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The guideline contradiction: health visitors' use of formal guidelines for identifying and assessing families in need

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Abstract

The aim of this paper is to examine health visitors' use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support. With the increasing emphasis on targeted health visiting, a case study was used to explore the extent to which health visitors in three case sites use needs assessment guidelines in the assessment of family health need. The findings indicate how the presence of core visiting protocols hints at elements of control by managers, leading to conflicts in the relationship between professional judgements and official guidelines. Despite a management ethos of guideline formulation, several contradictions exist for which these guidelines are a focus. These include: little involvement of health visitors in guideline development, some staff not informed about the existence of formal guidelines, little evidence of guidelines contributing to improved client outcomes and their limited use by many health visitors in practice. Thus, even when guidelines exist, no accurate predictions can be made about health visitors' knowledge of or use of such guidelines in practice.
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1. Introduction

The potential for health visitors to accurately identify children and families in need, to promote family health and well being and to protect vulnerable children is acknowledged in current health and social policy (Home Office, 1998; Department of Health, 2000). Health visitors are in a unique position to identify parents and children experiencing stress and to undertake short-term preventative work with families because of their current, albeit often limited, universal access to families (The National Society for the Prevention of Cruelty to Children, 1996; Department of Health, 1999). As such, assessment of family health and social need is a central feature of the health visitor's role in which a range of skills and knowledge are used. These assessments are crucial in identifying children and families in need and in determining levels of health intervention to be offered. Drawing on recent empirical research, this paper examines health visitors' use of formal guidelines in identifying health needs and prioritising families requiring extra health visiting support.

2. Universal vs. targeted service

Health visiting is a health-promoting service offered to all families with pre-school children. Health visitors are registered nurses who have undergone post-registration specialist training which focuses specifically on health promotion and disease prevention amongst all population groups. Most health visitors work in the community and through a combination of home

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visiting, clinic work and community-based activities are well placed to identify and work with vulnerable groups.

Despite the importance of health visiting support to families being advocated in current policy, at grassroots the profession is facing considerable turmoil (Cowley, 2002; Pearson, 2002; Malone et al., 2003). There has been a long and continuing debate within the profession about the extent to which services should be targeted at the level of the individual or the community. It is assumed that families who display no overt problems at a single contact (a first visit, used to assess needs) have no need for a health-promoting service and therefore should not be visited on a routine or regular basis (National Health Service Executive, 1996). In contrast, those defending the maintenance of a universal home visiting service have argued that it is often the most vulnerable and those not coping who are unable to seek help, and that programmes of selective visiting may fail to identify need adequately (Smith, 1998; Robinson, 1999; Elkan et al., 2000, 2001). Furthermore, the universal nature of the health visiting service appears important in helping clients to view it as non-stigmatising (Mayall and Foster, 1989) and socially acceptable (Machen, 1996; Deave, 2003).

In the United Kingdom (UK) identification of children in need is addressed through public health values and primarily universal access to professionals through a core child health promotion programme (Hall and Elliman, 2003). Targeted work with a child/family would only begin once a health need is identified, yet this individual focus is not reached unless all the population has access to child health promotion services.

The child health promotion programme implemented by Primary Care Organisations (organisations responsible for managing and delivering primary care in the UK) ensures that regular contacts are offered to families with young children. This provides the gateway to undertake both child and family health needs assessments and to offer extra interventions where necessary (Appleton and Clemerson, 1999). Hall and Elliman (2003) have recommended regular visits to mother and baby in the first 10 days following birth, contacts at 6–8 weeks, at 2, 3 and 4 months of age, then negotiated, but not necessarily face-to-face contact at 8–12 months, 2 years and 3.5 years. The core programme is important because families may not easily be able to acknowledge or raise their worries, or make any link between these concerns and their health status (Cowley and Appleton, 2000). However, the review programme is implemented differently across the country and 'regular contacts', not necessarily as many as suggested by Hall and Elliman (2003), are offered by a range of primary health-care team members. In many areas only one health visitor contact is guaranteed. Ideally, this programme should enable health visitors to address the values outlined in Every Child Matters DfES (2003) and reach all children to identify those who with their families are potentially in need of advice, support and guidance, yet in reality this is not always possible.

3. Identifying children and families in need

Child health promotion work forms the basis for assessment and targeted work with children and families in need. Health visitors have traditionally adopted a number of approaches to identify children and families requiring extra health visiting. These include risk assessment screening, the use of guidelines and a reliance on health visitor professional judgement. These approaches are reported in more detail elsewhere (Appleton, 2002a). However, there is a dearth of research evidence exploring how health visitors use such processes in their daily practice.

A feature of the literature is the limited amount of research investigating health visitor professional judgement in the identification of children and families in need (Appleton, 2002a; Appleton and Cowley, 2003). This is surprising in view of the fact that since the National Health Service and Community Care Act (1990) there has been considerable interest surrounding the impact of needs assessment on health-promoting activities. It is interesting to note that most research in health visiting has tended to focus generally on 'needs assessment' (Chalmers, 1993; Cowley et al., 1995, 2000; Carney et al., 1996) or assessment of family 'vulnerability' (Appleton, 1995, 1999; Williams, 1997).

Furthermore, since the introduction of the internal market into the British National Health Service (NHS) in the 1990s, managers have increasingly required practitioners to use guidelines and structured assessment tools to identify children and families in need. Initially, this practice stemmed from a policy emphasis on specifying needs for which vulnerable families were to be targeted (Audit Commission, 1994), and has now moved to a focus on addressing health inequalities (Department of Health, 2001; Department of Health, 2003) by centering attention on disadvantaged groups. This has resulted in a proliferation of formal guidelines designed to identify those families most in need, fuelled by management pressure to standardise health visiting practices and reduce resources spent on home visiting.

In view of the apparent NHS impetus to develop such guidelines (Department of Health, 1998), it seemed pertinent to undertake a study to establish the existence of practice guidelines for the identification of children and families requiring extra health visiting. A postal survey of the Senior Nurses in the 179 Community Trusts (fore-runners of PCOs) in England employing health visitors was conducted (Appleton, 1997). The survey had two purposes. Firstly, to assess the extent to which guidelines were in existence throughout the

country to assist health visitors in identifying families requiring extra support. Secondly, copies of local Trust guidelines were requested with the intention of examining the documents to determine their validity and reliability.

Through this preliminary research it became evident that while many different guidelines existed, they were largely subjective and had limited validity (Appleton, 1997, 2000). This therefore raised questions about the extent to which formal guidelines direct health visitors' in making assessments of family health needs. There has also been little research to support the usefulness of these tools in achieving the goal of identifying children and families in need of increased support. Where such tools have been examined, this has led to recommendations that health visitors should not rely on structured assessment tools/guidelines to identify health needs or to determine frequency of contacts (Cowley and Houston, 2003; Houston and Cowley, 2003; Mitcheson and Cowley, 2003). Therefore, a deliberate intention of this study was to select three Community Trusts where contrasting guidelines were issued to practitioners to assist in the identification of families in need. This strategy was adopted to examine health visitor professional judgement and to explore the impact of differing guidelines on practice.

4. Study design

A case study strategy (Stake, 1994, 1995; Appleton, 2002a, b) guided by a constructivist methodology (Guba and Lincoln, 1989) was used to undertake an in-depth examination of how health visitors identify families deemed to require additional support. Insights from the preliminary survey work influenced the purposive sampling strategy to select three main study Trusts and one pilot site where contrasting guidelines were issued to health visitors to assist in the identification of families requiring extra health visiting. The focus of interest was to attempt to understand the factors that may influence a health visitor in making a judgement to offer a family extra support. The study sought to consider how formal guidelines and professional judgements contribute, if at all, to the process of targeting health needs.

In all Trusts access was sought via the Senior Nurse who had responded to the preliminary survey. Once permission had been granted and approval gained from the four Local Research Ethics Committees, all health visitors working in each Trust were invited to a meeting to discuss the proposed research. Following these meetings, volunteer samples of five health visitors from each Trust were recruited to participate. Health visitors were selected on the basis of perceived co-operation, their potential contribution to increasing understanding about the concept of professional judgement and that they were willing to be accompanied on home visits to families receiving extra support. Table 1 provides a summary of the participating health visitors' employment experiences.

It was planned that all clients to be involved in the study would be selected by their health visitor as caseload manager. The criteria for selection were that clients were currently receiving an increased level of input from their health visitor (as defined by the practitioner) and were agreeable to participate in the study (to be observed and later interviewed by the researcher). Because of the sensitive nature of the research, it was deemed important for health visitors to maintain control over the 'selection' of clients taking part. A nominated sampling approach was regarded as the best way to reach the group of interest. Care had to be taken to ensure that the researcher/health visitor relationship was maintained at a professional level at all times, to avoid being collusive in nature. This was important to ensure that clients were not coerced into participating and gave their informed and written consent to participate.

The study was carried out between 1996 and 2001; data were collected in the first half of that period, during 56 observed and tape-recorded home contacts to families receiving extra health visiting. Following these visits, separate in-depth interviews were conducted with clients and health visitors. The focus of the health visitor interview was the accompanied home visit and the aim was to explore health visitors' judgements and use of guidelines in identifying health needs and offering the family increased support. Through these in-depth interviews the researcher gathered insights into the perspectives and constructed realities of the health visitors (Erlandson et al., 1993), by exploring cues and

Table 1
Health visitor employment details/experiences

Area	Years worked as a health visitor			Years worked in this Trust			Time in current caseload		
	Range	Mean	Median	Range	Mean	Median	Range	Mean	Median
Site A	3.5 yr–20.5 yr	10.27	8	20months–18.5 yr	8.6	5.33	2 yr 4months–11 yr	4.13	3
Site B	3 yr 3months–20 yr	8.62	5	4months–21 yr	11.38	15	4months–15 yr	5.32	5
Site C	2 yr–14 yr	6.5	3	18months–14 yr	6.4	3	9months–6 yr	2.6	2.75

significant events from the accompanied home visit. Interviews with clients focused on their perceived health needs and their views about the health visitor's role.

In qualitative research, data analysis is on-going and takes place both during and following periods of data collection. Each recorded home visit and all tape-recorded interviews were transcribed and QSR.NUDIST software was used to assist data handling and retrieval (Richards, 1997). Data analysis were informed by constructivism and this method of analysis can be summarised as: (i) unitising; (ii) categorising; and (iii) completing patterns (Lincoln and Guba, 1985). It soon became evident that there were going to be multiple phases to the analysis, each illustrating different aspects of the data (Coffey and Atkinson, 1996). In addition, issues that had emerged during the preliminary work, which had informed data collection in this study and provided insights about professional judgement, were also to inform the analysis, thus highlighting the sequential nature of the work.

Throughout these lengthy analytical processes initial coding was constantly compared and refined, so that where links and relationships were identified codes were either merged together or hierarchies developed with a main category and series of subcategories. The features and properties of categories were continually examined. Tentative working hypotheses and links/connections between categories were explored; for example, health visitors' perceptions about formal guidelines were examined in light of the case sites existing policy guideline. Transcripts were closely scrutinised for the existence of any evidence about the use of formal guidelines in practice. Codes and categories were continually reviewed, questioned and revised as analytical processes progressed and disconfirming evidence sought.

5. Findings and discussion

A feature of the analysis was the variety and range of criteria available for the identification of families needing increased support. Table 2 illustrates the formal guidelines existing in the case sites. The following sections will describe in more detail the characteristics of the guidelines existing in each site.

5.1. Case study sites

5.1.1. Site A—Health Profile

Trust Site 'A' had no formal guideline to assist health visitors in identifying families needing extra support. A 'Strategy for Health Visiting' had recently been implemented in the Trust and a framework outlining the service which acknowledged different aspects of health visitors' work. This included:

- Family health needs assessment (Health Profile).
- A core programme of proactive contacts for children.
- High intervention work.
- Group-based health promotion work.
- Public health work.

The Health Profile is an assessment document which takes the form of a trigger list of potential family health needs to discuss with the parent/carer. The profile focuses on lifestyle factors (including smoking, diet, exercise, alcohol and drugs), coronary heart disease, cancer, sexual health, mental health, allergies, childhood (developmental problems) and other significant health needs. Practitioners described how the Health Profile was linked to government public health targets and many regarded it as an aide memoire for assessing family health. It is supposed to be completed at the new birth visit or at a transfer in visit and updated at the 2-year development check. However, health visitors described using the profile flexibly.

There was a view that the Health Profile enables health visiting to take a broader focus, in that it offers practitioners an opportunity to discuss wider family health issues that may not be routinely addressed. One health visitor stated:

> I think it's very useful … and certainly the families don't seem to resent you going through all these areas with them - it never seems to be a problem and certainly for a lot of them it does enable you to give them a lot of advice that you know you might not otherwise get round to (HV1.15).

Others were more critical of the profile. For example, one practitioner found it awkward to introduce and use in practice, describing it as 'quite clumsy to work with' (HV1.82) and containing too much information to memorise. She stated that it did not fit in with her approach to health visiting and was critical of the guideline for not necessarily addressing a family's immediate needs.

Despite the potential auditability of the Health Profile, there was a shared view amongst participants that nothing is done with the information collated; it is filed away in the child's record and only reviewed when a child is 2 years old.

5.1.2. Site B—Priority Index Guideline

In Site B the guideline for health visitors to identify families in need took the form of a vulnerability screening tool of risk indices. With the Priority Index Guideline, an A5 index card is prepared for all pre-school children and any individuals receiving extra health visiting on the caseload. Subsequent contact is planned according to assessed need, then prioritised and recorded on the index card and health visitor record. Index cards are then filed in a box, with Trust guidelines

Table 2
Case study sites—guideline summary

HV	Formal guidelines				Other practice guidelines and HV awareness of			
		Type of formal guideline	HV aware of formal guideline	HV use of formal guideline	Core programme	Local assessment framework	HV aware of local assessment framework	HV use of local assessment framework
1.15	No	N/A	N/A	N/A	Yes	Health Profile	Yes	Yes
1.25	No	N/A	N/A	N/A	Yes	Health Profile	Yes	Yes
1.39	No	N/A	N/A	N/A	Yes	Health Profile	Yes	Yes
1.70	No	N/A	N/A	N/A	Yes	Health Profile	Vaguely mentions by name	Not apparent
1.82	No	N/A	N/A	N/A	Yes	Health Profile	Yes	With difficulty
2.06	Yes	Priority Index Guideline	Yes	Yes as a prompt	Yes	N/A	N/A	N/A
2.20	Yes	Priority Index Guideline	Yes	Yes	Yes	N/A	N/A	N/A
2.38	Yes	Priority Index Guideline	Yes	Yes for classifying needs. As an aide memoire	Yes	N/A	N/A	N/A
2.77	Yes	Priority Index Guideline	Yes	Yes to structure work	Yes	HV records	HV records	HV records
2.91	Yes	Priority Index Guideline	Yes	Yes—"loosely"	Yes	N/A	N/A	N/A
3.07	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No	Yes	HV records/proforma NCAST, CDP and IUM	HV records/proforma NCAST only used in some localities refused to use CDP and IUM	HV records/ proforma
3.49	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	Uses CDP	Adheres to CDP	CDP and IUM	CDP and IUM	CDP only at present
3.53	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No	Yes	A family profile and scoring system	A family profile and scoring system	No
3.71	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No	Yes	NCAST and local assessment framework	NCAST and local assessment framework	NCAST and local assessment framework
3.89	Yes	(i) Map of risk factors and professional judgement (ii) List of risk factors	No	No	Yes	N/A	CDP	No

CDP = child development programme; IUM = integrated urban model; NCAST = nursing child assessment satellite training tool.

stating that these should be updated monthly to organise the work and reviewed weekly to assess progress.

Clients needs are assessed and prioritised according to high, medium and low priorities. The guideline consists of six high priority categories (families requiring short-term intensive health visiting), 16 medium priority categories (clients whose needs are being reviewed regularly) and low priority, which is the remainder of the caseload, offered the basic health visiting service of routine child health surveillance contacts.

One of the key advantages of the guideline is its use in highlighting planned contact with clients. It can therefore be helpful as an aide memoire and appears to be a way of logging an assessment, then prioritising and planning the workload. There was a consensus of opinion that it can be useful in highlighting need on a caseload if a health visitor is away, as every health visitor is supposed to be familiar with and using the system.

In reality, however, the system is unlikely to be foolproof for identifying families in need. Problems were highlighted in two areas. Firstly, one health visitor described having logged a family under medium, but actually visited as if they were a high priority, because of intuitive concerns. Therefore, the level of recorded prioritisation did not reflect this health visitor's working practice, because the health visitor logged the family under medium rather than high priority. Furthermore, anyone covering the caseload would not recognise that high priority work had been conducted. Secondly, another participant described how in the event of a vacant caseload, where the index box was not kept up to date, it soon became redundant as a work-planning tool.

Difficulties can also occur with the risk indices when a health visitor makes an assessment that a family needs extra support for a reason that does not closely fit the criteria. Practitioners were critical of health needs having to be made to fit categories that are not necessarily appropriate. A frequently cited example was post-natal depression being categorised under 'mental health issues'. One health visitor explains her discomfort:

> I don't like the terminology of it. I think if it was a postnatal depression written down there I'd be quite happy, but I think there is so much stigma attached to postnatal depression [that] to log it under mental health issues … just doesn't … feel right … (HV2.06).

A major problem with the guideline and one described by all the health visitors was that in reality it does not actually help in the assessment of families in need. Instead, health visitors make an assessment prior to categorising need within the prioritisation guideline framework. Health visitors frequently described making their own judgements about whether families needed extra support without referring to the guideline at all:

> Well I don't think it helps you assess because … I mean basically it's your judgement that puts them under the certain criteria (HV2.06).

5.1.3. Site C—Map of risk factors

During the preliminary study, two lists of risk indices were received from Site C, an older risk assessment tool and a recently introduced guideline. The recent version was a map of pre-disposing risk factors contributing to an explanation of child abuse, with indices focusing solely on the parents and social environment. However, accompanying guidance acknowledges the ability to exercise professional judgement as a caseload manager.

A significant feature and one that became very apparent as the study progressed was that none of the participants in Site C was aware of either guideline. This appeared to indicate that guidelines had been developed at a managerial level, yet information about such policies had not been disseminated effectively to field staff. Indeed Site C was split into several localities, with staff working in each area adopting very different assessment strategies.

One participant was a first parent visitor using a structured assessment approach informed by the Child Development Programme (CDP) (Barker, 1984; Barker et al., 1994; Emond et al., 2002) and regarded it as 'the best tool [she'd] ever been allowed to use'. She was adopting the Integrated Urban Model (IUM), where she did all the first parent visiting and then kept the families on her own caseload. She described offering first time parents approximately seven visits in a baby's first year and 12 if extra support was needed.

Another health visitor working in a different locality refused to adopt the IUM despite management pressure. She was critical that the model was introduced without a thorough audit being conducted first and regarded the name 'The IUM' as inapplicable to her practice area, a rural market town. She described it as:

> … unworkable because of my caseload … and apparently it was supposedly to show outcomes; however, it didn't actually state or there was no room to show that anything that I had said, done or written made any influence on the change … It could have been anyone or anything. It didn't reflect on me… (HV3.07).

In practice, this health visitor had no guideline to assist in identifying families in need.

Another health visitor described piloting the use of two different assessment guidelines. Firstly, the NCAST tool (Nursing Child Assessment Satellite Training) which consists of a series of scales to score parent–child interaction during either feeding or play. It is an

American model, developed in Seattle and was being piloted in the locality. Secondly, she described a local assessment framework intended to be used by all the community nursing team to prioritise need and overcome an emphasis on crisis working.

The diversity of local assessment frameworks was evidenced further when HV3.53, who worked in a different locality described, another tool that combined a series of questions to profile family health needs incorporating a scoring system. She described the potentially intrusive and probing nature of some of the questions and clearly felt uncomfortable with its content, 'You feel a little bit when you're doing it, that it's a bit of the third degree …' (HV3.53). Similar concerns surrounding the use of such guidelines have been highlighted recently (Coombes, 2000; Houston and Cowley, 2002) and it was interesting to find that both this health visitor and HV3.89 said that in practice they did not use any guideline.

5.2. Core child health review programme

The presence of a core programme of contacts closely linked to child health review programmes was a feature in all three sites. Core programmes outline the structured visiting protocols existing in each Trust and offered to families with pre-school children. Although not a formal guideline to assist in the identification of families in need, most health visitors regarded any client contacts outside these programmes as an indicator of families receiving extra health visiting. Health visitors described how in recent years there has been an increasing management emphasis on adherence to such structured contact programmes.

The demands of the core programme differed only very slightly between the three study sites. Health visitors regarded the core visiting protocols as having been imposed on them by their employers, with no consultation about whether these contacts were sufficient to assess and meet client needs. Without exception, practitioners regarded the core programme as a minimal service resulting in very limited client contact. One practitioner commented: 'You know it's not even basic really, it's scaled down so much' (HV1.25).

Health visitors believed that managers equate core programmes to the actual numbers of visits that families need and that they are being used to ration services. One said:

> I think in my opinion the Trust seem to have mistaken the core programme for … the number of visits that families need. So … although it's useful, I think it's being used as a guideline to save money … we have said that we've got to do extra visits. They say they understand that, but the important thing is to get the core programme sorted out (HV1.70).

A strongly held view was that limited core programmes impede preventive work with families. One consequence is that it can result in conflicts between a professional's judgement about a family's health needs and management demands for 'routine' service delivery. Such conflicts can mask the extent of workloads and, as such, are potentially disempowering to practitioners. Rather than challenging such local policies, health visitors appeared to adopt strategies to manage the core programme constraints, either by working to their own practice frameworks as Chalmers (1992) has previously described or conspicuously ignoring the requirements of visiting protocols. Both approaches to managing the core programme are potentially problematic in terms of client expectations of the service. Such deviations could raise client expectations or be equally problematic if clients get fewer 'routine' contacts than the programme outlines. Unfortunately, these idiosyncratic practices may perpetuate an organisational view that the core programme is satisfactory.

A further consequence is that health visitors may be unable to respond to or identify needs early as they have very little time to actively 'search' out needs, with the result that some family needs may be missed. Of particular concern is that two practitioners even acknowledged not responding to client needs because of lack of time.

In practice, health visitors strive to maintain a universal service to families with pre-school children. There is perhaps an assumption on the part of both employers and practitioners that a minimal service is better than none at all. Yet, a paradox of this universality is that while a limited core service exists, health visitors are unable to fulfil their role properly. In practice, health visitors were often unable to build up relationships with clients over a period of time, relying instead on the quality of the 'immediate relationship'. Several adopted a somewhat resigned view, commenting that there is rarely time to get to know a family well enough for a client to feel able to seek out the service if needs arise. With such acute rationing there is likely to be a concomitant fall in level of consumer satisfaction. Cynically, one could argue that this may be a deliberate management policy, for such service rationalisation resulting in widespread consumer dissatisfaction could result in its eventual disbandment.

In all sites, health visitors indicated that a management assumption exists that clients with needs will contact the service; however, several clients described how difficult it can be to seek out professional help. When people are feeling particularly low or vulnerable, contacting a professional is not easy. One client explained how much easier it is if her health visitor keeps in fairly regular contact:

> It's like a safety net, I've got that contact with her. If she wasn't coming out I wouldn't feel that I've got that contact, do you know what I mean? …And, say next week, if I had a problem, I'd find it hard to ring up about it … because you don't like to be a nuisance… (C2.06.3).

5.3. Using guidelines

Tables 3–5 illustrates the use of practice guidelines at each accompanied visit. It was fascinating to discover that there was little evidence of health visitors using guidelines in their practice. A major contradiction exists in that even when guidelines are available, the majority of participants appeared to ignore their presence when making needs assessments. Indeed most denied using guidelines during the observed home visits.

Of 56 visits observed, there was evidence in only five of health visitors using formal guidelines. One routinely used the Child Development Programme as a structure for all four accompanied visits, while another practitioner from Site A undertook an assessment using the Health Profile with one family. In another four visits, two health visitors (HV2.38 and HV2.77) used the Parent Held Record as a framework for the visit.

In all sites, there were clear indications that most health visitors were not adhering to guidelines in practice, but instead described using professional judgements in identifying families in need:

> It is a judgement, and I'm sure different health visitors judge it in different ways, but I think if the parent is coming to you and asking for help with whatever problem, then you must supply that help either yourself or through another agency, and … it's got to be supported help, you know it's no good just doing a one off bit of advice. You've really got to try and follow it through and make sure that whatever you said either worked or didn't work and modify it if it didn't, but it is a judgement and I'm sure as the years go by you get more experienced at it … (HV1.15).

While it is acknowledged that professional judgement is not necessarily always sound judgement (Cioffi, 2002), the health visitors' reliance on this skill and its apparent significance to their practice cannot be ignored.

5.3.1. Involvement in guideline development

As Cowley and Houston (2003) also reported, the preliminary study data indicated that guidelines are often introduced because managers genuinely believe that this is a good thing to do to ensure consistency of approach amongst practitioners. There is also a need to ensure that scarce health-care resources are targeted at those with most demonstrable need, as well as an increasing urgency to link health visitor interventions against measurable outcomes. In this study, however, there was little evidence of health visitors being involved in the development of guidelines to identify families in need. Only one was involved in developing a Local Assessment Framework. Furthermore, a level of contradiction exists when, as in Site C, health visitors were unaware of the existence of the formal guidelines that had been introduced by managers. This appears to be an example of the theory practice gap. As Grimshaw and Eccles (1998) have pointed out, when practice guidelines are developed it is reasonable to expect representation from potential users on the development group. One explanation for health visitors not adopting guidelines in practice may be due to their lack of involvement in guideline development reflecting non-ownership of both the process and product (Wyatt, 2000).

Other health visitors were generally critical of guidelines for interfering with professional skills. One felt worried that she may miss important cues by using a structured guideline:

> I think you can miss an awful lot … my perception is that you'd be strait jacketed to a piece of paper that says, … have they done this, have they got that, do they perceive to be this and I'm worried that you miss … vital observation… non-verbal cues … and where you should be using the skill of listening, you may miss something… (HV1.25).

6. Conclusion

The requirement to target health visiting interventions to those families with increased health needs has led to a rapid growth in the development of formal guidelines to assess families in need (Appleton, 1997). While it is acknowledged that extra health visiting support should go to those children and families with most demonstrable need, there seems to be a view that equity in access to scarce health-care resources can be addressed by the development of such guidelines. This paper has described the different guidelines existing in three case sites for the identification of families requiring extra support. An important feature of the analysis is the variety and range of guidelines in existence even in one Trust. Furthermore, several contradictions and tensions exist for which the guidelines are a focus.

Firstly, the impact of core visiting protocols in providing a baseline for client contacts, with any contact above this being perceived as an indicator of extra health visiting. Without exception, health visitors regarded the universal core programme as minimal provision. This results in practitioners adapting the core programme, leading to conflicts between professional judgements and Trust guidelines. Furthermore, the management

Table 3
Health visitors' use of formal guidelines in Site A

Visit	Observed use of guideline	Type of guideline	Pre-home visit interview—HV planned use of guideline	Post visit interview—HV use of guideline	Client comment about guideline
1.15-1	No	N/A	No	Says has own agenda but open to client's view. Uses own judgement	N/A
1.15-2	No	N/A	No	Says has own agenda	N/A
1.15-3	No	N/A	No	"Just professional judgement"	N/A
1.15-4	No	N/A	No	Completed Health Profile with client "in early days"	N/A
1.25-1	No	N/A	Refers to 2 year check	No—Does not use any guidelines and says assessment is not structured "I just gather information"	N/A
1.25-2	No	N/A	No	No—Specifically states no guideline used	N/A
1.25-3	No	N/A	No	No assessment guideline and would not like to adopt a structured assessment	N/A
1.25-4	No	N/A	No	No	N/A
1.39-1	No	N/A	No	Mentions she will undertake Health Profile at next visit	N/A
1.39-2	Yes undertook HP sought parents' permission to do so	Health Profile (HP)	Planning to do Health Profile if mum calm	Yes—discussed use of Health Profile	Feels it is important for HV to know about family medical history
1.39-3	No	N/A	No	No—Professional Judgement	N/A
1.39-4	No	N/A	No	No—Professional Judgement	N/A
1.39-5	No	N/A	No	No—Professional Judgement	N/A
1.70-1	No	N/A	No	No—PJ. But feels a guide on how to make assessment might be useful	N/A
1.70-2	No	N/A	No	No—PJ. Guidelines must have become embedded with her personal experiences	N/A
1.70-3	No	N/A	No	No but HV feels guidelines might be deeply embedded in practice	N/A
1.70-4	No	N/A	No	No	N/A
1.82-1	No	N/A	No	No	N/A
1.82-2	No	N/A	No	No—Assessment focuses on multiple issues	N/A
1.82-3	No	N/A	No	PJ only "Just my professional judgement"	N/A
1.82-4	No	N/A	No	Judgement and experience	N/A

CDP = child development programme; CONI = care of next infant; HP = health profile; NCAST = nursing child assessment satellite training tool; PHR = parent held record; PIG = priority index guideline.

Table 4
Health visitor's use of formal guidelines in Site B

Visit	Observed use of guideline	Type of guideline	Pre-home visit interview—HV planned use of guideline	Post visit interview—HV use of guideline	Client comment about guideline
2.06-1	No	N/A	No	No	No
2.06-2	No	N/A	No	No	No
2.06-3	No	N/A	No	Guidelines do not tell HV how to make an assessment	No
2.06-4	No	N/A	No	No	No
2.20-1	No	N/A	No	No	No
2.20-2	No	N/A	No	No	No
2.20-3	No	N/A	To undertake 18 month check	Describes the use of CONI guidelines when a baby	No
2.20-4	No	N/A	No	Refers to PIG in terms of registering family need after the assessment. HV visit agenda discussed in relation to PIG	No
2.38-1	No	N/A	No	No	No
2.38-2	No—but appears to use PHR as a framework for the visit	Parent Held Record (PHR) framework	No	No	No
2.38-3	No—but PHR visit framework	PHR framework	No	No	No
2.38-4	No—but PHR visit framework	PHR framework	No	No	No
2.77-1	No	N/A	No	Describes placing mum and child in PIG box	No
2.77-2	No uses PHR as a guide for 18 month assessment	N/A	To undertake 18 month assessment	HV describes some of the problems of PIG	No
2.77-3	No	N/A	No	Relies on own professional judgement	No
2.91-1	No	N/A	No	No	No
2.91-2	No but adopts a structure for 18 month assessment	N/A	No	Describes undertaking 18 month assessment but not using a guideline	No
2.91-3	No but appears to adopt a structure for 18 month assessment	N/A	To undertake 18 month developmental checks	Describes undertaking 18 month assessment and adopting a structure but not using a guideline	No
2.91-4	No	N/A	No	No	No

CDP = child development programme; CONI = care of next infant; HP = health profile; NCAST = nursing child assessment satellite training tool; PHR = parent held record; PIG = priority index guideline.

assumption that clients in need will contact the service is negated by data from the client interviews, which reveals how difficult it can be for vulnerable people to seek out professional help.

Despite an NHS ethos of guideline formulation, an apparent contradiction to guideline development lies in their limited use in practice. Realistically guidelines and assessment tools will only be utilised by health professionals to the extent that the practitioner feels they are useful, they have had a part in their development or local application, or they are coerced into using them by governing authorities (Richey and Roffman, 1999; Wyatt, 2000; Greenhalgh, 2002; Mitcheson and Cowley, 2003). An overwhelming feature of this study was that even when guidelines exist, in reality most health visitors use their own professional judgement in making family assessments. This was especially evident in Site B where health visitors were very clear that the Priority Index Guideline did not help in the assessment of families needing extra support. Therefore, even when guidelines exist (as the preliminary work revealed; Appleton, 1997), no accurate predictions can be made about health

Table 5
Health visitor's use of formal guidelines in Site C

Visit	Observed use of guideline	Type of guideline	Pre-home visit interview—HV planned use of guideline	Post visit interview—HV use of guideline	Client comment about guideline
3.07-1	No	N/A	No	No	N/A
3.07-2	No	N/A	No	No	N/A
3.07-3	No	N/A	No	No	N/A
3.07-4	No	N/A	No	No	N/A
3.49-1	Yes and HV agenda focused	CDP	Yes	Yes	Thinks some of cartoon material a bit obvious
3.49-2	Yes	CDP	Yes	Yes	Both she and her sister like the cartoon material and she keeps it
3.49-3	Yes	CDP	Yes	Yes	Yes some cartoon material useful
3.49-4	Yes—focuses on own agenda	CDP	Yes	Yes	No
3.53-1	No	N/A	No	No	N/A
3.53-2	No	N/A	No	No—Refers to routine programme of visits	N/A
3.53-3	No	N/A	No	No	No
3.53-4	No	N/A	No	Mentions wanting to see mother more often than core surveillance programme	N/A
3.71-1	No	N/A	No	Will use local assessment strategy at next visit	No
3.71-2	No	N/A	No	HV refers to having undertaken an NCAST teaching assessment with parents and 2 year old. Will do reassessment at the end of 8 week period of extra support	Parents mention HV having undertaken an 'assessment' with parents and 2 year old—did not recall name
3.71-3	No	N/A	No	HV said she was mentally going through the local evaluation sheet	Feels there should be more clear guidelines about when HV's will visit
3.71-4	No	N/A	No	No	No

CDP = child development programme; CONI = care of next infant; HP = health profile; NCAST = nursing child assessment satellite training tool; PHR = parent held record; PIG = priority index guideline.

visitors' actual knowledge of or use of such guidelines in practice. Furthermore, in Site C none of the participants were aware of the formal guidelines that had been sent during the preliminary study. Thus in some situations, it would appear that managers, who may or may not communicate their usefulness to the field staff, adopt practice guidelines. This raises issues about the extent to which managers attempt to control practice by not involving field workers in the development of those guidelines or practitioners to maintain control by conspicuously ignoring them. Some might interpret this latter point as an illustration of the reluctance of a workforce to question or change their practice, others as an example of poor leadership and change management.

Arguably if a guideline is developed with input from practitioners, is proven by research to be effective and efficient and is presented to practitioners as a means to improve client outcomes, then practitioners may be more willing to change practice. However, the literature points to the fact that there are significant difficulties associated with rigid adherence to formal assessment guidelines. Problems highlighted include the potential for client disempowerment (Mitcheson and Cowley, 2003), increased stress and anxiety for vulnerable individuals (Cowley and Houston, 2003) and needs being missed (Appleton, 1995). While for health visitors, insensitive questioning (Appleton, 2002a, b; Cowley and Houston, 2003), adoption of mechanistic and controlling practices (Twinn, 2000; Mitcheson and Cowley,

2003) and potential deskilling (Barker, 1996) are serious professional issues.

Health visitors need to consider whether the use of formal guidelines could constrain professional practice and examine the legal and ethical issues surrounding their use (Wyatt, 2000). For those PCOs contemplating the introduction of a guideline to assist health visitors in identifying children and families in need, due consideration must be given to the complexities of managing change in practice. Practitioners and managers also need to consider whether such guidelines can really ensure positive outcomes for families, as research evidence has indicated they may not (Houston and Cowley, 2003). Where guidelines already exist, practitioners should critically assess their validity, examine whether they are evidence based and consider their usefulness and appropriateness in practice (Appleton and Cowley, 1997, Cluzeau et al., 1999).

The findings of this study indicate that on the whole participants were actively resisting the ethos of guideline formulation. This has tremendous implications for practice and raises serious questions about why managers persist in facilitating their development. It also raises the important issue of why health visitors do not exert influence on their organisations not to rely on such guidelines. Or, at the very least, where health visitors have evidence that guidelines do not help in their assessments of families needing extra support to raise managers' awareness of this fact. Health visitors may underestimate their potential to influence policies affecting health, despite representation on Primary Care Boards. We recommend that health visitors seriously question whether it is ever appropriate to attempt to replace professional judgement by the apparent shift towards greater adoption of general and invalid formal guidelines in health visiting practice.

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