THE PRINCIPLES OF HEALTH VISITING

opening the door to public health practice in the 21st century

Sarah Cowley

Marion Frost

ISBN 1-872278-68-X ISBN
(from 1 January, 2007): 978-1-872278-68-1

Published by **Community Practitioners' and Health Visitors' Association**
Tel: 020 7505 3000
Fax: 020 7780 4142

www.amicus-cphva.org
Price £ x members, £ x non-members
Logos: Amicus CPHVA UKSC

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PREFACE

This updated edition of the 'Principles' is a very timely and relevant publication. It demonstrates that the health visiting principles are as relevant to health visiting today as they were 30 years ago when they were first published. Every profession requires a framework on which to base its activity; the 'Principles' have for 30 years provided health visitors with just such a mechanism to articulate what they can provide to healthcare through preventative and early interventions and through the use of public health approaches.

It was not the intention in this new edition of the 'Principles' to revisit them, merely to update the 1992 booklet in the context of healthcare in the 21st century. The working group supported the view that they were as relevant to health visiting practice today as when first conceived. The book follows the format of the 'original' 1977 edition, which also included a historical perspective for those less familiar with our profession. Furthermore, the rationale for the 'Principles' is discussed and will prove helpful to students and policy makers.

This edition of the 'Principles' has been produced in response to demand from the higher education sector, who have relied on previous editions to understand the professional training of health visiting. We hope that it will prove a vehicle for moving the profession forward and asserting the contribution health visiting makes to the maintenance of health. As this edition is published, we celebrate the 110th birthday of CPHVA. Over 110 years the profession has faced many challenges. It has demonstrated its ability to mould and adapt to changing needs and political dogma. It has influenced many improvements in healthcare and we expect it to continue to do so.

Whilst this edition does not analyse the 'Principles' in the context of today's healthcare systems, we expect it to be a trigger for debate. For example, are the four basic 'Principles' still appropriate and if so are they sufficient? How do they fit within the NHS and with an illness-dominated public health movement? What about the issues of universality and availability? Do the processes of home visiting and relationship building need highlighting more effectively? Should there be another investigation?

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1 INTRODUCTION

Health visiting defined

The professional practice of health visiting consists of planned activities aimed at improving the physical, mental, emotional and social health and wellbeing of the population, preventing disease and reducing inequalities in health. Its overall purpose is to improve health and social wellbeing through identifying health needs, raising awareness of health and social wellbeing, influencing the broader context that affects health and social wellbeing, and enabling and empowering people to improve their own health. The health visiting contribution to public health takes account of the different dynamics and needs of individuals, families and groups, and the community as a whole. The health visiting process is achieved through a focus on four clear principles, which are:

- The search for health needs
- The stimulation of an awareness of health needs
- The influence on policies affecting health
- The facilitation of an awareness of health needs

Health visitors provide a proactive service, concerned with identifying and fulfilling self-declared and recognised as well as unrecognised health needs of individuals, families and social groups. Health visiting is distinguished by the emphasis that it places on the proactive search for health needs, rather than only responding to the demand for care; on primary prevention and promotion, not just treatment; its focus on people as members of groups, families and communities; and its concern with the health of populations as well as individuals.

Health visiting practice takes place in a variety of settings, particularly in people's homes, but also in communities, for example, neighbourhoods, housing estates and villages, and in institutions, such as schools, prisons and healthcare organisations and, in collaboration with others, extends to settings such as healthy cities, towns or areas. Health visitors work particularly with infants and children and their families, but also with young people and those of working age, with the retired population and older people, and vulnerable groups of any age.

The policy context

Health visiting has always been heavily influenced by policies pursued by the government of the day. This is because so much of its work is focused on areas about which political views are strongly held and often polarised, such as the family and communities. Health visitors need the skill to work within current policies, whatever they are, without being dependent upon them, since there are always likely to be marked shifts when governments change.

When the New Labour government was elected in 1997, it came into office with a clear vision about how it would change and improve society by ending perceived unfairness, inequalities and social exclusion. This was to be achieved by tackling 'root causes' and 'joined-up thinking' across government departments; long-term social change was sought, with sustainability as a

key watchword. In terms of public health, this meant focusing on the underlying determinants of health and disease, on the social environment and on inequalities as a cause of ill health; cross-sectoral working and multi-disciplinary collaboration were seen as essential. Families were prioritised, too, as the basic building blocks of society. Early intervention and family support were seen as central to developing a fairer society, with multi-disciplinary and cross-agency working being central components of service delivery. These policies were very different to those pursued by the former New Right government, and might have heralded a new era of positive practice for health visiting, but that has not fully materialised.

Since 1997, the NHS as a whole has benefited from much additional funding and large staff increases across the NHS, but neither have reached health visiting. Although the key visions are similar, devolution has led to some clear differences in policy in the four parts of the UK, which can be confusing for students and for practitioners moving between countries. Also, changes to the training and regulation of health visitors have led to confusion, which has drawn attention to the fundamental principles that underpin the profession.

The principles: background

The principles of health visiting were first identified in the 1970s as part of a lengthy inquiry into how best to teach and practise the profession. The document published in 1977 set out the fruits of that investigation, explaining their background and why they were considered so relevant (Council for the Education and Training of Health Visitors (CETHV) 1977). It was a forward-looking booklet that, nevertheless, was published along with expressions of concern that health visiting would need to be focused and clear about its future direction. The authors explained that 'over the last decade rapidly changing health and social conditions have led to the introduction of new legislation and new patterns of working and to changing consumer expectations' (CETHV 1977:7). The transfer of health visitors, along with other public health and community nursing staff, from their local authority employment into the hospital-dominated NHS in 1974, seemed to present a considerable challenge at that time (Batley 1983).

Four clear, guiding principles were identified as a way to help explain the work, and to inform practice. The principles were not mere statements of intent, but encapsulated an underlying philosophy of practice and value attached to the work. A nationwide programme of workshops and conferences was developed to help ensure their implementation and use; two further documents were published recording the discussions (CETHV 1980, 1982). Overall, the programme took the CETHV eight years to complete. The CETHV stopped being the regulatory body when its powers devolved to the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) in 1983.

By the early 1990s, the profession recognised that the previous decade, as in the 1970s, had seen 'Government reforms affecting health visiting practice include not only a radical restructuring of the health service, but also nurse education' (Twinn and Cowley 1992: 1). A further series of workshops was convened through two organisations; the then Health Visitors' Association (HVA) and the United Kingdom Standing Conference on Health Visitor Education (UKSC), to re-examine the principles and discover whether they remained pertinent to contemporary practice at that time. The profession concluded that the principles remained equally relevant at that time, although there was an urgent need to recognise the place of evidence as well as values in their implementation. The booklet published at that time updated the policy and included

contemporaneous literature and practice examples (Twinn and Cowley 1992), but it is now out of date and out of print.

Principles in the 21st century?

Fourteen years after the 1992 booklet was published, the profession remains convinced of the relevance of the principles to their practice, but continues to face unprecedented challenges to their work and education. Although the rhetoric of public health and prevention have never been higher on the government agenda, the pace of legislative change has continued to increase along with escalating demands on their time; at the same time, the numbers of health visitors in practice have been falling steadily since 1988 (Cowley 2003, News 2006a).

The Nursing and Midwifery Order 2001 removed health visiting as a distinct profession in statute, and closed the health visiting register in 2004. A new register, maintained by the Nursing and Midwifery Council (NMC), has included health visitors under the part labelled 'Specialist Community Public Health Nursing', along with school and occupational health nurses, and family health nurses (Scotland). The standards of proficiency required for admission to that part of the register incorporated the principles of health visiting, but they have been relabelled as 'domains', and their origins and philosophical base were not made explicit (NMC 2004a). The position of health visitors in respect of their own profession and in relation to colleague professions, therefore, remains fluid and unclear.

A working group, convened by the Community Practitioners' and Health Visitors' Association (CPHVA), with support from UKSC, proposed that an updated version of the 1992 booklet should be developed, to meet the demand from student health visitors and universities. The aim is that it will, also, explain to other professions why health visitors regard these principles as fundamental to their practice. Colleagues, whether on the same part of the NMC register or not, may find the principles useful. Health visitors would be generally very happy to share them, if they help to inform and explain the kind of community public health activities undertaken by other groups. However, the extent to which they actually underpin the entire work of others would be for members of those occupations, not health visitors, to determine. Also, the meaning and underpinning philosophy represented within the principles both remain important; these need explaining in contemporary terms, to avoid distortion. Hence this new, updated booklet has been developed.

2 DEVELOPMENT OF A PROFESSION

The early years

Early in the 19th century, recurring outbreaks of disease and devastating epidemics demonstrated forcibly that public action was necessary to protect the health of all society, generating wide support to cover the cost of sanitary improvements (Ashton & Seymour 1988). Structural improvements to the wider environment were of great importance, with the Victorian engineers laying large sewers, enabling access to clean water, better housing through improved building regulations and better conditions of work in factories, all of which laid the foundations for some of the most far-reaching public health successes.

Much of this work was achieved through the charitable actions of individuals and philanthropic organisations, which focused on improving the whole of society, often using missionary zeal. This was a very gender-divided society, and the Manchester and Salford Ladies Sanitary Reform Association was formed as a branch of the main organisation, which was for men only. The very high rates of infant mortality (more than one infant in four died before its first birthday) drew attention to the need for families to be enabled to change the slum conditions in which they were forced to live. The Ladies realised that there was a need for real, practical help to achieve this. They felt the answer would be to send a local woman to visit the homes of these families to provide this help, along with advice and education about health, so in 1862 they agreed to raise the funds to begin this service (Dingwall 1977). The idea soon spread, and by the end of the 19th century, the home visiting service was being adopted across the country. In many places, qualified women sanitary inspectors (fore-runners of today's environmental health officers) were employed to undertake health-visiting duties in addition to their other work. Davies (1988) noted that many of these women were far better qualified than their male counterparts.

The Birth Notification Acts of 1907 and 1915 marked the beginning of a national service based on home visiting to new-born infants, and the right of local authorities to raise rates to cover the cost of the health visiting service. Formal control of the service moved from the lady volunteers to local authority Medical Officers of Health (MOsH) at around this time (Dingwall 1977). There were fierce battles as the pioneers of the occupation sought to maintain control over the direction of the service at a time when women were not permitted any formal authority or recognition for the work in which they engaged. With neither the women able to insist that the (male) landlords and factory owners followed the new regulations, nor the men able to achieve entry to the home and family (Davies 1988), the occupation continued to develop in a more circumscribed form. Initially a very practical response to broadly perceived health needs, it was delivered to everyone in order to avoid stigma, being consistently focused on health, not illness. However, once the service was formalised, the focus became more restricted, less practical and more advisory, and it was increasingly linked with midwifery and nursing in the years between the two world wars (Dingwall 1977, Robinson 1982). Health visiting began to be characterised as a specific solution to the problem of high infant mortality and poor child health; their prescribed activities became less practical and, in keeping with the new emphasis on personal prevention and individual blame at that time, more concerned with

cajoling and advising (Symonds 1992). Some maintain that the profession neither regained its original radical zeal (Dingwall 1977), nor achieved full legitimacy as a profession, in the face of the pressure from nursing, social work and general practice (Robinson 1982).

Changes in the role appeared fully in keeping with a public health movement which, itself, abandoned the early emphasis on environmental change in favour of more individualistic approaches for much of the 20th century. Ashton & Seymour (1988) identified four phases in the public health movement. It started in the 19th century with a focus on environmental control, adopting an emphasis on personal preventive behaviour in the early years of the 20th century, then shifted towards therapeutic interventions. In the last quarter of the 20th century, the movement took on board the ideals of the 'new public health', which combined and recognised the importance of all three preceding phases. Cowley (1996) suggested that these different phases of public health were mirrored in the progress of the health visiting profession over the same period.

Professional qualifications

From the end of the 19th century, there were an increasing number of certificated courses for health visitors; these were usually 2 years for direct entry, or 6 months for graduates, qualified teachers or nurses. Once local authorities were permitted to raise revenue via the rates to pay for health visiting, qualifications began to be stipulated. At first, this was patchy; in 1909, for example, the Health Visitors' (London) Order required post-holders to have a specific qualification. This first statutory qualification was for London only, but the Royal Sanitary Institute (later the Royal Society of Health) began co-ordinating qualifying courses for health visitors in 1916. When the Ministry of Health took over responsibility for the training of health visitors in 1925, the Royal Sanitary Institute continued as the designated examining body, maintaining a register of those who achieved the qualification.

Qualifications for health visitors were established in secondary legislation (Qualification of Health Visitors Orders), which were regularly updated in line with changes to the training rules and changing health needs (including tuberculosis visiting) through most of the 20th century. The 6-month training was expanded to 9 months, and continued to be overseen by the Royal Society for Health until the Council for the Education and Training of Health Visitors (CETHV) was established as the regulating authority through the Health Visiting and Social Work (Training) Act 1962. The CETHV developed a curriculum for a *'new breed of health visito*' based on a 51-week course, which was implemented 1965. At this point, a nursing qualification became a statutory pre-requisite for entry into health visitor training, along with either registration as a midwife or, at least Part 1 (the hospital component) of the midwifery training.

The remit of the CETHV was far wider than its fore-runner, since it not only maintained a register, but also operated to support and develop health visiting as a profession. To this end, it kept a watching brief on the numbers in practice and in training, both carried out and published research to develop the knowledge base and generally operated as the expert professional body for health visiting (Wilkie 1979, 1984, Batley 1983). According to Wilkie, the first director of the CETHV, the later implications of the decision to link health visitor training to nursing were not fully realised at the time it was taken. It led directly to inclusion of health visiting in the major reorganisation of professional regulation under the Nurses, Midwives and Health Visitors' Act 1979 and closure of the CETHV. Although a national campaign ensured that health visiting remained in statute when the 1979 Act was passed (Batley 1983), the

CETHV was wound up and its regulatory duties taken up by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) and four National Boards.

At first, health visiting matters needed to be approved by a Health Visiting Joint Committee (ie 'joint' between Council and Boards) before they could be implemented. This committee was disbanded when functions of the UKCC and Boards were restructured in 1992, and two years later pre-registration health visitor education was absorbed into a post-registration nursing framework for Specialist Community Health Care Nursing (UKCC 1994), sometimes known as the 'specialist practitioner qualification' (SPQ). In this, the former 51-week programme of study was reduced to a minimum of 32 weeks, with much of the learning shared across the community nursing field, and no specific requirements for a specialist teacher in the practice field. Many universities developed longer programmes than the minimum, and ensured the necessary content for proficiency, even though it was not an official requirement. Even so, concerns grew about inconsistency and the suitability of the SPQ programme for health visitor education. Soon after it was fully implemented in 1998, a raft of reviews and research showed these concerns to be well founded (Oldman 1999, Cowley et al 2000, Clark et al 2000, Pearson et al 2000). Further changes began to be considered from this point on.

Current professional practice

In 2000–2001, the then regulatory body (UKCC) commissioned PRIME Research and Development to complete a detailed analysis of the policy and literature, in order to determine standards required for health visitor education and training. The new standards were completed and accepted by the UKCC at its final Council meeting in 2002, then ratified and accepted for implementation at the inaugural meeting of the new Nursing and Midwifery Council (NMC 2002).

PRIME Research and Development (2001) carried out an analysis of policy and proposals for public health practice from the four UK countries. They showed considerable similarity in approach, although thinking in relation to the future role of health visitors was at different stages in each of the four countries. All four countries emphasised the need for public health to be a strong feature in all nursing and midwifery roles, with health visiting being seen as a major contributor to improving health and to the broader social inclusion agenda. Overall, the policy analysis showed that, to improve the public's health and wellbeing, health visitors across the UK are expected to:

- work with families and groups, and through them individuals and communities
- focus on the promotion of health and wellbeing, protection and prevention.

An analysis of the health visiting literature and a series of workshops and questionnaires also highlighted the importance of the principles of health visiting for the work. The review identified 11 aspects of the work that were important, which were incorporated into the 'Requirements for pre-registration health visiting programmes' (NMC 2002). These aspects are included in full below. The wording used in the original is included with very little change, apart from minor updating such as the addition of more recent or relevant references. Also, the aspects have been themed under three headings that were not in the original (underpinning philosophy and professional perspective; service provision; capabilities and skills) and one further aspect has been added. This arose in professional discussions about the PRIME Report, and was formally proposed by UK Standing Conference on Health Visitor Education (UKSC) in response to the consultation document (UKSC 2002).

1[1] The underpinning philosophy and professional perspective:

a) A health-focused perspective with health being treated as a process (not a state of being) and a consideration of health in its overall socio-cultural context

Health visitors appear to treat health as a process (not a state of being to be obtained) and to consider health in its overall socio-cultural context. The extent to which an individual or group can call on the resources available to promote their health and wellbeing is dependent on the extent to which those resources are under their control. This also means that it is not the problem which individuals or groups face which determines whether they need support or not but the situation in which they are living (Cowley 1995a). The extent to which individuals need support and the nature of that support varies according to their own resources (including their confidence). For example, new mothers appear to initially want direct information on what to do but shortly move on to wishing for a more enabling and less directive approach (Pearson 1991). This means that health visitors need to identify the needs of the individual and group, the resources available to them and how these may change and develop over time. They also need to be able to offer support in different ways which are the most empowering for individuals and groups at different stages (Cowley 1995a, Cowley 2000a).

b) Maintaining an openness to others' concepts of health and wellbeing and how they wish to live

Health visitors appear to place high regard on others' concepts and views of health and acknowledge the impact of these concepts on how people live their lives. Health visitors need to be open to the great variety of perceptions and expectations about health, family life and mores (Cowley 1995a). Clients have reported that they did not feel subjugated by health visitors if the interventions were based on acceptance and a professional caring approach, although the opposite is true in that individuals can be further disempowered by their interactions with health visitors if practitioners do not accept individuals' views or are shocked by their situation. Relationship skills appear critical in determining the degree to which health visitors are acceptable to clients (Normandale 2001, Davis and Spurr 1998, Davis et al 2000).

c) Providing an accessible and non-stigmatising service

Health visitors are one professional group who are likely to have contact with, and provide an accessible service to, those who otherwise might not contact support services. For example, health visitors are ideally placed to support individuals who suffer from domestic violence as this often commences or intensifies during pregnancy, and women abused by their partners often have pre-school children. There is also evidence to show that domestic violence is linked to child abuse (Stover 2005), in which health visitors take a major preventive role. However, research has shown that health visitors do not always identify domestic violence and hence fail to provide the appropriate support (Frost 1997, Peckover 2002). This in turn suggests an education and training need for health visitors either during initial training and/or throughout their careers (Appleby and Sayer 2001).

2 Service provision

a) A focus on social groups, with families being one form of social group

The main target of health visiting practice is social groups, with families being one form of social group. Health visitors need to understand how groups (and individuals within groups) function and to develop skills to work with groups, and be able to recognise when their work should shift from one individual in a group to another (Machen 1996, 2000). In short, health

1 NB Based on extract from 'Prime Research and Development. Developing standards and competences for Health Visiting. A report of the development process and thinking' (Pages 10–15). UKCC, London, 2001' reproduced by kind permission of the Nursing and Midwifery Council.

visitors need a portfolio of skills they can apply to their work with different groups, a broad knowledge and understanding of change and transition in individuals across the lifespan, and an ability to identify and rapidly assimilate new information to apply to specific types of work (Pearson et al 2000, Macdonald 1992, Symonds 1993).

b) Provision of a service to address the factors that are likely to affect health and wellbeing (ie often working at the 'pre-need' stage)

Health visitors might be said to work at a stage which is 'pre-need'; that is, they act to prevent needs related to health and social wellbeing from arising, to reduce inequalities in health and wellbeing which are likely to lead to needs and to promote people's health and wellbeing (Standard Nursing and Midwifery Advisory Committee (SNMAC) 1995). Health visitors aim to identify those individuals and groups who are most vulnerable, or who are most likely to develop needs related to health and wellbeing (Appleton and Cowley 2003). The factors that are likely to lead to increased vulnerability are: housing problems, lack of money, mother's health status, non-use of health and social services, the disability of a family member, lack of support, parenting difficulties, relationship difficulties, and language difficulties (Appleton 1995). The extent to which these factors will become needs is influenced by the resources that are available to support individuals and groups in the short or longer term. In short, there is not a one-to-one relationship between factors and needs, as a factor that may lead to needs arising in one group might not cause the same need in another, due to other resources available to them and their expectations of the situation (Cowley and Houston 1999). This focus on preventing needs from arising can cause a tension in public services that are generally developed on the basis of being needs-led. In other ways, however, it is ultimately sensible, as the prevention of needs through being available as a resource is a long-term strategy and one that is potentially resource efficient (Billings 2000, Cowley 1995b, Kelsey 2000).

c) Acting as an interface between groups and individuals in the population and population-based approaches

Health visitors are in an ideal position to provide the context and background for why needs occur, or are likely to occur, in different populations as they are able to explain qualitatively the quantitative reporting of overall needs and inform strategies to address such needs. For example, a report from a Director of Public Health may identify a high incidence of accidents in the under-fives. Health visitors are likely to be able to explain the links of such accidents to maternal depression, or to poor housing or lack of play facilities. They might also predict longer-term health problems which will arise due to poor infant nutrition in families if preventive strategies are not put in place (Appleby and Sayer 2001).

d) Developing the capacity and confidence of groups and individuals to improve their own health and wellbeing

Research into behavioural change shows that people's acceptance of health messages relates to the value which individuals place on a particular goal together with their estimation of the likelihood that a given action will achieve that goal. People are also affected by their perception of their own ability to achieve the goal (hence the need for confidence building) and the factors that will reinforce or inhibit change. Such factors will include those who are significant to the individuals, and the social context and the social nature of health, ie improving health is more than working with individuals out of the context in which the live (Macdonald 1992).
Education needs to be liberating and not oppressive, involving people in groups to identify and critically assess their problems, creating a vision of what they want from a healthy society and developing strategies to achieve this (Freire 1973, Macdonald 1992).

e) Improving service provision for groups and communities
Health visitors need to achieve an important balance between ensuring that services are well coordinated and that they are provided in a way that is meaningful and accessible to local people and local needs. They also seek to change the culture in an area so that the local community itself develops its own capacity for health and meeting health needs. This means that health visitors need to think about the social environment (eg crime, housing, individualistic culture etc), the physical environment and the impact of particular disease pathways or diagnoses, such as post-natal depression (Cowley 2000b).

3 Capabilities and skills

a) An ability to develop effective relationships based on trust and openness
Time is needed for the development of relationships; time also needs to be available for health visitors to be a resource, and for them to be in a position to identify any issues and needs (Normandale 2001). Health visitors have reported that they take time to try and make sure that individuals are able to identify risk factors for themselves within the whole context. Such time will also be necessary to sift through the mass of information which might be presented to the practitioner and establish all of the parameters that may be relevant and to establish a reflective relationship (Cowley 1995b quoting Schon 1983 on problem setting).

b) An ability to work in a range of settings acting flexibly with other services
The best setting for interactions between health visitors and groups and individuals relates both to the nature of the relationship and its purpose. For example, mothers tend to feel less pressured or threatened when they are on their own ground and this in itself may even give them more time and breathing space. Being able to see individuals in their own setting is helpful in understanding their context, potentially leading to better preventive work (Normandale 2001). Health visitors may work in a variety of settings, but there is evidence to show that some settings (such as the home) may be beneficial for some purposes (Elkan, Kendrick, Hewitt et al 2000).

c) An ability to assess risk in complex situations
Health visitors have to manage many risk factors due to the complex and often ambiguous nature of the social situation and the families and groups with whom they work. The risks might arise from the direct relationships between group members, from outside, relate to one group member, or be as a result of factors within the group or from outside (Cowley 2000a). This requires health visitors to develop a fairly sophisticated concept of risk to guide their work and for them to develop a range of risk assessment and management approaches that they can apply in different situations.

d) An ability to deal with conflicting priorities and ambiguous situations, knowing when to use different, sometimes contradictory theories and perspectives. (This point was suggested as an addition (UKSC 2002))
Health visitors need to learn how to handle a wide range of conflicts and confusions in practice. For example, the work is about public health, but is most often delivered in the private sphere of the home (Symonds 1993). Health visiting draws mainly from a social model of health, but the service has become increasingly medicalised over the last 20 years (Robinson 2000, Cowley et al 2004). Health visitors focus on the antecedents of health-enhancing behaviour in families, as well as on the determinants of health in the wider community (Cowley 2002), and work towards long-term ends (health, educational and social) in a service

that requires short-term measures of success (health only) (Campbell et al 1995). Although health visitors operate largely through social support, befriending and facilitating, they need clarity of purpose and authority, particularly when children need protection or vulnerable adults are experiencing violence and abuse (Dingwall and Robinson 1990). Health visitors develop the capability to 'know when' to implement and apply particular approaches and knowledge (Robotham 2001), which may be the key ability enabling health visitors to deal with the many contradictions they meet in practice.

Nursing and Midwifery Council

The Nursing and Midwifery Order 2001 set up a new Council that is empowered to regulate nurses and midwives, but not health visitors (except in that they are regarded as nurses or midwives). The health visiting register, therefore, had to be closed and a new part of the register was opened in August 2004, for 'specialist community public health nurses'. These were deemed to include health visitors, school and occupational health nurses and family health nurses (Scotland). The newly established requirements for pre-registration health visiting programmes (NMC 2002) were rejected as the basis for this register, so could no longer be used as the primary standards for preparation.

Following a rapid consultation, a new set of performance standards were drawn up to suit the varied needs of these specified occupational groups. Standards devised for the newly established voluntary register for public health specialists, which are recognised as central to all public health practice, were mapped across to the principles of health visiting and expanded using some of the standards from the health visiting competences (NMC 2002) and some from the former specialist practitioner framework (UKCC 1994). The new regulations NMC (2004a) to some extent improved on the SPQ programme that ran from 1995 onwards. It was felt important that properly qualified practice teachers were used to support health visiting students in training and the length of training was specified as 45 programmed weeks, improving on the minimum standard of 32 weeks in the SPQ programme and offering a basis from which the profession could continue to develop. This revised edition of the 'principles of health visiting' has been produced as part of that continuing development.

3 THE VALUE OF HEALTH

In the original investigation into the principles of health visiting (CETHV 1977), it was recognised that different views about what constitutes 'health' have a very large influence on approaches to work that concentrates on improving it. Indeed, the terminology changes regularly, with the early health visitors engaging with 'sanitary work' and practices to 'improve hygiene', without apparently regarding such phrasing as quaint or old fashioned. At the start of the 21st century, there has been a resurgence of talk about 'public health' as an all-embracing ideal, whereas in the last quarter of the 20th century, the literature focused far more on 'health promotion', regarding that as a broader and more meaningful concept.

The working group that re-examined the principles of health visiting in 1992 acknowledged that both the World Health Organisation (WHO) (1986a, b) and the work of Seedhouse (1986) influenced their thinking, adding to the ideas contained in the original CETHV (1977) document. The WHO have continued to develop their ideas about health and public health (eg WHO 1998a, b). Also current policy and research has added new understandings about public health and health inequalities, which have all informed this updated edition.

Public health

Public health is the 'science and art of promoting health, preventing disease, and prolonging life through the organised efforts of society' (Acheson 1988). The World Health Organisation (1998a) recognises it as a social and political concept aimed at improving health, prolonging life and improving the quality of life among whole populations through health promotion, disease prevention and other forms of health intervention. The political aspects stem from public health being seen as the 'organised efforts of society', whether at a national, international or local level. Public health has implications for every person, and each individual's health has an effect on the accumulated health of the public. This gives rise to a profound paradox:

- As a sphere of activity and interest, public health cannot function at a single, individual level; yet it cannot progress without involving those people who make up the population, and whose individual states of illness or wellbeing are collectively described as the 'public health' (Cowley 2002).

This paradox inevitably creates tensions and contradictions about whether to concentrate on to immediate, clinically-based (individual) or population-based activities. Also, broad definitions of public health mean that any planned activity that contributes beneficially to the health of a population might be regarded as public health. That raises questions about the nature of public health practice, particularly for health visitors, whose work is considered to be entirely about public health (CPHVA 1997).

- Activities are justified as public health interventions if their main purpose is to contribute to the health of the whole population they serve, even though they meet the immediate health needs of individuals and families along the way (Cowley 1998, Keller et al 2004).

The usual health visiting focus on early childhood is justified because the home environment and patterns of parenting influence biological pathways that lead to health or to disease in later life (Power et al 1996, Shonkoff and Phillips 2000). The development of competence and coping skills, self-esteem and a personal ability to care for oneself are all significantly affected by early childhood experience. Patterns of attachment within the family, across the life course and within one's particular society and culture all have a demonstrable impact on both the potential risk of disease and for healing and health creation to be gained from autonomy and social cohesion (Rijke 1993, Fonagy 1996, Stewart-Brown and Shaw 2004).

- Following 'new public health' ideals means that health visitors draw on a comprehensive understanding of the ways in which lifestyles and living conditions influence health.

It is not possible to recognise 'public health' by a simple focus on the activities being undertaken or strategies being planned, because the scope of the work is so diverse and wide ranging (CPHVA 1997). However, public health approaches feature the identification of health needs and desired outcomes; knowledge of population health needs even when caring for individuals; emphasis on collective and collaborative action and recognition of people as members of groups, not only as individuals (SNMAC 1995).

- Public health focuses on the underlying causes of health and disease, on multi-agency collaboration and local community action (CPHVA 1997).

Hicks (1999) describes the goal of public health practice as being to maintain and improve the health of populations. However, the practice of public health involves identifying determinants of health (that is, the underlying causes) and effective means of influencing them, and then applying that knowledge in practice. To be effective, in Hicks' view, a public health practitioner must influence at least one determinant of health. The challenge is to identify examples of how that works. Setting up a post-natal support group can influence one such determinant, for instance, by preventing the isolation that causes mental health problems. Another example might be a focus on supporting healthy weaning, using it to avoid future obesity by reaching out to family eating patterns and from there to the underlying determinant of local culture/attitudes about food.

- Health visiting practice involves collaboration, co-ordination and networking from a single individual or family to the wider community and back again, or from a single caseload across statutory and voluntary agencies (CPHVA 1997).

Health visitors are often active in promoting community development work and outreach services to disadvantaged or vulnerable groups. Community networks are central to social capital (Swann and Morgan 2002, Morgan and Swann 2004), which is often seen as a mediating link between socio-economic inequality and health (Wilkinson 1996); in this respect it is an important concept for health visiting and public health. Although it is a contested concept, there is broad agreement that social capital is concerned with the amount of trust, participation and supportive behaviour in a local area or social group. Where these so-called 'moral resources' (Putnam 1993) are established, there exists the sense of civic community and social cohesion known as 'social capital'. Conversely, where isolation, lack of support and anti-social behaviour become entrenched, there is more social exclusion, increased vulnerability and wider health inequalities (Putnam 1993, 2000).

- To promote social capital, health visitors need to focus on the wider community and the position in which people find themselves (their situation), and not only on presenting problems. The significance of enabling the development of situational resources through facilitating, listening and providing a timely and reliable source of support should not be underestimated (Cowley and Billings 1999a).

The connection between relationships in the home during childhood and health in later life are traced by Stewart-Brown and Shaw (2004), who explain how patterns of parenting may nurture the roots of social capital. There is an increasing emphasis on the importance of child public health, not only because children matter as individuals in their own right, but also because health in childhood determines health throughout life and into the next generation (World Health Organisation (WHO) 2005). Pregnancy and the period between birth and 5–6 years of age is particularly important for individual and public health (WHO 2005), and for action to reduce health inequalities (Acheson 1998).

- The Independent Inquiry into Inequalities in Health recommended as among the most effective approaches 'policies that promote social and emotional support for parents and children; specifically the further development of the role and capacity of health visitors to provide social and emotional support to expectant parents and parents with young children' (Acheson 1998: 76).

Public mental health is equated with mental health promotion by the Mental Health Foundation (MHF) (2005), who criticise emphasis on lifestyle choices in government policies. Instead, they argue that the importance of mental health, and its place within public health and health inequalities, calls for a more preventive strategy which:

- intervenes to prevent mental illness and encourages mental health and wellbeing through the provision of information and advice. The proven mental health benefits of a healthy diet, regular exercise and moderate alcohol consumption should be actively promoted.
- actively discourages people from putting their mental health at risk. Lack of exercise, over-consumption of alcohol and work-related stress must be tackled, and steps need to be taken to warn people of the mental health dangers associated with recreational drugs.
- protects children and young people's mental health through universal parenting support and ensures that services and support for people with mental health problems should be improved to maximise their quality of life and wellbeing (MHF 2005: 5).

All of these aspects make public mental health a significant area of interest for health visitors (Adams 2005). Infant and perinatal mental health are rising on the agenda as understanding grows of the importance of early brain development and the influence of patterns of parenting and attachment on later mental health (Lowenhoff 2004, Shonkoff and Philips 2000).

Overall, public health work is very diverse, and may be carried out from a variety of places, like a general practice base, a children's centre, extended school or geographical locality. It requires consultation with service users and collaboration with local people. Wherever it occurs, facilities are needed to support networking across boundaries, and practitioners need to be authorised to collaborate and refer across different agencies, disciplines and communities (Cowley 1997).

Public health values in practice

When the principles of health visiting were first being discussed in the 1970s, the public health movement as a whole was just beginning to acknowledge a need to move on from the so-called 'therapeutic era' (Ashton and Seymour 1988) towards a wider understanding of the determinants of health. The original principles document identified the importance of both environmental issues and personal behaviour. Also, it spoke of the need for both health education and health promotion, which was a new concept at that time. The CETHV (1977) identified health as a value that is worth pursuing for its own sake, and which should underpin

the principles and practice of health visiting, and spelt out the importance of a broad understanding of this.

Picking up on this issue, Robinson (1985) warned that 'health' is a phenomenon which is fraught with ambiguity, and which defies objective definition and quantification. However, later working groups of health visitors have continued to support this ideal, despite the difficulties it poses in evaluation (Twinn and Cowley 1992, Campbell et al 1995). Instead of trying to define the value of health, the working group that met in 1992 decided to emphasise its practical application through health promotion, identifying seven key, underpinning beliefs that informed their practice.

1 Rights and responsibilities
Everyone has a fundamental right to the best possible state of health. In accepting this, health visitors take on a responsibility to address current inequalities and inequities in healthcare.

2 Health in context
Health cannot be separated from the socio-economic and cultural context in which it is experienced. This is why health visitors focus at different times on individuals, families and communities.

3 Choice and blame
Health must be regarded in broad, holistic terms, encompassing individuals and families within their personal situation. This has implications for the extent to which people are able to exercise personal choice, and to which they can be held solely responsible for their state of health.

4 Positive health
Health is a positive concept, encompassing social and personal resources, as well as physical capacities. Resources which contribute to positive wellbeing may be personal and internalised, or may arise externally from the social and family context in which the individual lives. Health promotion, therefore, involves finding ways to create resources for health.

5 Health improvement
Health promotion is important because having a positive sense of health enables people to make full use of their physical, mental and emotional capacities, so they can reach their full potential for achievement.

6 Empowerment
Achieving health means that people have the power to shape their own lives and those of their families. This implies that people have the potential to achieve health for themselves, through active participation as individuals, families or community groups. It emphasises the importance of empowerment as a form of health promotion.

7 Community partnership and participation
Healthcare services should be readily accessible and acceptable, and involve full community participation. This is the basis of primary healthcare, which needs a full, equal partnership between professionals and the people they serve.

The impact of different circumstances on health was well recognised in the 1977 book, which referred to disadvantage and poverty and the need to provide additional support to those who

needed it (CETHV 1977). Since then, there has been increasing recognition and strong research to show that adverse social circumstances are an important cause of ill health (Acheson 1998, Graham 2001, Marmot and Wilkinson 2000, DH 2003). However, it was quite unusual and forward-looking of the 1992 working group to use the term 'inequalities', as it was politically unacceptable to the government of the day to discuss such matters. Also, despite the strong support for health promotion in publications from the World Health Organisation, it was not very easy to implement in practice, when government policies tended to focus very much on individual behaviour and narrowly conceived health education approaches (Cowley 1997). Those approaches were criticised by the 1992 working group for their tendency to foster a climate of blame towards the most disadvantaged in society, instead of focusing on the underlying determinants of health.

The working group acknowledged that health is a social rather than an individual construct, and that understanding the whole family and community perspective is essential in health promotion (Twinn and Cowley 1992). This was associated with the idea that 'empowerment' is an essential basis for health, which can only be developed internally by individuals, families or community groups (Rissell 1994). It cannot be prescribed or dispensed by an outsider, but a facilitator might encourage or assist that development by working in a genuine, respectful partnership (Davis, Day and Bidmead 2002). There is a delicate balance between the need to allow, enable and encourage people to own their health in the sense of exercising full autonomy and choices in the way they live their lives (Rijke 1993), and the individualistic approach to health promotion which stresses personal responsibility and blame.

There is a further contradiction. Independence, autonomy and empowerment are significant and provide a necessary basis for individual health, yet decisions made to protect the health of the public as a whole may sometimes, of necessity, seem to limit the extent of personal choice. By encouraging parents to breastfeed or bring their infants to be immunised, to agree to give up smoking or eat an 'approved diet', health visitors can be seen to be contributing to the greater public health effort; alternatively, this might be a way of exerting 'official control' and limiting choices. This can seem particularly difficult when policy headlines emphasise choice as a public service expectation. The ability to cope with such contradictions is a feature of health visiting practice (see Chapter 2).

In contrast to the earlier administration, the current government focuses heavily on disadvantaged groups. The 'inequalities agenda' is a major focus of all current policies, running across policies throughout government (Chief Secretary to the Treasury 2003, DH 2003, 2005; Secretary of State for Health 2004). Meeting this agenda is not only a matter of providing services for people who are experiencing poverty or living in adverse conditions, even though those are both major causes of poor health. In addition, it needs to be recognised that disadvantages extend across a gradient through the whole of society, and so do health inequalities.

Graham and Kelly (2004) identify two different policy responses to evidence about the links between people's socioeconomic circumstances and their health. One is to focus on the most socially excluded, those with most risk factors and who are the most difficult to reach. Policies falling into this group include neighbourhood renewal or community-focused projects, and the development of initiatives like Sure Start (Glass 1999) or Starting Well (Shute and Judge 2005). Such interventions help only a relatively small part of the population, and take a long time to show results. Health visitors have been heavily involved with their development and implementation.

The second policy approach responds to the broader social gradient in health and the large numbers of people who, while they may not be formally regarded as socially excluded, are relatively disadvantaged in health terms. This second approach would acknowledge the need for a universal service, which has been a major defining influence in health visiting since the profession began. However, the government has tended to favour targeted approaches (as promoted in the health visitor development pack (DH 2001) for example). This has made the delivery of a universal health visiting service increasingly difficult to maintain in some areas, leading to disillusion on the part of some families, who have had reduced opportunities to gain the reassurance and support they sought (Roche et al 2005).

Health inequalities are socially defined, and information about precisely how these factors influence health is increasing at a rapid pace. Summarising the known 'solid facts' for the World Health Organisation, Wilkinson and Marmot (2003) focus on the multiple underlying factors that lead to health inequalities. In turn, these focus attention on the 'critical transitions' listed as emotional and material changes in early childhood, the move from primary to secondary education, starting work, leaving home and starting a family, changing jobs and facing possible redundancy, and eventually retirement. All of these transitions can affect health by pushing people onto a more or less advantaged path, so they are a useful focus for health interventions (Wilkinson and Marmot 2003). People who have been disadvantaged in the past are at the greatest risk in each subsequent transition, which could be factored into a comprehensive, universal health visiting service. The principles of health visiting, outlined next, provide guidance about the nature of this form of comprehensive service.

4 PRINCIPLES OF HEALTH VISITING

An introductory section describing the nature of the principles of health visiting was written in the re-examination booklet (Twinn and Cowley 1992), which praised the original CETHV (1977) document as very forward-looking. The Investigation into the Principles of Health Visiting was intended to clarify the knowledge base for the profession, and drew on Chater's suggestion that 'principles state a relationship between two facts that may be used to explain, guide and predict action' (1975: 7). Two potential principles considered in 1977 (page 63), but set to one side for later consideration, were based on the concepts of 'universality' and 'availability'. These have not been addressed in the subsequent publications, but the issues they reflect have, perhaps, risen higher on the agenda in recent times. Four principles were identified and explained in depth:

- The search for health needs
- The stimulation of an awareness of health needs
- The influence on policies affecting health
- The facilitation of health-enhancing activities

The principles were clearly intended to inform practice and teaching about health visiting, and were a formal step towards identifying the profession's knowledge base. K. Robinson (1985: 164) suggested that the principles are a 'characterisation of the role and functions of the occupation in the wider social context'. This is an important description, since it clarifies that the principles are not simply skills to be learnt or tasks to complete, nor are they activities in themselves. Indeed, their translation into single competencies, including some changes to the wording, for the specialist practitioner qualification (SPQ) training (UKCC 1994) both diminished and undermined their over-riding significance.

In 1992, the Working Group felt that the four principles remained applicable to contemporary health visiting practice, although they noted the extent of overlap in the way the principles are applied. Although the principles have always been listed sequentially, they may be best viewed as circular, inter-related and cross cutting. Figure 4.1 was developed to explain this way of thinking.

Figure 4.1 The principles in practice (to follow)

Since the principles are all integrated and interlinked, any aspect of practice will be informed by all the principles. However, it may be possible to single out one principle as dominant within a particular health visiting activity, or at a particular point in time. Although their origins are neither cited nor acknowledged in the current required proficiencies for qualification (NMC 2004a), the principles are used to describe over-riding 'domains' for learning about community public health. This does allow the flexibility, within programmes, to ensure that the principles are fully assimilated into the whole of practice.

The Working Group that met in 1992 realised that health visitors often seem to start out by dealing with narrow, specific or individual problems, which broaden out to become more complex as details are shared and explored. This approach is less usual among other

professionals, who tend to sift one predominant problem out from among a range of concerns. The expanding focus of the work became a key feature explored by the later working group in 1995, convened to examine why health visiting practice is so difficult to evaluate (Campbell et al 1995). This aspect, like the concepts of universality and availability, has not been developed further within the principles documents, although it helps to explain why it is sometimes difficult for other professionals to understand the importance that health visitors attach to universality, relationship building and having acceptable opportunities to open discussions about health.

When brainstorming around various topics in 1992, the working group discovered that they used a number of words that were not emphasised in the original document. The same might be said in 2006, with many of the words reflecting a newer terminology in common use today, and linked with shifting policies and changing ideologies around public health and health inequalities. Some of these newer terms have been incorporated in Figure 1 along the strands which show how the principles are integrated with practice. Thus, the diagram shows that the central pivot of health visiting practice has shifted from a focus on health promotion to public health as the primary purpose of the work. This incorporates a range of issues (such as advocacy, partnership, empowerment and so on) and skills (listening, reflecting, assessing and so on).

Wording of the overarching principles remains unchanged, because they are at a high level of abstraction and can be modified in application without losing their enduring meaning. However, explanations, applications and the words used to explain their implementation into practice have changed over time, and tracing these shifts and adjustments shows the developing knowledge base of health visiting, anchored in the framework of the principles. This changing focus is picked up next, with each of the four original health visiting principles being explored in a separate chapter, before going on to question where and how the work should be carried forward.

5 PRINCIPLE: THE SEARCH FOR HEALTH NEEDS

For the health visiting profession, the search for health needs is a fundamental part of health visiting practice and is an essential starting point for improving the health of populations and tackling health inequalities. The search for health needs, identifying then assessing their impact and planning appropriate responses has become the accepted basis of professional practice. Whilst some elements of this principle are common practice across primary healthcare, health visiting differs in that the search for health needs is focused on *health and wellbeing* rather than disease or illness. A positive state of health is recognised as being both desirable and achievable by individuals, groups and communities with appropriate support and interventions. By contrast, colleagues in the field of primary care nursing normally enter into a professional relationship with a client that is constrained by a pre-determined diagnosis of an illness or disease, which may take less account of wider issues related to health needs, such as poor housing or noise pollution.

Terminology

This updated edition of the principles of health visiting draws on the published deliberations of earlier working groups (CETHV 1977, Twinn and Cowley 1992, Campbell et al 1995). In the original text, then in subsequent work, the use of particular words used within the principles gave rise to considerable comment and discussion, but the overall principle was consistently regarded as helpful and still relevant. Decisions were made by later working groups to retain the wording in the original, whilst acknowledging variations in emphasis as needs and policies change.

- The word **'search'** led to some concerns from the start that it implies inquisition, suspicion and aggression rather than partnership, whether at an individual, family or community level (CETHV 1977; Twinn and Cowley 1992). However, it is the manner in which a search is carried out that will make it acceptable or unacceptable to the client. The search requires the use of a variety of skills, including high levels of competence in active listening, observation and questioning.
- Alternative terms were first considered, then rejected by the earlier working groups (Twinn and Cowley 1992). **Identification** and **assessment** were terms that, to some participants suggested a more dynamic activity, which were more familiar, and could possibly reflect current practice more accurately. However, it was felt that both assumed that a need had been, or would be, found. That rules out the possibility of a futile search, or one that accurately discovers no active health needs at the time.
- A key difference between health visitors and most other health professionals is that the latter often clarify their work by focusing down onto a key diagnosis or priority need. In contrast, health visitors often start from a single topic or scheduled contact, such as child health development or follow-up of attendance at an accident and emergency department, using it as an opportunity to open the discussion and search for wider health needs (Twinn and Cowley 1992, Campbell et al 1995). This may occur at the level of an individual, family or community, and accounts for the unpredictable nature of a great deal of health visiting activity (Cowley 1995b).

- The processes involved in searching for health needs are, in many respects, parallel to those involved in **research**, which was another suggested alternative to 'search'. It implies a systematic search, involving the analysis and interpretation of data to identify health needs within the community. However, whilst this was explored in 1992, there was some concern that the term may be abused or misunderstood in practice, particularly as research skills are becoming more significant.
- **Need:** The distinction between 'need' and 'problem' was discussed in the 1992 working groups, since the terminology of 'problem' can create difficulties in health promotion. Although the word 'need' is used more freely these days, it may still be used in a way that implies 'problems', which may be stigmatising. The clients' perception of the relationship between problem and need, and recognition of their perceptions, seem important still (Cowley et al 1996).
- The nature and meaning of the term **'health needs'** is highly contested, albeit that it has been widely used in policy by successive governments (eg DH 1989, DH 2000a, DH 2002a). Emphasising the importance of 'needs-led' healthcare can create dilemmas for practitioners as there appears to be no agreed definition of the concept of health need or method of ranking priorities. The views of professionals and clients may inevitably differ, as may views between professionals and between the state, voluntary and private sector. One of the key issues, developed when considering the 'stimulation of an awareness of health needs', is that people with the greatest health needs are often unaware of them; alternatively, those in power may not acknowledge the needs felt by some sections of the community. The search, therefore, includes both recognised and unrecognised health needs.

  Relative needs change with time, as do patterns of disease, highlighting the need for a much greater emphasis on primary prevention. When the working group met in 1992, they focused on the epidemics of coronary heart disease and HIV/AIDS, which remain concerns in 2006, although new priorities have arisen. There is also, perhaps, a wider awareness of the importance of early prevention now. Wanless (2004) chose obesity and diabetes as key 'markers' to show how early prevention (of obesity) could avoid later expensive and debilitating disease (diabetes). Key health issues identified in the most recent English public health white paper (Secretary of State for Health 2004) include smoking, an increase in obesity, alcohol misuse, risk-taking sexual health behaviour, mental health problems and teenage pregnancy. The importance of improving the health of the population through reducing the rates of heart disease, cancer and mental health problems, improving the life chances for children and responding to the chronic illness agenda is central to current health policy and driving primary care practice. The search for health needs operates at the level of the individual and family, and at the level of the community or caseload.

Individual and family health needs

The use of non-directive and non-authoritarian listening approaches rather than didactic questioning are more likely to be welcomed by service users (Austerberry et al 2004, Machen 2000). Searching for health needs is therefore an activity that should involve 'working in partnership', recognising that clients, as well as health professionals, may be equally knowledgeable in finding, identifying and solving health issues (Chalmers 1993). Recent research (Appleton 2002, Cowley and Houston 2004) has also highlighted that health visiting needs assessment processes often occur concurrently with meeting some of the needs (eg for information, reassurance, advice etc). Developing family health plans with clients whilst simultaneously enabling them to identify health needs as they see them (DH 2001) is one example of this.

The identification and affirmation of a health need may be the starting point for empowering clients, including those with emotional barriers, those lacking sufficient knowledge or insight into their problems. For example, whilst the activities of the health visitor at the new birth visit may be determined by the health organisation's protocol or checklist, the use of advanced communication skills enables both actual and potential health needs to be identified. It is important to recognise that there may be conflicts between the goals of the organisation in meeting government targets and the goal of the health visitor to promote health and empower clients.

Whether clients are willing to build a trusting relationship with a health visitor as part of the empowerment process will also depend on the context in which the search for health needs occurs. Traditionally, the emphasis in health visiting has been on the value of the home visit for both preventing health problems occurring and proposing plans of action for those that already exist (CETHV 1977). In recent years the increasing emphasis on cost-effectiveness by government and National Health Service organisations has led to a nursing managerial culture that questions the value of the home visit in achieving health outcomes. However, evidence suggests that home visiting is associated with several positive health outcomes for families with young children, such as improved detection and management of postnatal depression and amelioration of child behaviour problems (Elkan, Kendrick, Hewitt et al 2000, Bull et al 2004).

Resource constraints have influenced the delivery of a home visiting service particularly in inner city areas where staff recruitment and retention is a problem. Health visiting workforce figures indicate a decline in numbers over the last 15 years, with less than a quarter being aged under 40 years (Cowley 2003, News 2006a). The rapidly spreading use of a skill mix model of health visiting, with health visitors leading a team of community staff nurses and nursery nurses, may also mean that practitioners other than health visitors are delegated the responsibility of searching for health needs as part of the health visiting service. In terms of professional accountability, appropriate training and support is required to ensure that all levels of staff are able to recognise their limitations and abilities in health needs assessment. This may occur within the home, the child health clinic, the school, during group-based programmes or opportunistically, and raises issues of accountability under the *NMC Code of professional conduc*t for the health visitor team leader (NMC 2004b).

Sharing information

Currently, health information is stored both in computer records and paper-held systems, making difficulties in accessing data. The lack of a single NHS information technology system has further compounded the issue although the NHS Care Records Service, once in place, is supposed to allow information to be shared by health professionals and accessed by clients. In the interests of safeguarding children, there is clear guidance about sharing information where there are concerns about child welfare, and computerised child index systems are being developed to assist this (HM Government 2006a). A common assessment framework (CAF) has also been agreed, which is helpful for interprofessional and interagency working when there are complex needs, or additional needs that cannot be met by a single professional or agency (HM Government 2006b).

The CAF has two advantages for health visiting, in that it emphasises strengths as well as needs, and also uses 'open fields' as trigger areas for discussion (which do not all need to be completed) , rather than closely worded questions. Assessment tools that rely on questioning can inhibit listening, so are less effective at identifying needs, particularly amongst those with

the highest level of need (Cowley and Houston 2003). Cowley and Houston (2004) identify three approaches to assessment, which are all important in health visiting practice:

1 assessment that is primarily concerned with promoting health
   a) an open agenda is needed
   b) partnership working and empowerment are uppermost
   c) operates simultaneously with the other principles of health visiting (stimulation and facilitation)
2. targeted assessments, used for screening or planning programmes of care
   a) analagous to the diagnostic process
   b) well-validated instruments are needed
   c) systematic processes and organisational planning are central
3. assessments for prioritising, used for purposes of public health
   a) population-wide; analogous to epidemiological assessment of needs
   b) deprivation scores and population 'risk factors' dominant
   c) designed to inform distribution of resources.

These three approaches are all equally important, but cannot necessarily all be carried out at the same time. Instead, a system is needed, whereby information can be collated into community or caseload profiles, which are extremely helpful to commissioners and service planners.

Community and caseload profiling

Wanless (2004) identifies the importance of good quality health data for monitoring the health needs of populations, yet information collected is generally poor. Health visiting students required to develop profiles of caseloads, communities or other populations find difficulties in accessing good quality information as data may be out of date, difficult to access or not available. For example, students profiling domestic violence in an inner city area found inconsistent data available in health visitor profiles, no mention of the issue in the public health report but national figures that indicated this was a key health need. Health visitors are very well placed to make sense of such contradictions, but to achieve this they need to have specific knowledge and skills, for example:

- research skills
- familiarity with information technology
- the ability to collect, collate, analyse, interpret and communicate data on the health and wellbeing of defined populations
- the ability to produce a report in a format that is accessible to both:
  – practitioners working in the field of public health and
  – to service users, carers and the wider public
- the development of a questioning approach and the ability to record information in a systematic manner, which will be essential for effective health profiling.

Porter (2005) identifies that at least three types of information are required to profile the health needs of a population, including information to describe the basic characteristics of the community, information to describe and monitor the health status of the community and information on the determinants of health in the community. However, as Raymond (2005) suggests, this creates dilemmas for those searching for health needs, as populations do not consist of homogenous groups or communities. Differences in distinguishing characteristics,

relative health needs and attitudes to health make the process of data collection and analysis exceedingly complex.

Part of the search process involves developing and sustaining relationships with individuals, families, groups and communities, with the aim of improving health and wellbeing and identifying those most at risk and in need of support. These data can then be used to help inform the development of service provision at a local level, which is explored further under 'the influence on policies affecting health' (Chapter 7). It is therefore important to raise awareness of potential health needs as well as acknowledged health needs in order to predict future health trends and meet the existing and changing health needs of a population. Health visitors should use both qualitative and quantitative data when developing health profiles in order to allow the voice of actual and potential service users to be heard.

The search for health needs, and elements of it, has been widely researched to show the complexities of health visiting practice, and it is not possible to include all aspects in this chapter. Suffice it to say that the search for health needs is a complex process involving activities of partnership with the public, including empowerment of clients to express their own health needs, data collection, data analysis, and, most importantly, dissemination of the data to stimulate an awareness of health needs with those responsible for commissioning of services.

6 PRINCIPLE: STIMULATION OF AN AWARENESS OF HEALTH NEEDS

The principle of the search for health needs is seen by many as a starting point for health visiting practice. Today, it seems obvious that data collected through the search provides a useful source of information for prioritising the key health needs of a population. If fully collated, these data can enable commissioners and service providers to respond appropriately to identified needs, arranging services that promote the health of actual and potential service users and their carers and reduce inequalities in health. When the earlier working group met in 1992, the internal market in healthcare was a very new phenomenon, of which they were acutely aware (Twinn and Cowley 1992). They concluded that there was a need for an approach which encompassed three different levels of action, which had not been recognised in the original document (CETHV 1977). Now, it seems clear that the stimulation of awareness of health needs encompasses clients (individuals and communities), health service managers (from both commissioning authorities and provider units), and politicians and policy-makers at a national level, where it overlaps with the 'influence on policies affecting health'.

The idea is that the principle should not be restricted to pointing out where needs lie, or stimulating awareness among 'needy' individuals or communities. It should also be seen as an opportunity to ensure that those who are responsible for providing or commissioning services become aware of any hidden or unmet health needs in their area. This aspect is especially important since constraints imposed on health visitors by inappropriate contracts may prevent health visitors from being able to work effectively. Also, if society in general, or politicians in particular, remain unaware of the impact or seriousness of certain health-related matters, they are unlikely to enter discussions about policy formulation. This can only be achieved if health visitors and others work collaboratively to ensure that politicians and those who are responsible for commissioning or providing services are made aware of the actual and hidden health needs of populations, as well as clients being empowered to take responsibility for their own health where possible.

Terminology

As with the other principles, working groups chose the words carefully in the first instance, and have revisited them each time the principles were considered. The overall phrasing of the 'stimulation of an awareness of health needs' seemed particularly clumsy, yet no agreement could be reached about alternatives and the conclusion was that the principle remains extremely meaningful as it stands (Twinn and Cowley 1992).

- The working group that met in 1992 discussed the connotations attached to the term **'stimulation'** (Twinn and Cowley 1992). The thesaurus links the term to activate, augment, increase, invigorate, so it can be seen as having a ripple-on effect and applies both where some awareness already exists and where it does not.

- In the original document (CETHV 1977) there was a great deal of attention to the idea of **'motivating'** people, but using this word suggests the health visitor is doing something 'to' or 'apart from' a client, rather than working in partnership, or 'with' people. To some extent, this applies to the idea of 'stimulation', which may seem one-sided.
- Other suggested alternative terms included **'promotion', 'development' and 'facilitation'.** These all seem able to include shared ownership of the activity more readily than 'stimulation', but each suggests increasing an awareness that is already established. The term 'creation' can suggest 'bringing into existence' where no awareness existed before; however, it also implies a practitioner-led activity. No clear alternative was identified. Greater interest and consumer awareness in a whole range of issues, including health matters, is welcomed. Increasingly, health visitors are taking opportunities to work with established lay organisations and community groups. Stimulating awareness of health needs within a community may result in the establishment of an action or pressure group, or a self-help group.
- The NMC (2002, 2004a), having mapped standards for education against those required for public health, use the phrase to **'raise'** awareness of health needs in their proficiency standards. This seems to take a more passive stance than the invigorating activity implied by 'stimulation'.
- The original text barely considered the term **'awareness'**, yet this is a complex concept. 'Awareness' encompasses different levels of knowledge, belief, understanding and psychological acceptance. It is influenced by personal experience, social and cultural background, individual agendas for action and political stance. Both the practitioner and the client are 'aware' to some degree. Considerable advanced skills are needed for health visiting interactions which involve different levels of 'awareness' on all sides (Cowley 1991). Awareness of health needs occurs at the level of the organisation and the public, as well as between client and practitioner.
- Awareness of health needs is an essential pre-requisite for the facilitation of health-enhancing activities, pointing once more to the circular and inter-related nature of the principles. A recent term that has been introduced into policy is the **'personalisation'** of health plans, which is promoted in the English public health White Paper (Secretary of State 2004). That activity seems to need awareness of health needs on the part of service users, before they will seek support to develop health plans.

Awareness of individual and family health needs

The importance of recognising the adverse effects of poverty and deprivation on health has been clearly recognised in previous documents related to the principles of health visiting (CETHV 1977, Twinn & Cowley 1992). Within the UK the health gap between those in affluent sections of society and those in the most disadvantaged continues to persist and widen (Acheson 1998, DH 2003). The government aims to reduce health inequalities by tackling the wider determinants of health such as poverty, poor educational achievement, poor housing and unemployment through a co-ordinated programme of action (DH 2003). For many the experience of living on low incomes, in poor-quality housing, often in areas with high rates of pollution and where social exclusion is the norm, may lead to mental trauma and subsequent poor health. For health visitors working in deprived inner cities or where rural poverty is rife, the aim of empowering people to make informed choices about healthier lifestyles is hindered greatly by environmental and social factors.

If people are to become motivated to lead healthier lives, a complex process of building self-esteem and developing supportive environments is required, as well as providing appropriate support services which aim to tackle both short-term and long-term health and social issues. Stimulating awareness that health is a positive resource may enable people to fulfil their

potential and achieve wellbeing (Twinn & Cowley 1992) and is often achieved through one-to-one contact and building trusting relationships with clients that are built on mutual confidence. Health visitors need to recognise and encourage the further development of the skills and strengths of clients that promote healthy lifestyles and challenge any of their own value judgements that inhibit this process.

Deep-seated health needs are often highly sensitive, or may be psychologically buried so that individuals are not fully aware of them themselves. This is particularly the case where people have lived complex and deprived lives. In such situations, a point of contact about a 'safe' topic for discussion, such as infant feeding or weight, may provide an opportunity to open the discussion within a safe relationship. 'Routine' or scheduled activities can offer such opportunities, with the initial purpose of the contact being the mere 'tip of the iceberg' on many occasions (Collinson and Cowley 1998). It may be necessary to defend the existence of a minimum number of scheduled contacts to some health commissioners or colleagues, by stimulating their awareness of the hidden health needs of 'hard to reach' families (Barlow et al 2004).

Awareness of community health needs

Enabling communities to take action to improve poor housing, schools, play areas and local health services should also be part of routine health visiting practice and will require collaborative working with other agencies. The establishment of pressure groups, self-help groups and support networks may arise as a result of raising awareness of health issues. Involving service users in the planning and provision of state-run services such as Sure Start ensures that health professionals and others are made more aware of community health needs.

There also needs to be a greater awareness of the balance between individual rights and responsibilities so that people who participate in unhealthy activities are more aware of the effect on their own and other people's lives. Whilst life expectancy has increased, so has participation in unhealthy lifestyles such as smoking tobacco and cigarettes, drug taking, excessive consumption of alcohol and intake of poor diets. These problems are frequently compounded by lack of exercise, which may lead to obesity, low self-esteem and depression. An issue for the health visitor is the ethical dilemma of respecting the client as an individual and protecting and supporting the health of the wider community. The provision of health information at the individual level and family level is therefore an important part of health visiting practice and contributes to the wider health agenda of improving the health of the public.

The influence of the media on health related matters is increasingly widespread and whilst this may be beneficial in terms of increasing access to information, the quality of the accuracy of the data and the manner in which an issue is reported may lead to misunderstandings and health choices that may be detrimental to both individuals and communities. It therefore remains important that the public has access to knowledgeable health professionals such as health visitors, who are able to provide evidence-based information that is tailored to meet the needs of the individual. For example, advice on immunisations is not only important for promoting individual health but also the herd immunity of the community, thus protecting vulnerable individuals.

Furthermore, it is important that health visitors offer support and advice to voluntary organisations and consumer support groups and work with them to stimulate an awareness of health needs.

Similar problems of accuracy of data may arise through access to information on the worldwide web, where a plethora of information and multiplicity of viewpoints may provide the public with a greater awareness of health issues but creates confusion as to what information is reliable and valid. Health visitors require a sound research knowledge base and IT skills to be able to access and interpret data and use it appropriately to raise awareness of health needs with clients and others in order to keep people healthy and out of the healthcare system wherever possible (Secretary of State for Health 2004).

Whilst the government has identified key target areas for improving the health of the population (DH 2005), it is important that health visitors continue to identify and stimulate an awareness of potential health needs that are pertinent to local communities and take into account cultural issues. For example, identifying actual levels of post-natal depression is notoriously difficult as checklists of mood assessment such as the Edinburgh Postnatal Depression Scale are imprecise and do not ask appropriate questions that identify differing states of mental health relevant to all cultures (Coyle & Adams 2002). The recommendation is for the tool to be used alongside professional judgement and a clinical interview as part of the decision-making process.

Expanding awareness of health needs

Health visitors also need highly developed decision-making skills in order to determine when it is appropriate to act as an advocate for service users and carers and communities, to stimulate an awareness of health needs at a local level with health service managers and at a national level with policy makers. Health visitors have a duty of care which involves identifying and minimising risk to clients and must ensure that healthcare environments do not jeopardise standards of practice (NMC 2004b). If actual or potential health needs are identified and service provision is inadequate or non-existent, the health visitor needs to act on behalf of their clients to raise awareness of such issues at the appropriate level.

When acting in an advocacy role, health visitors also need to be aware of confidentiality issues related to sharing data. Information about individual clients must be treated as confidential and shared only with those professionals involved in the direct care of the client. Consent for sharing information outside of the immediate team is required unless the action can be justified in the public interest, in child protection situations or is required by a court of law (NMC 2004b). Health visitors will therefore need to be mindful of how data are presented when stimulating an awareness of health needs.

Whilst it is very difficult to prove the economic worth of prevention, recent government policy (DH 2004: 42) states that the National Health Service must become 'more of a health service and not just a sickness service'. The aim is to extend improvements in health to all members of the population through tackling inequalities in health and alongside this improving the health of the nation even further. Stimulating an awareness of actual and potential health needs at the individual, local and national levels may result in an initial increase in costs of service provision but will hopefully lead to long-term savings in terms of prevention of ill health. Enabling individuals to become more aware of the advantages of improving the quality of life both for

themselves and for the community and to take appropriate action to achieve this goal should be an integral part of health visiting practice.

Working in partnership with clients and communities to raise awareness of shortfalls in service provision that promote health in the broadest sense will require health visitors to work collaboratively with a variety of agencies across different sectors, including health, education, social care and housing (NMC 2004a). Taking on a leadership role and becoming more politically active will also be essential skills for future practice to ensure that relevant data is considered at appropriate levels to improve public services that promote health and wellbeing. The acquisition of assertiveness skills, lobbying skills and negotiating skills during health visitor training are all essential requirements for future practice.

Health visitors therefore need to be able to stimulate awareness at appropriate levels of society about factors that create and inhibit health and social wellbeing, including the availability and suitability of service provision and resources to meet both acknowledged and unacknowledged health needs. They must continue to support individuals, families, groups and communities to take action to improve their own health and wellbeing through stimulating an awareness of actual and potential health needs. At the level of both service commissioning and provision, and at the political level, they must be able to use evidence-based information to articulate the health needs of populations, acting as advocates for the communities. The next chapter will consider the activities of the health visitor in influencing policies at these levels in order to promote the health of local populations.

7 PRINCIPLE: THE INFLUENCE ON POLICIES AFFECTING HEALTH

This has always seemed the most controversial and difficult of the principles, partly because it seems so large in scope, but also because health visitors may be considered (by themselves, or others) too unimportant in the hierarchy of the health service to be permitted to 'influence' (Cowley and Appleton 2000). However, with the new emphasis on public health, which is itself a highly political activity that depends upon influencing and developing policies, this has become a more important element of the health visiting function.

Campbell et al (1995) highlighted the difficulties of influencing policies that were considered to lie outside the remit of the health visitor. Biomedical and physical illnesses were clearly identified as undisputed aspects of the work, but at that time it was not considered legitimate to focus on health inequalities or social and community issues. A decade on, national policies highlight the importance of public health and health inequalities. Even so, pressure for health visitors to focus on screening or provision of care for people with identified illnesses, such as long-term conditions, remains undiminished (DH and CPHVA 2003), and NHS provider organisations rarely approve time spent by practitioners on influencing policies affecting health.

Terminology

In 1992, the debate among group participants generated much discussion about the terms used within the principle. The terms **influence, affecting** and **policy** were all discussed at length.

- **Influence** can mean working with people at all different levels to raise awareness, to guide or give direction, to work upon, make oneself felt, to have mastery, to hold good offices. However, also implicit in the concept can be the opposing argument in that debate. 'Influence' can also mean to impel and bring pressure to bear. The principle was very clearly geared towards influencing policy-makers, rather than individual clients or the public, so there is an element of advocacy involved. Health visitors may serve as a resource, for example, in supporting local pressure groups working to improve local services or to support neighbourhood regeneration. Such activities need both the authority and the political skill to avoid compromising either individual health visitors, or their employers.
- The term **affecting** also generated debate in the earlier working groups, with some participants considering that 'promoting' provided a more accurate description of the activities carried out by practitioners and was more acceptable. However, practitioners not only work to influence factors that are perceived as being good for the health of an individual or community, but also attempt to change those policies that might adversely affect health. It was, therefore, decided that the term promoting was too limited to use in this context.
- The debate between **strategy** and **policy** highlighted a useful spread of understanding of the term. It was felt that the influence should not merely be considered in terms of NHS or political policies, but also in relation to the much wider arena of the methods used by

practitioners to go about their work. The importance of inter-sectoral work was highlighted in this discussion, and it was suggested that the term 'policy' might be interpreted as referring to a local strategy, so that the principle could seem more manageable and less threatening.

A major focus of the discussion that took place in 1992 included an emphasis on innovatory practice initiated by health visitors in response to changes in society, but also the major changes in the NHS at that time (Twinn and Cowley 1992). The introduction of a 'purchaser-provider split' was identified as providing health visiting with the opportunity of influencing policies (Twinn and Cowley 1992). This organisational division continues, with commissioning bodies having a specific brief to first identify, then provide, services to meet the health needs of local populations. The activities of community development and community profiling were singled out as key ways for informing and influencing policies at a local level. Since that time, the focus has turned to three intertwined mechanisms through which this principle may be implemented:

- information/health intelligence
- innovation and change within NHS/health sector
- acting as a resource.

Health intelligence

Good information is needed to identify health problems early enough to develop policies to prevent them (Wanless 2004). As a result, the DH is encouraging the development of 'health intelligence' as part of the wider public health endeavour (DH 2006). Specialists in this field are being appointed, and are keen to gain accurate information about what is happening in the local area. Whilst objective, published epidemiological evidence is highly important, health visitors can offer a broader and possibly more immediate and holistic view of health, incorporating individual and community views and interpreting sometimes puzzling information. As a result of the 'search for health needs', those working at the grass roots often have information ahead of the published statistics, for example:

- knowing when a criminal drugs syndicate has moved onto a housing estate targeting new mothers, long before crime statistics catch up with this
- understanding how new policies, such as tax or welfare benefits, or about family support, housing or asylum seekers are being implemented locally and are affecting individuals and families on their caseloads; this means health visitors are able to pick up information about emerging needs before they reach high levels
- familiarity with local cultures and knowing the pivotal features in an area, such as local employment (eg single major employer, vulnerable in times of recession, or wide commuter belt leading to social isolation), transport and housing policies, and how they affect families and communities.

By highlighting the personal impact of issues and explaining how these feed through to influence health, health visitors can help policy-makers understand the implications of proposed or needed policies, at a local or national level. Cowley and Billings (1999b), for example, used community profiling within an action research approach to convince local health commissioners to invest in a full-time community development worker and a health visitor for school-aged children in one deprived area. Coining the term 'micro-public health', Grant (2005a, b) used community participatory appraisal methods to identify the views of the community about what their health needs were, then supported the development of a range of

different groups and services to meet those needs. The groups, in turn, provided a rich source of information to the local Public Health Directorate, to inform wider service developments.

Health visitors are well placed, in this way, to help collect useful information about the health status of the population they serve. Generic health visitors have contact with all mothers who have recently delivered babies. Although the universal nature of the service may be threatened by reductions in their numbers, health visitors use their work with mothers and babies as an 'entry gate' to the whole family and the wider community. From this range of contacts, health visitors can distil information that is very helpful for service planning. Such data are not best achieved through checklists or questionnaire-type assessment tools. A metaphor coined by Sir Muir Gray (cited in DH 2006: 11) suggests that 'Information is like water. It must be gathered from where it falls, channelled, cleaned, treated and tested before being stored in reservoirs. It must then be made available on tap to those who need it, wherever and whenever they need it.' Making it 'routine' to ask everyone a series of questions about issues of concern to service commissioners, instead of allowing clients the opportunity to discuss their health needs in their own preferred way, creates anxiety, inhibits empowerment and interferes with the 'search for health needs' (Cowley and Houston 2003, Cowley et al 2004). It is not feasible to develop a single instrument suited to both family health needs assessment and the purposes of health intelligence (Cowley and Houston 2004). Instead, health visitors need to be given the time to analyse and synthesise the (anonymous) information they have to hand, before passing it on.

Innovation and change

The development of new services and new approaches to service provision has been a long-standing feature of health visiting, with adaptations (as described in Chapter 2) recorded back to the start of the profession. It is not always possible to disentangle the contribution of health visitors within multi-agency or multi-professional projects, particularly since the major purpose of developments is to improve services, rather than promote professions. In the last decade, as well, there has been an increasing tendency for official documents to refer to 'nurses' but not to health visitors, which obscures their contribution. When the government established a development project for health visitors in 1998, for example, 31 demonstration posts were set up, but the post-holders had to be called 'public health nurses' to be funded. Included in the development programme were four whole-systems pilots, which highlighted the complexities and need for strong organisational support to implement really far-reaching adjustments to practice (PHAAR 2003, Brocklehurst 2005).

However, the usefulness of health visitors acting as a bridge across agencies has been widely recognised (DH 2002b). To achieve this, health visitors need to operate as members of multi-disciplinary working parties, project steering groups and so on. Whilst not every health visitor in an area needs to be on every group, it might be argued that each health visitor should be on at least one, representing their colleagues in the planning and organising of local service provision. The need for their input continues to be acknowledged in running multi-agency activities such as Local Sure Start Programmes and in establishing new Children's Trusts. Again, time needs to be allowed for this activity in service contracts.

Acting as a resource

This element incorporates two aspects of the influence on policies affecting health: either direct (health visitors influencing) or indirect, where health visitors are asked to provide or interpret health-related information to individuals or groups who, themselves, wish to influence a policy.

Direct influence may be exercised by undertaking and publishing research undertaken about key areas of practice or about what affects health; such studies will be identified by policymakers, or can be cited in response documents. Appleton's (1996) work, for example, was influential amongst public health departments in showing that most of the clinical practice guidelines about how health visitors should prioritise families for support were invalid. Similarly, Elkan, Robinson, Williams et al (2000) argued cogently from the systematic review they had recently completed, that a universal, not selective, health visiting service was needed. Numerous small, local studies or academic theses are completed and not published, yet Elkan, Kendrick, Hewitt et al (2000) demonstrated that this is one of the most consistent sources about health visiting knowledge and development of the profession.

Health visitors may lead policy developments (including, but not limited to, service developments) themselves, or more often they may influence by informing or responding to policy proposals or consultation documents, whether about local services or national organisations such as the Department of Health, Nursing and Midwifery Council and so on. This may be achieved either by an individual health visitor who has an interest in a particular field, through employing organisations, or through professional bodies (such as the CPHVA and UKSC, who are responsible for producing this book) and special interest groups. When making responses, it is important to set out clearly who it is from, identifying who has been involved in formulating the response (eg small group discussion? formal consultation exercise across the whole union or one branch?). Also, responses from employing organisations must be formally sanctioned, that is, must be written with the agreement of management. Having said that, policy-makers generally appreciate carefully constructed feedback, particularly when it includes information that is not available elsewhere, and facts and figures that can be substantiated. Making a response raises the profile of the responder, so organisations, too, often value an offer to collate information about key areas. Again, this needs to be recognised as a core component of health visiting practice, and time allowed in the working week – not a common situation at present.

Working indirectly, health visitors may influence policies affecting health by enabling pressure groups to access and understand information about health. Community development activities, for example, may include working with a neighbourhood group who want to improve local public transport, and who need help to explain the impact of social isolation on health. As always with this principle, it is important to be politically aware of the potential ramifications of this approach to influence.

This indirect approach may include an element of advocacy, particularly where existing policies are sufficient but may need interpreting differently. Such matters are rarely reported, since (though cumulatively important) individually they are not always regarded as sufficiently important to publish. One reported example involved a mother being asked by a police officer to refrain from breastfeeding in public; the matter was said to have been 'taken up by a health visitor' although the police denied receiving a formal complaint (News 2006b). Another, unreported, example included collaborating with the environmental health department so that, during routine inspections of food premises, their officers would just ask the question 'Do you

have facilities for mothers to breast feed?' As these examples show, the influence on policies affecting health includes ensuring that policies are understood and implemented in a manner that is conducive to good health.

Overall, this principle appears to be the most daunting for practising health visitors. Yet it remains as much the case now as when it was first coined that 'If it is accepted that health is of value and worthy of achievement, then the health visiting profession has a responsibility to influence policies that affect health, and in order to achieve this, health visitors will have to engage in political activity' (CETHV 1977: 44).

8 PRINCIPLE: THE FACILITATION OF HEALTH-ENHANCING ACTIVITIES

In the original booklet (CETHV 1977), facilitation was linked with the term 'enabling', which has become more commonly used in recent years. It is of note that neither term expresses the act of doing things for or to a client; nor are they concerned with assisting or helping. In this respect, it helps to distinguish the work of health visitors from many other health professionals who aim to offer treatments or rectify self-care deficits. The principle focuses on social aspects, considering how these might be a factor in the activities undertaken by people, as individuals, in families or communities. Although this emphasis on social aspects can be traced back to the start of health visiting, even when the principle was first identified it was considered quite contentious (CETHV 1977). It stressed that practising in a way that focuses on disease eradication, rather than health-enhancement, would lead to dependence on professionals, rather than enabling people to develop their own resources for health.

Now, there is a wealth of research showing the importance of the social context of people's lives, since this affects the kind of activities they engage in (Wilkinson and Marmot 2003); also that operating through an 'expert model' inhibits health, whereas a partnership approach enhances independence and development (Davis, Day and Bidmead 2002). Notwithstanding this, successive working groups have expressed difficulty in having the social focus of their work regarded as legitimate (Twinn and Cowley 1992, Campbell et al 1995) and health visiting has become increasingly medicalised (Cowley et al 2004).

Terminology

As with the other principles, the wording of 'the facilitation of health-enhancing activities' was the subject of debate and discussion among successive working groups, with a general consensus that the individual words and phrases were less problematic than the whole phrase, which, in turn, was still accepted overall.

- The term **'facilitation'** was originally felt to be clumsy and inelegant, yet the working group re-examining the principles in 1992 hardly mentioned it, as it had become such a commonly used word. It is still widely used and accepted, although the actual meaning of the word ('the process of making something easy, or easier; to make possible') may have been obscured by over-use. The thesaurus links 'facility', 'facilitate' and 'facilitation' with:
  - possibility and availability
  - potential, enabling and empowerment
  - simplification and smoothing the way by removing difficulties.
- Current government policies stress choice and personalisation of services (DH 2004), although there is little detail about the complex process of facilitation that this entails. Originally, facilitation was said to operate at two levels: that of the individual client, and of the healthcare team (CETHV 1977). The working group that met in 1992 wanted to emphasise a broader community stance than the individualised focus implied in the original text. Communities and

social groups, as well as individuals, could be the focus of facilitation and may be regarded, collectively, as clients. The NMC (2004a) have made clear that the term 'social group' includes families, despite the (otherwise) apparent emphasis away from family support in the new framework for health visitor education.

- When the working group met to discuss the principles in 1992, they discussed the phrase **health-enhancing** activities. The substitution of health-promoting activities was suggested, since health promotion is fundamental to the practice of health visiting. To some, 'health promoting' seems a more familiar and meaningful phrase than the rather elevated and lofty tone suggested by 'health enhancing'. At that time, general understanding and recognition of the phrase 'health promotion' had increased. Some confusion about the difference between health promotion and health education continues, with health promotion being of particular interest to health visitors, as it is mainly associated with primary prevention and with creating structural or community changes. On the other hand, health education tends to be linked with a more individualistic stance and with the medically-oriented screening activities for secondary and tertiary prevention (Cowley 2006). In 2006, it has become less common for 'health promotion' to be used as an overarching term in policy documents. 'Health improvement' and 'public health' occur more widely. Using the term 'health-enhancement' reclaims the positive focus of health as a resource for living (WHO 1986a) and a potential for achievement (Seedhouse 1986), which are both of central interest in health visiting (Cowley and Billings 1999a).
- **'Activities'** was originally selected as a term in preference to 'behaviour', as it was considered more neutral and less likely to attract judgemental comment. Lifestyle is well recognised as a source of health or disease (Marmot and Wilkinson 2006), and there has been much policy attention to separate aspects of this, particularly focused on smoking, use of illicit drugs or alcohol, food behaviour and physical activity (Secretary of State 2004, DHSSPS 2002, Welsh Assembly, 2001, Scottish Executive 2005). By focusing on the facilitation of health-enhancing activities, the principle recognises the complexity of people's lives within a psycho-social and cultural context, which affects their activities and the choices they make.

A key issue for the group that met in 1992, which has become even more pertinent for this updated issue of the principles of health visiting, was to see 'facilitation' applied at multiple levels. Individuals may need support with managing specific difficulties or with accessing services; this is also true of vulnerable population groups and communities. In this respect, it links closely with the principles of 'the search' and 'stimulation'. The work may be carried out by health visitors themselves, through teamwork or by multi-agency liaison and collaboration, where it links with the principle of 'influence'. It fits closely with the economic imperative of enabling the whole population to become 'fully engaged' in their own health, by engaging in activities that reduce the likelihood of them needing to call on NHS provision (Wanless 2004).

Empowerment

The longstanding commitment by health visitors to work towards empowering their clients (CETHV 1977, HVA 1987) was reiterated by the working groups in 1992 and 1995 (Twinn and Cowley 1992, Campbell et al 1995). Recently coined terms for this way of working include 'partnership working' (Davis et al 2000) or a 'strengths-based approach' (see Box 8.1). This is more effective than focusing on deficits and problems (Macleod and Nelson 2000), and more acceptable to clients and families using the service (Machen 2000, Normandale 2001).

Box 8.1 Strengths-based practice
(adapted from Kruske 2005)

- A belief that all families have strengths and capabilities and are more likely to respond to interventions that build on these than to ones which identify deficits and weaknesses (Darbyshire and Jackson 2004)
- A belief that working in partnership with families empowers them to parent more effectively and builds on strengths identified by them. Expertise of the professional is complementary to expertise of the parent (Davis et al 2000)
- Concerned with focusing on family strengths, particularly working with mother/parent to influence child's health and development (Barnes and Freude-Lagevardi 2003, Darbyshire and Jackson 2004)
- Concerned with building skills and capacity rather than dependency; the professional acts as a resource and facilitator; requires active participation of client (Twinn 1993, Cowley and Billings 1999a, Houston and Cowley 2002)

Working in a way that emphasises the 'normal' rather than the deviant (Chalmers 1992), and enabling people to develop their own capacity and resources (Cowley 1995a) are important in maintaining a strengths-based approach to practice. A community-oriented approach, which involves facilitating groups of people with similar needs and enabling them to develop their own strengths, is another significant way of enhancing health. This may increase social capital in an area, which becomes a self-reinforcing resource (Cowley and Billings 1999a).

Outreach

Cowley (2001) has suggested that the 'twin pillars' of health visiting action are home visiting and community outreach, which are known to work well in complex community interventions designed to combat health inequalities. Home visiting programmes have been shown to be very effective at enhancing health in disadvantaged populations (Elkan, Kendrick, Hewitt et al 2000, Bull et al 2004), for example, although national policies have tended to discourage this approach (DH 2001). In one study, when new mothers were offered community groups as an alternative to supportive home visits, only 19% took them up, compared to 94% for the visits (Wiggins et al 2004). Discussions about whether home visiting, or centre-based (community) services, should be provided have been overtaken by research showing that a strengths-based (empowerment) combination of both home visiting and community outreach delivers the most improvement. In an international context, multi-faceted programmes, which combine home visiting, welfare, educational and health-related services are generally regarded as most effective (Macleod and Nelson 2000).

This multi-faceted approach is increasingly adopted in health visiting services. Group activities require well-developed facilitation skills, as well as suitable venues, which are not always available in NHS bases. It is made easier as multi-agency services are developed, whether in Children's Centres in England (DfES 2004), or through Community Health Partnerships in Scotland. Provision of a one-to-one, individualised home visiting service may be ideal in some circumstances, especially for the most vulnerable, who are often also the most disadvantaged. However, group-based activities may provide far better opportunities for people to gain peer support and acceptable practical information, make friends, reduce social isolation and promote wellbeing.

A national survey of health visitors, with 966 valid responses from caseload holders, showed they or their team offered a wide range of activities, from traditional work such as well baby clinics (98%), breastfeeding support (74%), antenatal/parentcraft (73%) and postnatal groups (65%), to the more recently introduced options of baby massage (64%), parenting groups (54%), or sleep and behaviour groups (45%) (Cowley and Caan 2005). Health visitors working in areas where it is possible to combine home visiting and group activities often report higher attendance by people from the most disadvantaged backgrounds. Although these people are often unused to group activities, it seems that attendance can be facilitated by first developing a client/professional relationship through home visiting.

Community outreach involves three different forms of activity, each of which is significant to the facilitation of health-enhancing activities:

- community-based groups (as above) focused on specific topics
- targeted outreach to disadvantaged populations
- community development.

There is a long history of health visitors providing specialist services that reach out to significantly disadvantaged populations. Groups such as asylum seekers, homeless people, travellers and looked-after children may need a specific service, particularly since they often have difficulty in registering at a general practice. Alternatively, there may be a decision within a local area to increase service uptake by key population groups, or to focus on specific topics from within the universal service. Considerable skill is involved in engaging the interests of the most disadvantaged people, who may perceive health professionals as 'authority figures', and feel their particular views are not readily taken into account (Barlow et al 2004, Peckover 2002). Part of the key is the ability to offer what are regarded as 'normal services' (Chalmers 1992) to avoid the perceived stigma attached to specialist services; in this respect the universal provision can help. Having a variety of different approaches and mechanisms through which vulnerable people can access services, such as 'routine' contacts and invitations to scheduled groups or other activities, can also enhance uptake of service provision. Health visiting is in an unusual position in the health service, in trying to increase, rather than reduce, use of services, particularly by the most disadvantaged groups.

Community development work is in keeping with the government's agenda to reduce health inequalities (DH 2003). This kind of approach can be traced right back to the radical strand of 19th-century health visiting, which aimed to change the adverse and health-harming social conditions in which people lived, by challenging the status quo and oppressive power structures (Dingwall 1977). Community development aims to bring about change within an area, by challenging structural features of disadvantage that undermine and disempower people living in poverty (Dalziel 2002). Most community development workers operate as solitary project workers, perhaps linked to a team of health visitors, but rarely holding a caseload simultaneously. Community development work is notoriously difficult to evaluate (Beattie 1995, Billings 2000), but there is a huge literature to show direct benefits of involving local residents in developing their own communities.

9 FURTHER ISSUES

Underpinning knowledge

The CETHV embarked on the eight-year investigation and debate about the principles of health visiting with the explicit intention of developing the knowledge base of the profession, for purposes of research, curriculum development, teaching and, most importantly, to inform practice (CETHV 1977). Since that time, the principles have served all the originally planned purposes, being carried forward in numerous workshops, curricula, publications and research (see Appendix 1), and have provided a unifying framework through which to explain the central philosophy, core values and essence of health visiting. Indeed, the growth of publications, empirical work and citations of the principles indicate quite clearly that they are as important now as when they were first conceptualised and identified some 30 years ago. Over that time, they have expanded and been adapted and modified to contemporary circumstances, whilst maintaining their value base and integrity as a single, unifying and explanatory framework for the profession. '*The principles*' has become a shorthand term to signify the basic framework and philosophy through which the knowledge base for health visiting practice is implemented.

However, as with each of the earlier publications, this one comes at a time of great uncertainty for health visiting. Revisiting the principles raises many questions about them, but does not provide answers. Should these questions be taken forward? If so, by whom? Two key areas need addressing:

1 the principles in relation to health visiting
2 the principles in relation to colleague occupations.

The principles in relation to health visiting

As shown in the preceding chapters, the principles are neither static nor self-perpetuating. Instead, they need constant attention from the professionals who use them if they are to remain relevant and useful as a framework for practice, teaching and research. There has been a gradual, but steady erosion in health visitor numbers since 1988 (Cowley 2003), leading to a real and present risk that the ever-reducing staff numbers prevent practitioners from implementing the principles that underpin their profession. Also, there is far more influence on practice now than ever before, from colleagues, managers and commissioners who are not health visitors. This can be very positive, with multi-disciplinary teamwork and inter-agency collaborations that accept and value the different contributions of all concerned in a shared endeavour. In those circumstances, the framework of the principles can help to explain the work, but some explanations may fall on deaf ears. What if practice is carried out without a strong, positive value afforded to health, or if it eschews the proactive, universal implementation of the search, stimulation, influence and facilitation? Is it *health visiting* practice in those circumstances? Some may suggest that it does not matter if it is not. However, as identified in the preceding four chapters, the principles of health visiting offer a coherent, guiding framework for implementing sound, evidence-based practice, and explaining the

purpose of the work. Where different values and knowledge are used to underpin practice, the evidence base and purpose are not always clear.

Emergent principles

Health visiting services are described as 'universal' in some government documents (eg DfES 2004), yet there is no clarity about what that means. Universality was identified as a concept that needed further investigation when the original principles work was being undertaken in the 1970s, which has not happened. As explained in Chapter 3, activities are considered to be public health interventions if their main purpose is to contribute to the health of the whole population they serve, even if they operate through meeting the immediate health needs of individuals and families (Cowley 1998, Keller et al 2004). This kind of intervention requires the whole population of interest to receive a service. Health visitors have provided a service to all families where there is a newborn baby since the early years of the 20th century. Services delivered in 2005 were the subject of a national survey of health visitors, in which over half the respondents described providing only one (new birth) or two visits and an invitation to attend the well baby clinic (Cowley and Caan 2005) to all families. This may be a universal service, but such restricted provision would be unlikely to contribute to the health of the whole population, so would not be regarded as a 'public health' service (Keller 2005).

A variation on universal service delivery, popularised over a decade ago (Audit Commission 1994, NHS Executive 1996), suggests that a sustained health visiting service should be offered only to those who have what have been called 'indicated needs', requiring early preventive interventions (Box 9.1). This approach has become known as targeting within a universal caseload. There is no evidence that it is possible to assess needs accurately at one contact, or that single assessments are effective as a mechanism for identifying those who most need help. There is considerable evidence that many health visitors have developed expertise in enabling people to recognise and act on their health needs (Appleton and Cowley 2003, Williams 1997), but this usually requires a sound relationship to have been developed through a series of contacts.

Box 9.1: Forms of prevention

(adapted from Mrazek & Haggerty 1994 and WHO 2004)

Universal prevention is defined as:

- those interventions that are targeted at the general public or at a whole population group that has not been identified on the basis of increased risk.

Targeting takes two forms:

- **Selective prevention** targets individuals or subgroups of the population whose risk of developing a disorder is significantly higher than average, as evidenced by biological, psychological or social risk factors.
- **Indicated prevention** targets high-risk people who are identified as having minimal but detectable signs or symptoms indicating predisposition for disorder, but who do not meet diagnostic criteria for disorder at that time.

Health visiting has been limited to the pre-school population in situations where restrictive service contracts and staff shortages have prevented expansion. Even there, contacts with mothers and babies have been used to reach out to all age groups, and to other needy

populations in the area (Cowley and Caan 2005). Specialist health visitors targeting vulnerable population groups have also been a long-standing feature of the profession (Elkan, Kendrick, Hewitt et al 2000), operating either through a universal approach to an identified group, or selectively to a specific public health topic. So, there are pertinent questions about whether the concept of 'universality' is of overarching relevance, or is a potentially important basis for health visiting. If universality were examined further, and acknowledged as a principle for the profession, decisions would need to be taken about how it would phrased.

The second concept set to one side in the 1970s, yet considered sufficiently important to note, was that of 'availability'. Is that similar in meaning to universality, or does it relate more closely to access and accessibility? If the latter, it would be very relevant to current government policies promoting access by disadvantaged groups, and the idea that all services should be organised to the convenience of service users, rather than professionals (Secretary of State 2004, 2006). Or perhaps, like so many concepts embedded in the principles of health visiting, it is double-edged in that availability of services is closely dependent upon the resources available to health visitors, and of the health visitors themselves. Health visitors cannot sensibly contribute the information they hold in their heads to health intelligence units, for example, when they have no access to computers or suitable software through which to draw up community profiles. If no venues are available in which to hold community group activities, multi-faceted services are impeded.

As with universality, the concept of availability seems to need further exploration, to discern its importance and relevance to health visiting. The questions that arise, then, are first, who will take this work forward, and second, are the principles, in general, still relevant, given the changed status of health visiting as a profession that is no longer recognised in statute?

The status of the principles

As indicated in Chapter 2, health visiting has existed as an occupation for more than 140 years; it was a profession recognised in statute between 1907 and 2004. During that time, service provision varied along with changes throughout the public health movement (Cowley 1996), but the underpinning knowledge and philosophical base has continued to develop and the evidence base strengthened, as outlined in this booklet. Despite this, when the Nursing and Midwifery Order was passed in 2001, the decision was taken to remove all reference to health visiting from the laws in which it had previously been mentioned, culminating in closure of the health visiting register in 2004.

These changes have left many unanswered questions about the status of health visiting at the start of the 21st century. Is it still a profession in its own right? If not, what is the status of all the practitioners currently employed as health visitors? And what will, or should, happen to the health visiting knowledge base in future? Until 2004, education and training was linked to regulation on a health visiting register, which has been replaced by programmes for specialist community public health nurses (SCPHN). Although the NMC have developed a non-statutory system of noting their qualification next to the name of registrants transferred onto the SCPHN part of the register (known as 'annotation'), it is not clear whether this will continue. Standards developed by the NMC (2004a) recognise that it is not possible to become proficient across defined areas of public health practice in the 45-week programme, but no standards have been established for annotation, so there is no mechanism for carrying this forward. The newly developed requirements for health visitor programmes (NMC 2002) became optional once the health visiting register closed. Overall, therefore, it is not clear whether it will be possible to qualify as a health visitor once existing validated programmes

have run their course. Without annotation, neither employers nor the public would be able to discern those individuals who are qualified and approved as competent to practise as health visitors. University programmes may be pressurised by purchasers to develop a generic SCPHN who is able to work in any setting but lacks the specialist skills necessary for health visiting practice.

In the face of such uncertainties and questions about the future of health visiting as a profession, some may suggest that it makes no sense to continue subjecting the principles of health visiting to a critical review and development. On the other hand, their value in terms of education, practice and organisation of the work is widely accepted, and there is no obvious alternative. Furthermore, testimony of each of the earlier publications is that, in times of great uncertainty, clarification of the underpinning principles of health visiting helps to determine direction and purpose for the future.

The principles in relation to colleague occupations

Although health visiting no longer exists as a profession in statute, the needs of service users have not reduced, so the function continues to be needed. The public health importance of providing a supportive health visiting service to mothers and young children, in respect particularly of its impact on health inequalities, and on the immediate and later health (mental, physical and social) of children, is acknowledged in much research and government policy (eg Acheson 1998, Barnes & Freude-Lagevardi, 2003, DH 2003). Also, the relationship between health visitors and colleagues in other fields and professions has never been more important, although neither the controversies nor the collaborations raise completely new issues. Nearly 30 years ago, Robinson (1982) completed an in-depth review of the policies and influence of social work, general practice and nursing on the development of health visiting through the first three-quarters of the 20th century. Today, we might add the child and family workforce and the emerging public health profession to that list. All have something important to offer, and increasingly exert influence over the present and future of health visiting practice.

In the context of this chapter, perhaps the most significant question is whether the principles of health visiting might be subsumed into the field of specialist community public health nursing practice. There are also questions about the relevance of the health visiting principles to practice in specialist community public health nursing. Decisions about whether it is possible or desirable to merge nursing and health visiting into one profession, through the mechanism of the new register for SCPHNs, have a wider impact on the relationships between health visiting, public health, social work and the child and family workforce.

Health visiting and nursing

As indicated in Chapter 2, health visiting became gradually intertwined with nursing as the 20th century progressed, with some ambivalence on both sides. Robinson (1982) suggested that many nurses and doctors, being aware of the chronic shortage of trained nurses to care for the sick, have tended to denigrate those who move away from that work as 'deserters', regarding health-focused work as a waste of nursing skills. Concluding her review, Robinson (1982: 19) commented that:

> 'Health visiting sits uneasily between social work and nursing, and enjoys a somewhat reluctant relationship with general practitioners. The expansion of social work and the consolidation of social services structures have been, to a certain extent, at the expense

> of health visiting. Nursing, on the other hand, has not denied health visiting a place, but instead has tended to diminish the preventive function. In so doing, an attempt has been made to 'level down' the educational requirements, and reduce the status of the role.'

There is not the space to undertake another in-depth review of similar policies for the final quarter of the 20th century. However, it may be argued that through the Nursing and Midwifery Order 2001, the contribution of health visitors and their particular preventive role has often been misunderstood and undervalued in policy since their register has been closed. This lack of clarity of the specific contribution health visiting can make may lead to the term 'public health nursing' being introduced to describe a new way of doing things, with health visiting cast in an 'old-fashioned' mould. This approach provides a self-reinforcing mechanism to support any stereotyping argument that health visiting is outdated, whilst simultaneously preventing it from developing.

In a national survey of registrants holding a health visiting qualification (N=1459), only 8% agreed that nursing and health visiting are the same, whereas 18% regarded it as completely different and a further 39% as somewhat different (Cowley and Caan, 2005). Proposals to replace health visiting with nursing roles and titles, therefore, lead to confusion about the extent of substitution and nature of change that they represent. Given these circumstances, the question of whether the nursing profession would be prepared to adopt and develop the principles of health visiting seems pertinent.

Specialist Community Public Health Nursing (SCPHN)

If the nursing profession as a whole seems often at odds with health visiting, there are many who point to the shared interests and similarities with some sections of it, such as school and occupational health nursing. A substantial minority of health visitors (34%) supported the idea that health visiting and nursing are 'somewhat similar', and 32% were pleased that the new SCPHN register had been set up, with 36% being undecided (Cowley and Caan 2005). For these people, perhaps, there are two main benefits to be gained from forging closer links between nursing and health visiting. First, many believe that establishing a register for specialists in community public health nursing makes a positive statement about the importance of public health in respect of the entire nursing workforce. The second (contested) belief is that health visiting is a form of public health nursing practice, but that the latter is broader in focus than health visiting. In this view, allowing health visiting a place alongside other groups within a public health nursing register enables greater flexibility than would be feasible with a specific health visiting register.

As initially configured, the SCPHN register included registrants who, under the UKCC, had been recognised (through registration or recording of specialist practice qualifications) as health visitors, school nurses and occupational health nurses. These groups all have a shared interest in, and commitment to, delivering public health services to individuals, communities and social groups (with families being one form of social group). They all differ from other nurses in that the primary purpose of their service is public health, including prevention, protection and promotion of health and wellbeing, rather than a focus on individuals with diagnosed health problems.

Although the principles of health visiting are not mentioned within the performance standards required for entry to the SCPHN register, identical wording has been used to describe over-arching 'learning domains' (NMC 2004a), which means that programme leaders could still teach the principles to all or some students, if they wish. Of the 24 specific performance

criteria, eight were drawn directly from the requirements for health visitor programmes (NMC 2002). Also, the guiding principles for the programmes, particularly under the heading of 'service: fitness for purpose' (NMC 2004a: 6) include many key values and criteria that are recognisably commensurate with the principles of health visiting, as outlined in this booklet.

The question about whether the principles of health visiting, along with their underlying philosophy, are acceptable or useful to the nurses included on the SCPHN register can best be answered by those practitioners. There are clear differences, as well as similarities, between occupational health and school nurses, and health visitors. School and occupational health nurses, for example, focus on specific age ranges, whereas health visiting incorporates all ages. All three are employed in different situations, with more overlap between school health and health visiting than with occupational health. Strengths-based practice (see Chapter 8) is of central importance when dealing with individuals from disadvantaged groups, whereas clear understanding of risks and regulations is key to safety in the workplace. Family health nurses (Scotland) have a primary focus on clinical issues, not shared by the other three groups. Given the scale of these differences, the SCPHN register may not be sustainable in the long term. Unifying around the principles that have served health visiting well over the years might help to promote sustainability, if this grouping were to take on responsibility for their development.

Health visiting and other professions

In recent years, most attention has focused on connecting nursing and health visiting more closely, which distracts attention from the links and shared interests between health visitors and other colleague professions. Social aspects and social determinants of health are central to health inequalities and public health, yet they are not a key feature within the NHS. The advent of Children's Centres and Children's Trusts, which will bring together social services, early years/education and child and family workers, is of great interest to health visiting. These are developing under the auspices of the local authorities and will apply across England by 2008, renewing debate about whether health visitors should be based in these geographically-located centres, rather than in general practices and Primary Care Trusts. Amongst other things, all those working with children are expected to achieve a core of competences (Secretary of State 2004), which are not included in the SCPHN register. In part, this is to promote flexibility and the potential for movement across the different occupations within the children's workforce. Health visitors should be well placed to participate in these developments, as so much of their expertise is related, not only to children and families, but also to concepts derived from the educational knowledge base (Cowley 1995a).

The public health profession, too, is developing a multi-disciplinary focus. Once the exclusive preserve of doctors, there is a voluntary register now established, with a view to seeking statutory regulation in due course. The key message has been that admission to the register is dependent upon achievement of firm, required standards that demonstrate the person's ability to do the job, rather than qualifications acquired before embarking on the training. Health visitors are generally very clear that their work is concerned with public health, with 88% in the national survey agreeing that public health and health visiting were either the same or somewhat similar (Cowley and Caan 2005). Where doubts arise, it is often because of different perceptions about what constitutes 'public health', fuelled by policy documents that promote the preferred alternative functions of long term disease management, outreach to specific target groups, and responding to established and identified needs (DH 2001, DH & CPHVA 2003).

One difficulty that arises from linking health visiting exclusively into the nursing field is that it tends to keep health visiting separate from everyone else, including colleagues in community

and public health, and those working with children and families. Only those who are already registered with the NMC are allowed to enter training for the SCPHN part of the register. The Nursing and Midwifery Council consulted on a direct entry route for this part of the register when first proposing it; 80% of respondents, including individuals (professionals and service users), organisations and those from all parts of the NMC register, supported the idea (NMC 2003). However, the NMC chose not to carry the idea forward, without explanation.

As a result of this decision, the health visiting profession is impeded in its ability to participate in many of the multi-disciplinary workforce developments being carried forward by both the children's and the public health task forces, and supported by the government's wish to reduce barriers in professional education (DH 2000b, 2002). In the national survey of registrants holding a health visiting qualification (N=1459), only 29% opposed the idea of direct entry training (Cowley and Caan 2005). When asked to choose which workforce should be responsible for developing their profession, 26% chose nursing, 29% the child and family task force, and 37% chose public health.

The way forward

The way forward for health visiting seems less clear than it ever has; yet this has been the case when concluding each of the preceding booklets focusing on the principles underpinning the profession. Two issues of major importance are obscuring the way at present. One is clear, immediate and urgent, being the steady reduction in the number of health visitors across the country (Cowley 2003, News 2006a) and the extent of services they are able to provide. This is being compounded by a wave of service cuts threatened across the country, and reports that training places are being reduced (News 2006c). If there are no health visitors to implement them, the issue of underpinning knowledge base and use of the principles of health visiting has no relevance.

The second major concern is far messier, relating to the ownership and use of the principles of health visiting. The old professional idea of a 'unique knowledge base' was recognised as outdated thirty years ago (CETHV 1977), when the combination of skills, knowledge and approach in practice were put forward as identifying health visiting as a profession, with their principles as a marker and unifying framework. Since that time, there has been an enormous growth in professional knowledge and technical advances in all fields, which leads to a paradox:

- there is more specialist knowledge within each role, and
- there is more in common across healthcare roles than ever before (Warner, Gould and Picek 1998).

As a result, the future lies in an increase in inter-professional teamwork, with different members each holding a common core of knowledge and each making a specific contribution to the overall task of the team.

The principles of health visiting provide a platform from which to contribute to this multi-disciplinarity, both in order to share their knowledge and to explain the particular contribution of health visitors. Some answer needs to be found to the questions of how these unique and valuable principles can be maintained and developed into the future. This is needed to ensure that health visitors can continue to provide the important service that has been a cornerstone of primary care, and of community, family and public health provision in this country for over 140 years.

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