I've heard [the health visiting team member] say quite a few times, you know, 'You're always welcome to come. Your husband can come, your boyfriend, whoever, friends can come. You can bring anyone with you.' And I think I felt a lot of people felt very positive about the men coming. I personally thought it was really nice to sit here and either dads would come on their own or with their wives or girlfriends and I thought that was really nice. (Louise, mother of four)

May, who attended the same centre, also commented on how pleased she was to see fathers coming to the groups:

I think men actually find it harder to make friends because, like, there's a guy who does come to the group, because he lost his job so his girlfriend had to go back to work, and he comes on his own and he's brilliant. I love seeing him with his little boy. It's so beautiful and it is nice to see them having that one on one time. (May, mother of one)

As the data throughout Section 6.3 has shown, from the perspective of mothers and fathers in our study, the dynamics at play in interactions between health visitors, health visiting services, mothers, and fathers are influenced by many factors. Whilst health visitors are generally inclined to engage with fathers within the home and at Health and Children's Centres, this engagement is hindered by the incompatibility of home visits/group activities and fathers' working hours; the largely mother-dominated nature of health visiting settings; and prevailing social expectations of gender roles in parenting. Occasionally, when there are difficulties in the relationship between mother and father and the mother is keen to have a one-to-one interaction with the health visitor, fathers' engagement may not be appropriate and health visitors need to have the sensitivity and skills to elicit and understand the mother's preferences and act accordingly. We discuss the significance of these and the other findings examined thus far in the next section.

7. Discussion

In the previous section we looked closely at conversations with parents (mostly mothers) who had had some form of sustained contact with the health visiting service as part of a Universal Plus or a particularly engaged Universal level of 'family offer'. In this section we draw out the central messages of our analysis and examine them in relation to the questions that we set out to address in this study. In doing so, we also explore some of the ways in which our findings link to the health visiting literature we examined in Sections 2.2 and 5, and in our *Why health visiting?* review (Cowley, et al., 2013). In Section 7.2 we outline some useful links between our findings and healthcare research more broadly. Through this exercise, we aim to illuminate connections and relationships between different bodies of academic work that have the potential to enrich health visiting research and enhance cross-fertilisation between disciplines.

7.1 Addressing our research questions

In this study, as detailed in Section 3, we aimed to address four fundamental questions:

- 1) What is already known about service users' experiences of health visiting?
- 2) What aspects of health visitors' practices do service users find valuable and enabling?
- 3) What service would parents like to see available (and how do these match the new service vision)?
- 4) What combinations of professionals and forms of teamworking do parents find most helpful?

Here, we discuss how our findings relate to our original research questions. We examine questions 2 and 3 together as they are tightly interwoven in parents' accounts of their experiences.

7.1.1 Research question 1: What is already known about service users' experiences of health visiting?

A focused review of the literature on service users' views of health visiting

Our focused review of the literature on service users' views on health visiting adds further depth to the findings from our *Why health visiting?* scoping review (Cowley, et al., 2013), which we summarised in Section 2. Drawing together research studies that explore – to greater or lesser degree – service users' views and experiences of engaging with health visiting services, we confirmed the importance of service user-healthcare worker relationships for family health and wellbeing, which we also discussed extensively in our earlier review (Cowley, et al., 2013). However, almost all the research identified in our earlier work referred exclusively to relationships between health visitors and parents, rather than to the wider team. We noted a dearth of research about skill mix teams or collaborative work across community services. The present study is, therefore, new in identifying that successful

relationships can be forged across the wider team. Indeed, **successful relationships between parents and health visiting team members allow the service to offer the best support possible to family and parents to perceive and appreciate this support.** These relationships prove enabling when based on trust and grounded in person-centred and culturally sensitive approaches to family support. In *Why health visiting?* (Cowley, et al., 2013) we discussed the fundamental principles of the health visiting ‘orientation to practice’ – e.g. the adoption of salutogenic, person-centred, and human ecology-mindful approaches to practice and the cultivation of health visitor-client relationships – and how these have strong roots in the history of the profession, pp80-82, (Cowley, et al., 2013). However, our focused review on service users’ views of health visiting highlights that, despite these health promoting and collaborative foundations of health visiting work, research that explores the language and practices of collaborative approaches to family support and of service user active involvement in service design, delivery, and evaluation is scarce in the health visiting literature. We also found that research on fathers’ engagement with health visiting services remains scarce and that, similarly, the needs of specific groups of the population (e.g. travellers, homeless people, minority ethnic groups) with whom historically the service has found it difficult to engage, remain largely underexplored. In the following paragraphs, we examine how our empirical work adds to this body of literature by offering more in-depth understanding of the interpersonal and organisational features that contribute to parents’ perceptions of adequate support.

Traditionally the discourse in health visiting has been concerned primarily with an epidemiological focus and public health (Welshman, 1997), which is associated with risk factors and assessments that centre on the child (Cernik, Kelly, & Grimes, 2007; Cowley, et al., 2004). The use of pre-defined needs assessment schedules suggests that health visiting activity can be sanctioned and clients’ needs supported only if they reach the threshold of pre-determined, epidemiologically-defined risk. However service users’ experiences of health visiting indicate the importance of shifting the discourse (and service orientation) to focus on service users’ personal values, beliefs and preferences about parenting and their attitudes to seeking support or accepting standard care (Lee, Turner, & Bate, 2011). This perspective of health visiting has been described as being ‘client-centred’ (Machen, 1996) or a ‘person-in-context’ approach to health improvement that is mindful of and responsive to multiple, inter-related influences on health (Bryans, Cornish, & McIntosh, 2009).

7.1.2 Research questions 2 and 3: What aspects of health visitors’ practices do service users find valuable and enabling? What service would parents like to see available (and how do these match the new service vision)?

Fostering supportive relationships and addressing unhelpful approaches to practice promptly

Our empirical findings provide useful insights into the aspects of health visiting practice that parents find most effective in providing the support and advice that they seek from the service. For clarity of analysis we operated a somewhat artificial distinction between aspects pertaining more strictly to the interpersonal dimension of professional-service user interaction, and aspects more closely linked to

the organisational structure and systems. These two levels of course overlap extensively and are not identified as distinct by parents; however, they have analytical value in that they help us to practise a useful exercise in shifting perspective between the interpersonal level of service delivery and service organisation and policy. Our findings were consistent with those of previous studies, including Cowley's (1991) work showing that the ability to shift conversations and attention across levels was a purposeful approach used by health visitors to enable positive relationships and continued engagement, and the more recent study by Bidmead (2013), showing the potential impact of organisation on the ability of health visitors to form and maintain relationships with parents (e.g., by encouraging or inhibiting continuity of care). Our findings confirm this – but also offering richer understandings of the reasons why – **parents appreciated and valued feeling 'known' to the professionals in the team and perceiving that professionals cared about them and their family circumstances, were willing to listen to their concerns, and could address their questions respectfully and sensitively** (Chalmers, 1993; FPI, 2007; Knott & Latter, 1999; Machen, 1996; McIntosh & Shute, 2007; Mitcheson & Cowley, 2003). The importance of relationships between parents and health visiting team members that were based on trust¹⁶, familiarity, and tailored advice (e.g., Bryans, 2005; de la Cuesta, 1994a; Jack, DiCenso, & Lohfeld, 2005; Shakespeare, et al., 2006) stood out clearly in our findings, reaffirming the importance of exploring in more depth how these relationships develop and the organisational contexts that foster them. Further, the importance of the health visitor 'being known' to parents (as well as the health visitor getting to know parents) is well-established in the literature about reciprocity within the relationship (Bidmead, 2013; Chalmers, 1992a; Cowley, 1991). There is also some evidence that, if they feel sufficiently secure, parents use the opportunities afforded by contact with health visitors about 'legitimate' issues that can be openly admitted, such as child-centred and clearly health related topics (like immunisations, feeding advice, weight) to raise more intimate and potentially significant concerns, such as mental health, mother-focused or parent relationship issues (Collinson & Cowley, 1998b).

Although the majority of parents in our study had experienced positive, helpful interactions with their health visitors and health visiting teams, the accounts from those parents who felt that their needs had not been met by the service highlighted the significance and consequences of poor experiences for future engagement with the service. The health visiting literature reports on parents' experience of feeling judged by professionals or nervous about their approaches to interaction (e.g., Knott & Latter, 1999; Machen, 1996; Peckover, 2002). Whilst providing rich accounts of what parents find disempowering in their interactions with members of the health visiting team, **our analysis also points to the role that unsatisfactory encounters can have in causing parents' subsequent disengagement from the service.** Our analysis stresses the importance of ensuring that unhelpful practices are addressed effectively and promptly. We suggest that this is likely to require systems that

¹⁶ A small number of parents made explicit reference to trust being mutual – being able to trust the member of the health visiting team but also feeling 'believed' by them. Although this was not one of the main themes emerging from the data, we think it might constitute an important dimension of health visiting relationship that might benefit from further research. (see also Bidmead, 2013).

provide professionals with the tools and resources to critically examine their behaviours and practices and to develop corrective measures in sensitive and constructive ways.

Ensuring effective coordination of support for parents and their children

As we discussed in Section 5, 'coordination' emerged as a significant theme in the literature on service users' views on health visiting. Our analysis of interview data also shows that, in parents' engagement with the service, **effective coordination of care (e.g. appropriate referrals to other forms of healthcare and/or social support, coordination of health visiting team transfers, coordination of transitions from the support of one professional to that of another) contributed significantly to creating a good experience of the service for parents.** The more seamless parents perceived care to be, the more they reported being able to manage or come to terms with difficult circumstances. This was particularly evident for those families in which a child had complex health and social care needs. Establishing conditions for a smooth 'service journey' is particularly helpful in these circumstances and, once more, the individual components are well established in the literature (see Section 2.2 of this report; Collinson & Cowley, 1998a; Hanafin & Cowley, 2006).

We also found that the way in which **certain transitions in family support, and in particular that from antenatal care to health visiting support, are managed is central to parents' perceptions of health visiting and their engagement with services.** First-time parents in our study often learnt about health visitors from the health visitor themselves, at their first visit (see also discussion of research question 4, below). Mothers in our study reported having had little information about health visiting services, their scope and organisation as part of their antenatal care. Our study supports the promotion of stronger collaborative work between health visitors and midwives and of antenatal health visiting contacts with future parents, as recommended in current policy (Department of Health, 2011; Shribman & Billingham, 2009). We suggest that parents would benefit from having accurate and detailed information about health visiting services and the opportunity to discuss it if they so wish in the antenatal period. At this time, parents might be less burdened by the emotional and practical demands that often characterise the first few weeks after childbirth, and therefore more able to process complex information about services and to ask questions and clarifications about the support that will be available to them after the birth of their child. In addition, antenatal encounters between parents and health visitors have the potential to contribute to the lessening of parents' anxieties around the early postnatal period and to offer health visitors the possibility of early identification of issues that might require more sustained postnatal support.

A reliable service offering support at home and outside the home

We found that the clinic and the group activities at the Children's Centres had at least three very important roles in parents' successful engagement with, and perceptions of receiving support from, the service. First, **child health clinics supervised by a health visitor represented an important point of contact when queries and doubts that did not require immediate attention arose.** Second, **regular child health clinics and group activities facilitated ready access to a health visitor and opportunities for social interaction with other parents.** Parents found it helpful and

reassuring to know that they could attend the clinic on a scheduled day and discuss any questions or concerns they may have with a health visitor. Similarly, they appreciated being able to attend group activities as this helped them to 'get out of the house' and – often – to make new acquaintances and exchange information, experiences, and advice with other parents (predominantly mothers). Finally, **the availability of different professionals at Children's and health centres facilitated parents' choice.** It allowed parents to engage with different professionals and to explore possibilities for relationships when they were not entirely happy with their initial experience of contact with the service. In other words, being able to hear the advice and test the approaches of different health visitors or other workers in the team, allowed parents who were sceptical about engaging with services to identify the team member with whom they felt most comfortable and in tune and who could relate to them as individuals. In several cases, this helped to sidestep unsatisfactory experiences with the service and led to the development of links that were perceived as acceptable and helpful.

We suggest that these findings highlight the **importance of consolidating a health visiting service that combines home visiting with opportunities for support and advice outside the home** (at the Universal and Universal Plus level of the family offer and potentially also at the other levels of service provision). We found that both these health visiting modalities were central – at different times and/or in different combinations depending on a family's circumstances and changing needs – to parents' experiences of feeling supported at a difficult time. In our *Why health visiting?* report (Cowley, et al., 2013), we discussed how the health visiting 'orientation to practice' influences the way health visitors work in any situation and particularly in the delivery of Universal services, and how three core practices operate together at this level: 1) the health visitor-client relationship, 2) the health visitor home visiting and 3) the health visitor needs assessment (see Chapter 4, in Cowley, et al., 2013). **We suggest that health visiting support outside the home can be seen to represent a fourth core practice that complements and supports the existing triad.** A survey of 980 caseload-holding health visitors (Cowley, Caan, Dowling, & Weir, 2007) demonstrated that their activities were fairly evenly spread between home visiting (which was the most frequent) telephone consultations, child health clinics, consultations at the clinic/base, and development checks. The same health visitors reported frequently engaging in liaison and collaboration, also running support and parenting groups, or antenatal parentcraft and health education sessions.

From the accounts of the experiences of parents in our study, suggestions can be made for improving child health clinics and group activities (for example, promoting antenatal contact with health visitors, creating more opportunities for father-focused activities, increasing flexibility in timing of clinics and groups¹⁷). More could be done to encourage parents to share their experiences and knowledge with health visiting practitioners and lay workers/volunteers in a 'reciprocal network of help'. Health visitor-facilitated parenting support groups, based around notions of social inclusion (Beresford & Branfield, 2006), community health assets (Hufford, West, Paterniti, & Pan, 2009; McKnight & Van Dover, 1994;

¹⁷ Parents in our study also suggested other small changes to the service: ensuring clinics gave opportunities for confidential conversations and reducing waiting lists for high-demand activities such as baby massage. These were occasional suggestions and do not appear in our data only because they were not part of the main analytical themes.

Piper, 2011), self-efficacy (Whittaker & Cowley, 2012), and experiential knowledge/expertise (Borkman, 1976; Burda et al., 2012), could help to build capacity for parental support at a community level and help to empower service users to address issues that matter to them (Piper, 2011). Parenting support groups may also help individuals to identify relevant and achievable notions of 'good-parenting' (Partis, 2000) and define suitable parenting goals (for example around child feeding, family health or behavioural issues) rather than applying population targets or ideals to individual situations (Barlow & Stewart-Brown, 2000; Hoddinott, Craig, Britten, & McInnes, 2012; Naish, 1995; Scott et al., 2010; Shakespeare, et al., 2004). They could also provide opportunities for professional learning and development (Parker & Kirk, 2006) and to gain a fuller appreciation of service users' support needs (Whittaker & Cowley, 2012). Whilst general recommendations about clinic arrangements and community centre organisation would be inappropriate as local circumstances, resources, and priorities would need to be assessed by practitioners and managers for each health visiting team. This finding highlights the importance of harnessing parents' input for service development, to which we now turn.

Harnessing parents' views and experiences

Our findings highlight the potential that engaging more with parents and making use of their experiences and feedback would have to inform local service providers' strategies for service improvement. At present, many health visiting teams lack the resources or the support to systematically gather service users' feedback to inform direction of travel and more responsive and evidence-based service provision locally (Grant, 2005b). Whilst local survey data may act as a screening tool to identify potential problems in healthcare services, they do not always provide sufficient detail of what to do to improve that service (Tsianakas et al., 2012). It is therefore important to consider the types of service user experience information that are (or could be) collected (Reay, 2010), the way in which such information would be used alongside other forms of evidence of need and public health information (Goodwin et al., 2013; Sargeant, Heaps, & Miller, 2007; Williamson, 2010), and how best to support health visitors to implement innovations and sustain improvements (Lindley, Sayer, & Thurtle, 2011; Plumb, 2006; West, 1989). One-off or periodic surveys of service users' views – one of the most easily implemented systems for gathering feedback – risk missing the essentials of what constitutes service users' experience of a service (Robert & Cornwell, 2011). As Robert and Cornwell (2011) highlight the mismatch between what many current surveys measure and 'what patients want,' arguing that 'information for patients to support decisions and choices has to be service specific, recent and relevant to "what matters most" to them' (Robert & Cornwell, 2011, p9). Some participants in our study said that the interview was one way they could 'give back' to the service that had helped and supported them. One parent felt that taking part in the research was a useful way to offer minor criticism in a constructive way. Although these comments were sporadic, they invite further reflection around whether services could benefit from more systematic and engaging ways of harnessing service users' input. Individual NHS Trusts and services would need to develop systems that are appropriate and sustainable in relation to local resources and circumstances, but we suggest that systems based on active consultation processes – e.g. regular

group discussions for staff and parents, video diary booths, comments and suggestions boxes, celebrations of success and achievements with planning for improvement – may help to develop health visiting services that are more in tune with and responsive to the needs of their local communities. More interactive approaches allow health visitors and parents to deliberate and build understanding about individuals and communities; they could also support shared decision-making and partnership development over time.

Researching fathers' needs

Our findings also illuminate the barriers to and complexities of providing adequate support to fathers. The health visitors described by parents in our study were skilful at taking into account mothers' preferences for fathers' involvement. Where appropriate, health visitors actively invited fathers' involvement in consultations at home and promoted – alongside staff at Children's Centres – fathers' participation in group activities for parents. Direct contact between health visitors and fathers was, however, dramatically limited by the incompatibility of visiting times with standard working patterns, although our data suggests that alternative solutions could be found to increase fathers' opportunity to engage in home visits (e.g. listening in over the telephone). Our study also supports evidence from the literature that fathers who are willing to engage with the service may face an intimidating and potentially uncomfortable environment that is more geared towards the needs of mothers (Bayley, et al., 2009; FI, 2011; Greening, 2006). In addition, fathers who struggle in adjusting to fatherhood and to the changes in the relationships that this can entail may not immediately identify health visiting teams as a possible source of help and advice, especially if their relationship with their partner is strained or fragile and health visiting support is focused on mother and child. *The Healthy Child Programme* (Shribman & Billingham, 2009) places strong emphasis on the importance of involving fathers in communications and exchanges with support services. **We suggest that health visiting teams work together with parents to devise effective strategies for fathers' engagement with sources of advice and support. We also suggest that more thinking and research are needed to develop systems that foster this involvement appropriately and successfully, for the benefit of all families.** We propose that research collaborations and consultation exercises should involve professionals, managers, and commissioners, but also parents, academics from different disciplines (including, to mention only a few, organisational development, gender studies, philosophy and sociology of healthcare, etc.), and relevant independent think tanks (e.g. The Fatherhood Institute). Finally, this study raises the issue of whether health visiting services need to explore the extent to which they may be unwittingly reinforcing prevailing social stereotypes and expectations about the gendered division of labour in parenting and child care.

7.1.3 Research question 4: What combinations of professionals and forms of teamworking do parents find most helpful?

Roles and responsibilities in health visiting teams from a parent's perspective

The available evidence on parents' views and preferences in matters of skillmix and teamwork arrangements is limited, e.g., little is known about parents' views of lay workers taking on activities and roles traditionally associated with health visiting (Mackenzie, 2006; Perkins & MacFarlane, 2001; see also Cowley, et al., 2013). Our findings indicate that researching parents' views and experiences of this dimension of health visiting work may prove rather problematic, as parents struggle to identify individual roles and responsibilities within the team. Many parents in our study, especially first-time parents, were unsure about the designations of health visiting team members that they had been meeting regularly. **Roles in health visiting teams can be unclear – if not completely obscure – to first-time parents until their first routine postnatal visit.** Indeed, we found that **roles and responsibilities often remained unclear also to parents who experienced only minimal contact with the service with their previous children**; in these cases it was only when problems with the child were encountered that parents had the opportunity to appreciate the full scope of health visiting support. We strongly suspect that all health visiting team members introduce themselves on making contact with parents and carefully explain the remit of their work. However, our data suggests that this information is received by parents at a time when they are unable to take it in properly. We suggest that, in view of the expansion of health visiting being implemented by the Government through the *Health Visitor Implementation Plan* (Department of Health, 2011) and the standardisation of the structure of the health visiting offer across England, **it would be useful to consider whether action is required to promote better understanding of the role and function of health visiting support amongst the general public.**

We found that parents in our study had developed strong enabling relationships with various members of the health visiting team. In the case of traumatic birth experiences or children with complex needs, parents' main point of reference tended to be the health visitor. In other cases, parents developed a strong bond with the member of the team (health visitor or other worker) who had assisted them with a specific problem (e.g. child sleep pattern; breastfeeding) and then remained a point of reference for advice and support. In this respect, our data suggests – confirming what can be found in the health visiting literature (Appleton & Cowley, 2008b; Collinson & Cowley, 1998a; McIntosh & Shute, 2007) – that **health visitors have a role in ensuring that careful assessment of family circumstances orients the type of support that is put in place for parents.** Sustained relationships providing support and effective 'scaffolding' can develop between parents and different members of the team, as long as the practitioner's skills and approaches are in tune with the preferences and communication styles of the family in question. In-depth understanding of family circumstances and a degree of flexibility in the organisation of services that enables parents to develop and foster relationships that are right for them both influence the effectiveness of family support. Hence the importance – alongside accurate health visitor assessments – of services

organised in such a way that they allow parents to come into contact – through group activities and baby clinics, as outlined above – with different members of the team, should early encounters prove not ideal.

7.2 Health visiting research and the broader healthcare context

The findings from our study echo key messages from broader healthcare research. We highlight here some of the most obvious connections to contextualise our study and health visiting research more generally within broader healthcare issues and debates. Given the emphasis that our findings – and our scoping review before it (Cowley, et al., 2013) – place on the function and value of supportive relationships in health visiting practice, it would be worthwhile, for example, to see health visiting work draw more extensively upon discussions of relationship-centred care (Beach & Inui, 2006; Tresolini & Pew-Fetzer Task Force, 1994)¹⁸. The importance within health visiting work of building relationships that are supportive and enabling for parents also resonates with Iles' discussion of the conceptualisation and organisation of care in the NHS (Iles, 2011). In particular, our work is in line with Iles' discussion of care as 'covenantal'¹⁹ (in which patients/service users and professionals are in a covenantal relationship) rather than solely 'transactional' (that is care which is understood only as a set of transactions) (2011, pp.34-38). Iles describes a covenantal approach to care as one that can be 'envisaged through the metaphor of dancing: of being active, alive, creative, present, and taking some risk – but not too much – and holding the other, involving some uncertainty and requiring a degree of courage' (2011, p.36). Iles' analysis of the essential conditions for and challenges and constraints to covenantal understanding of healthcare provision, offers useful suggestions for the analysis of health visiting practices. Also her insights on professional behaviours in healthcare and of the tensions between professional autonomy and standardisation of care practices (see in particular pp.39-46) could offer a useful lens to examine the tensions between health visitor autonomy and professional autonomy and the standardisation of certain public health interventions in health visiting practice. Such tensions were evident in Mitcheson & Cowley's (2003) study, which showed that use of a structured needs assessment tool inhibited parents' engagement and expression of their needs. Also, clashes between the expectations of parents and health service staff, including health visitors, have been reported at pivotal points, particularly in the early weeks after birth in respect of breast feeding, and again around the introduction of solids (Hoddinott, et al., 2012). However, it is still unusual to see explicit discussion in research about the impact on parents of organisational requirements placed upon health visitors.

¹⁸ in Beach & Inui's model, relationship-centred care is based on four core principles: "1) that relationships in health care ought to include the personhood of the participants; 2) that affect and emotion are important components of these relationships; 3) that all health care relationships occur in the context of reciprocal influence; and 4), that the formation and maintenance of genuine relationships in health care is morally valuable." (2006, p.53).

¹⁹ In Iles' earlier work and in other work on patient experience the term 'relational' is preferred to 'covenantal'. Iles explains that 'relational' can run the risk of being equated by readers to the idea of 'being nice to patients' (2011, p.34). She supports the use of either term, so long as the richness and rigour of the conceptualisation she advances are taken into account (2011).

In exploring the long-lasting effects that unsatisfactory and unpleasant encounters with health visitors had for some of the parents in our study, we thought of the possible relevance of approaching the study of these critical points of interaction through the lens of 'emotional touchpoints' (Dewar, Mackay, Smith, Pullin, & Tocher, 2010). Emotional touchpoints have been used as part of experience-based design processes (Bate & Robert, 2007) to explore patient experiences of healthcare services with a view to improving services (e.g., Dewar, et al., 2010; Tsianakas, Maben, et al., 2012). This method 'focuses on emotion by asking patients and their families to think about key points in the patient journey and to select from a range of emotional words those that best describe how they felt about an experience' (Dewar, et al., 2010, p.31). The identification of emotional touchpoints is fundamental to co-design approaches in collaborative work between patients and NHS staff aimed at the improvement of services (see, for example, in the case of breast and lung cancer care, Tsianakas, Robert, et al., 2012; or in the case of emergency services, ledema, et al., 2010).

Also, health visiting practice could benefit from drawing upon existing healthcare quality improvement programmes and initiatives that specifically aim to improve outcomes and experiences for service users (Chakravorty, 1994). For example lean implementation-inspired initiatives²⁰ could offer suggestions for process improvement in health care (Grove, Meredith, Macintyre, Angelis, & Neailey, 2010), and the NHS Institute for Innovation and Improvement's Productive Community Services programme could improve service users' experiences of health visiting as well as efficiency, clinical or safety outcomes (Wilson, 2009), but as with any service improvement it is the way such initiatives are implemented that is key. It would be important to listen to both service users and practitioners to ensure service improvement rather than any top down implementation to drive efficiency and cost savings for example.

We discussed earlier how effective coordination of care contributes to ensuring that parents have an experience of support that has no major gaps or sudden interruptions. This applies to one-to-one relationships and to delicate transitions from one provider to another but also to the broader sense of information transfers and care referrals being successfully choreographed. Various dimensions of continuity of care have been explored in the broader healthcare literature (for a review of the concept across different areas of practice (see Haggerty et al., 2003), offering useful analytical perspectives to the study of what counts as successful coordination in health visiting practice. In discussing this dimension of health visiting, we also talked about the 'backstage' work that health visitors and their teams engage in for coordination to prove successful. In view of the different arrangements that characterise health visiting services in different NHS Trusts, with some teams being based in health centres and others in Children's Centres and with organisation of work varying as a function of managerial structures, we call for more ethnographic approaches to research in health visiting. These would provide richer and more theoretically sophisticated understandings of the mechanisms and processes through which seamless support for parents is or can be achieved in health visiting (see, for example, ethnographic studies of formal and informal team communication in other areas of

²⁰ "Lean is a quality improvement philosophy which aims to create more value with less resource." Grove et al., 2010.

healthcare, such as Adams, Robert, & Maben (2012) on the work of community nurses in the UK; or Ellingson's (2003) work on teamwork in the cancer clinic backstage in the US). In the process of transformation and strengthening of health visiting set in motion by the Health Visitor Implementation Plan 2011-2015 (Department of Health, 2011), these understandings would prove crucial to more grounded and context-sensitive policy developments.

Finally, our study underlines the extent to which parents' perceptions of reliable and trustworthy support from health visiting services is grounded in practices that make them feel listened to and cared for. The academic literature on service user involvement in care decisions and on the benefits and challenges of shared decision-making processes (and on how these are defined and measured) is vast (Charles, Gafni, & Whelan, 1997; Charles, Gafni, & Whelan, 1999; Elwyn et al., 2001; Fraenkel & McGraw, 2007; for an overview, Donetto & Cribb, 2011). Similarly, extensive research has been carried out to examine various aspects of patient involvement in the design, development, and evaluation of healthcare services and in healthcare research (e.g., Greenhalgh, Humphrey, & Woodard, 2010, for a recent review; Crawford et al., 2002, for a systematic review; Tritter, 2009, for a conceptual analysis; Smith et al., 2008, and Brett et al., 2012, for involvement of service users in research). We referred earlier to the importance of harnessing parents' views in developing the health visiting services of the future (see page 87); we suggest that conceptual and empirical work that explores the various dimensions of service user involvement in healthcare processes and practices - as well as the connections and tensions between them - would offer prompts for reflection and comparison that would enrich health visiting research and policy.

We have briefly identified some of the possible links between open questions and themes for further investigation in health visiting practice as highlighted by our study and the broader academic literature focusing on current healthcare issues and debates. These links are not comprehensive, but they represent useful examples of how health visiting research could benefit from, and also contribute to, our evidence-informed understanding of problems and strengths in disparate areas of healthcare. We see these links as an invitation - for practitioners, researchers, and funders of research - to foster and consolidate cross-pollination between different areas of research and practice with a view to strengthening the evidence supporting health visiting policy and practice and enriching the theoretical underpinnings on which such evidence rests.

7.3 Strengths and limitations

Our study was driven by policy questions that were topical at a time of fast-paced development of services. Our research questions were refined in view of policy concerns and service improvement requirements and might not therefore capture what is most important to service users. In the future, we would consider carrying out further research on health visiting practice in which service users had the opportunity to contribute to shaping the design and focus of empirical work.

Our review of the literature was not a systematic review, and was not intended to be, so we chose a narrative approach that examined the health visiting literature and set the scene for our empirical

research. There is very little literature on service users' experiences of health visiting in the UK, and so we believe this was the best approach in these circumstances. We were also able to refer to and draw upon our large review of the health visiting literature which we believe is a real strength in this work.

We carried out interviews in EISs in England with parents who were identified with the help of health visiting teams and who volunteered to speak to us. We are confident that health visiting teams identified potential participants to meet our study criteria, but we are also aware that parents participating in our study are most likely those who have had positive experiences with the service. We realise that the ethnic background of our sample is very homogenous. Although this reflects the characteristics of the local population engaging with services at the Universal Plus level of the family offer at the participating sites, it also means that we do not have data enabling us to explore the specific issues of ethnic minorities. However, our analysis did not aim to provide generalisable findings, but to offer useful insights into the experiences of parents who are willing to engage with services in areas where implementation of the new service vision is already in progress. Our findings prompt reflections and suggestions for policy, research, and practice that are likely to prove relevant to different health visiting contexts. Whilst not generalisable, the resonance with existing literature in some cases and with broader health care issues suggests that we have captured a range of important issues that can inform future policy, research and practice.

8. Implications for policy, research and practice

On the basis of our data analysis and discussion of our findings, we outline some potential recommendations for further policy and practice development and directions for future research in the field:

- 1) Successful relationships between parents and health visiting team members allow the service to offer the best support possible to families, and parents to perceive and appreciate this support. In addition, unsatisfactory encounters with services influence future engagement. **We recommend that structures and systems²¹ are put in place or are consolidated which ensure health visitors and health visiting teams have the space and resources to critically examine how their practices and behaviours influence their relationships with parents and to develop corrective measures in sensitive and constructive ways.**
- 2) Effective coordination of health visiting support contributed significantly to creating a good experience of the service for parents. **We recommend that stronger links between midwifery care and health visiting support are cultivated and that parents' contact with the health visiting team is facilitated in the antenatal period.**
- 3) In view of the above (recommendation 2) **we also recommend that NHS trusts support current policy and practice developments aiming at facilitating contact with health visiting services during the antenatal period.**
- 4) Child health clinics and Children's Centres represent an important point of contact and allow parents to explore links and relationships at their own pace and in line with their own communication styles and preferences. **We recommend that health visiting support continues to be organised in a way that ensures rich and flexible combinations of support at home and support outside the home.²²**
- 5) Engaging more with parents and making use of their experiences and feedback has the potential to inform local service providers' strategies for service improvement. **We recommend that systems supporting the active involvement of parents and carers in the design, development, and evaluation of health visiting services²³ should be implemented as a matter of routine practice in a manner that is mindful of local needs and circumstances.**

21 Examples of structures of this kind are (but are not limited to): regular team meetings focused on discussion of interaction with contribution of all members; opportunities for training and development of reflective and reflexive skills; mentoring systems.

²² We would list 'support outside the home' as a fourth core practice to be added to the existing triad of practitioners' 'orientation to practice' (see page 86).

²³ For example: regular group discussions for staff and parents, video-diary booths or suggestion boxes; celebration events for achieved improvements, 'parents' panels' to support and comment on services in general, etc.

- 6) Fathers engage little with health visiting services and there is limited evidence on parents' views of what would count as meaningful and effective sources of support for fathers. **We recommend that health visiting services work closely with parents to improve the support they can offer fathers and call for further research to explore in depth the ways in which primary care services could support fathers.**²⁴
- 7) Research efforts examining the language and practices of collaborative approaches to family support and of service user active involvement in service design, delivery, and evaluation are scarce in the health visiting literature, as are those exploring fathers' engagement with health visiting services. **We recommend that research is commissioned to explore participatory practices in health visiting work and policy that will generate more reliable evidence on the support that health visiting can offer to fathers.**²⁵
- 8) The role of the health visitor and the health visiting team is unclear – if not altogether obscure – to first-time parents until their first routine contact with the health visitor, which, for most parents at the time of the fieldwork was the first postnatal visit in both our research sites. **We recommend that policymakers and service managers consider whether action is required to promote better understanding of the role and function of health visiting support amongst the general public.**²⁶

We also make the following suggestions:

- 1) Parents in our study were often quite unsure about the roles and responsibilities of the health visiting team member/s they had met. **We suggest that children and family services may need to address parents' lack of clarity around roles and responsibilities of members of the health visiting team if meaningful evaluation of skillmix and teamwork arrangements is to be carried out successfully.**
- 2) Several links can be outlined between topical themes in health visiting and issues and debates in the broader academic literature on healthcare. **We suggest that health visiting practice and research should strive to promote cross-fertilisation between different disciplinary, theoretical, and methodological approaches to the study of processes and practices in family and child health support.**
- 3) Research in other areas of health and social care points to the value of participatory approaches to care. **We suggest that systems based on active consultation processes –**

²⁴ Research in this area should be trans-disciplinary and benefit from the collaboration with existing independent research and support organisations wherever possible

²⁵ For example, home visits or activities scheduled outside office hours.

²⁶ We acknowledge that the move towards routine universal antenatal contacts between prospective parents and health visitors envisaged by the Health Visitor Implementation Plan is a significant step in this direction.

e.g. regular group discussions for staff and parents, video diary booths, comments and suggestions boxes, celebrations of success and achievements with planning for improvement – may help to develop health visiting services that are more in tune with and responsive to the needs of their local communities.

- 4) A few parents in our study had experience of participating in TAC meetings due to their children's complex health needs and they found these meetings very valuable. **We suggest that more research is required to help illuminate the role of health visitors in the context of TAC meetings and processes for supporting families with complex social and health needs.**

9. Conclusions

In this report we have presented and discussed the findings from our narrative review of the literature on service users' views of health visiting and from our empirical qualitative research on parents' views of their experiences of the service in two EISs in England. We hope to have provided a rich picture of the dimensions – which for analytical purposes we categorised as interpersonal or organisational – of health visiting practice that parents in our study found useful and enabling, and drawn attention to forms of ineffective interaction that can have long-lasting negative effects on parents' engagement with the service. We have discussed the features of service organisation that contribute to fostering enabling relationships, ensuring effective coordination of services and support, enhancing parental agency, and reducing parental anxieties and social isolation. We have also explored some of the factors which, in participants' accounts, influenced the extent and modality of fathers' involvement with health visiting. In discussing the significance of our findings, we have examined how they helped us address our original research questions, but have also outlined some of the ways in which they are connected to the health visiting literature and the health care literature more broadly. Finally, we have made specific recommendations for policy, practice, and research with a view to highlighting the potential practical implications of the analysis presented in this report with the intention of contributing to policy and practice developments in health visiting.

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Appendices

Appendix 1: Advisory group membership

Dr. Cheryll Adams	Director	Institute of Health Visiting
Dr. Helen Bedford	Senior Lecturer in Paediatric Epidemiology	Institute of Child Health, University College London
Prof. Mitch Blair	Consultant and Reader in Paediatrics and Public Health	Imperial College London
Dr. Crispin Day	Head of Child and Adolescent Mental Health Services Research Unit, Head of Centre for Parent and Child Support	Institute of Psychiatry
Dr. Anna Houston	Health Visitor	Kent Community Health NHS Trust
Dr Lynn Kemp	Associate Professor and Director of the Centre for Health Equity Training Research & Evaluation	University of New South Wales, Australia
Prof. Sally Kendall	Professor of Nursing, Health visiting with expertise in child and family public health and parenting support	University of Hertfordshire
Ms. Suzanne Moss	Health Visitor	Somerset Partnership NHS Trust
Ms Ann Rowe	Implementation Lead, Family Nurse Partnership	Department of Health
Ms Sally Russell	Parent and representative of users of health visiting services, Director of Netmums	Netmums, parenting advice and information in England, Wales and Scotland
Prof. Stephen Scott	Professor of Child Health and Behaviour, Consultant Child & Adolescent Psychiatrist	The National Academy for Parenting Research
Prof. Alison While	Professor of Community Nursing	King's College London

Appendix 2: Participant interview guide



Research study: “**Health visiting: voice of service users**”

Interview guide

This interview guide gives you an outline of the areas that we would like to discuss with you at your interview/group discussion. This document is only a guide, so that you have an idea of what sort of things we would like to talk about. We will not necessarily ask you all these questions. The exact questions we ask will depend on the things we discuss with you on the day.

Question area 1: We will ask you a few questions to get a picture of your family context. For example:

- Would you mind telling me a little bit about yourself and your family?
- How many children do you have?
- How old is your youngest child now?
- Who looks after your child/children most of the time?

Question area 2: We may ask you about your reasons for seeing the health visitor and/or other health professionals.

For example:

- Other than the midwife, did you see any other health professionals (e.g. nurses, doctors, health visitors) about your baby before your baby was born?
- And after? What professionals you contacted (or contacted you) about your family health and looking after the baby?
- Do you remember seeing a health visitor?

Question area 3: We will ask you about the type of contact you had with health visitors and the circumstances of this contact.

For example:

- What were the main reasons for getting in touch with the health visitor or for them to get in touch with you?
- What type of advice or support did the health visitor give you?
- Did you feel you had all the information you needed on how to contact the health visitor?
- Did you find seeing the health visitor useful?
- Did you receive the help you wanted/needed?

Question area 4: We will ask your views on the sort of services you would like to see in practice.

For example::

- Do you find that health visitors could do something different to be more helpful for family/parents like yours/you?

Question area 5: We may ask you what kind of health professional you find most helpful and why.

For example:

- What is it that you think health visitors are best at?
- What sort of things should or could be done by other health professionals?
- Do you see any other health professionals to discuss things that have to do with looking after your child?

THANK YOU VERY MUCH FOR YOUR HELP.

For further information, please contact:

Sara Donetto, Tel: 0207 848 3791; Mobile: 07576449658; Email: sara.donetto@kcl.ac.uk

Mary Malone, Tel: 0207 848 3042, Email: mary.malone@kcl.ac.uk

Appendix 3: Participant information sheet

Research study: “**Health visiting: voice of service users**”

PARTICIPANT INFORMATION SHEET

We would like to invite you to take part in the research study we are carrying out as part of a programme of research at the National Nursing Research Unit, King’s College London, which is funded by the Department of Health through the Policy Research Programme.

This information sheet provides you with all the details necessary for you to decide whether you would be happy to take part in the study. If after reading this material you are not sure about whether to take part or not, please feel free to contact one of us at the addresses below for further information. A member of our team will go through this information sheet with you and answer any questions you have. Take your time to read this information and talk to others about the study if you wish.

What is the study about?

The Government is introducing some changes to the way in which health visitors work, in order to improve health visiting in England. We are carrying out this research to learn more about how health visitors support parents and carers of young children (from 0 to 5 years old) and their families. The findings from this study will inform the way in which health visiting services are developed nationally and might also help to improve health visiting services locally.

Who is invited to participate?

We are inviting parents and carers of children under 5 years of age who have been in contact with a health visitor in the last year. For this study we are inviting parents and carers who are older than 18.

Do I have to take part?

You do not have to take part. It is entirely up to you to decide whether or not to take part in this study. Please take time to read this information sheet before you decide and feel free to ask any questions you may have. Contact details for the researchers on this team are listed at the end of this information sheet.

What will I be asked to do if I decide to take part in the study?

If you decide to participate we will ask you to speak to one of the researchers (Sara Donetto or Mary Malone). This can be in a quiet space at the Clinic/Children’s Centre or in a public place (e.g. your local library) or over the telephone if you prefer. You can have your child or another family member with you if you want to. We will ask you a few questions about you and your child/children and your experience of seeing the health visitor. We will ask your permission to record this conversation on tape. This interview will take approximately 20-30 minutes and we will provide some refreshments. We will ask you to sign a consent form, that is a piece of paper saying that we explained the process to you and that you agreed to take part in the study. With your permission, we might contact you after the interview for clarifications or to request additional information. This will happen by 30th November 2012 at the latest.

What are the possible disadvantages of taking part?

Taking part in the project will mean you will need to think about your experiences of the care and support you have received. These questions are not intended to be upsetting, but if you have had unpleasant experiences with NHS services you might have some concerns. If you feel that outside of the interview you would like to discuss these concerns please contact [details of person to contact]. Participation in this study will not affect the standard of care you and/or your family receive now or in the future in any way.

What are the possible benefits of taking part?

We expect the findings of this study to inform the ways in which health visiting is organised, and ultimately to contribute to improving services for parents, carers, and children. This may not benefit you personally at this point in time, but may help to develop services in the future. As a token of our appreciation for your time, you will receive a £10 shopping voucher.

How will my information be handled?

Only the researchers you speak to will know your personal details. This information will be treated as confidential. That means that it will be stored on paper or on a computer in places accessible only to the researchers on this project (Sara Donetto, Mary Malone, Mary Adams, Karen Whittaker and the project leader Jill Maben). Any information that identifies you – for example your name or the name of the clinic you attend - will be held by the researchers for less than three months after the end of the study.

After speaking to you, we will assign you an invented name; this will be the only name appearing next to your comments. In our reports and publications we will always use these invented names to refer to people (and places) so that it will not be possible to identify who said what. At the end of the study the research data containing only these invented names will be stored for seven years in a safe place and then destroyed, in keeping with standard research practice.

The only case in which researchers will not be able to maintain confidentiality is if a participant shares information that raises concerns about the safety of a child. In this case researchers have a duty to report this information to the appropriate agencies (e.g. health visiting team; social services).

What if there is a problem?

Given the nature of this study it is highly unlikely that you will suffer harm from taking part. However, should any problem arise, King's College London has arrangements in place to deal with any unforeseen harm arising from participation in the study. If this study has harmed you in any way you can contact King's College London using the details below for further advice and information: Professor Jill Maben, Tel: 0207 848 3060, Email: jill.2.maben@kcl.ac.uk.

Is it possible to change my mind or refuse to participate?

Taking part in the study is entirely voluntary and you can decide to leave the study at any stage, without having to give any explanation. If at any stage you are unsure about your involvement and would like clarifications on specific aspects of the study, we will be happy to discuss this with you.

We will keep information you have already provided with your agreement and use it in the research unless you specifically ask otherwise. No more data would be collected in relation to you.

What will happen to the findings from this study?

The findings from this study will be included in a report that we will share with policymakers. They may also be published in a professional journal or presented at a conference. As mentioned above, no information that can identify you will be used in this material. If you would like a copy or a summary of the findings we will be happy to send you these in your preferred format; please let the researcher know.

Who has reviewed the study?

This study has been reviewed by [name of Research Ethics Committee and reference number].

We hope you find this information sheet helpful. Should you require any further details, please contact one of us at the email addresses below; we would be pleased to answer any questions you may have. If you are happy with the information provided here and would like to participate in the project, please sign the consent form we will provide and keep this information sheet for you to read again later. You can also ask for an electronic version of this sheet and/or of the consent form should you require one.

Thank you for taking the time to read this information. Your help is very much appreciated.

Research team contact details:

Sara Donetto, Tel: 0207 848 3791, Mobile: 07576449658, Email: sara.donetto@kcl.ac.uk

Team researchers from the National Nursing Research Unit at King's College London:

Sara Donetto is a Research Associate at the National Nursing Research Unit. She has a medical background and has undertaken research in anthropology and professional education.

Mary Malone is a Research Fellow at the National Nursing Research Unit. She is a health visitor and her research interests include child and family centred public health and health inequalities.

Karen Whittaker is a Research Fellow at the National Nursing Research Unit. She is a health visitor and has a strong research interest in understanding the support needs of parents in the early years.

Appendix 4: Examples of coding and categorising from early stages of analysis of interview data

Example of early coding scheme

Code	Notes, if any
Being judged/not being judged (or given a label)	
Being listened to/not listened to	
Assessing and re-assessing relationship with professional over time (individually/with husband input/ with family input/considering investment for future/considering expectations)	
Continuity of contact with same professional	
Being known (name, names of children)	
Reassurance/praise	
Not doing things wrong/Not being a bad mum	
Trust as a two-way/mutual dimension of relationship (being believed by HV)	
Being given confidence by HV	
Being given time	
Being able to contact service/accessibility	
Getting out of the house/Meeting people	
Importance of Groups/Centre	
Relationships within the health visiting team	
Fuzziness around professional roles/services available/channels to complain/	
Parent's understanding/expectations of professional expertise for HV	
Contradictory advice	
Trusting one's own judgement as a parent	
Dimensions of what is perceived as supportive	
Fathers' involvement	
Previous bad experience with health visitors	
Things that could be improved/done differently	
Useful vignette/mini-story	

Example of early exploration of categories

1) *Transitions in care –from midwife to health visitor, from hospital care to home care etc – and how choreographed?*

>>> Now extended to include all processes of coordination of services and transitions between services. One of the distressing aspects of people's experiences was the lack of reference points and frequent poor attention to making transitions as smooth and non-disorienting as they can possibly be.

2) *What makes an experience with a team a good/bad experience?*

3) *What makes an experience with an individual professional a good/bad experience?*

>>> These two categories were used in different ways by different team members but the essence is that we can definitely characterise what makes experiences helpful/not helpful both at interaction-with-individual and interaction-with-team level...

4) *Parents' expectations – from previous experiences with HV services, from personal life stories, from perceptions of own needs and how they could be met...*

>>> this category will need renaming to become something along the lines of "Parents' awareness and expectations of services" ; it should include the views/attitudes/approaches/prejudices that people form from previous encounters with the service...

5) *Fathers' involvement – what shape it takes, mum's preferences, other features...*

>>> in discussing how mums' preferences as to whether or not partner should/can be involved vary and how health visitors need to be aware of these variations...

6) *How do parents "navigate" services and why does it matter?*

>>> we noticed that some parents are proactive and skilful in identifying the professional they feel most comfortable with and selecting which services they make the most of...