The role of organisations in supporting the parent/health visitor relationship

› Abstract

This paper, the fourth in a series of five, presents selected data from a qualitative study undertaken to identify measureable indicators of the parent/health visitor relationship. It focuses on the role organisations play in facilitating the purposeful nature of the health visiting process based in relationship-building and partnership working. Slightly different skills were required for establishing and maintaining relationships. The data revealed the importance of organisations in supporting an approach that provided continuity of care, clinical supervision, manageable caseloads, time for home visiting and simplified record-keeping. These are discussed with reference to existing literature and research.

Key words

› Health visitor relationships › Organisations › Model of health visiting › Measurement indicators › Qualitative research

Health visitors (HVs) often assert the importance of relationships with parents in achieving effective outcomes, but this cannot be tested without a specific measurement tool (Bidmead et al, 2015). This paper is the fourth in a series of five reporting the process of developing a tool to measure parent/HV relationships.

Current literature and qualitative research were used to identify observable indicators of positive parent/HV relationships for the tool. The research methods are detailed in Bidmead et al (2016a). In brief, video stimulated recall interviews were carried out with six parent/health visitor dyads, then transcribed and analysed. The findings from the interview data were further discussed with a group of seven HVs and separately with a group of three parents.

The data were collected in a time of severe staff shortage, before the *Call to Action* (DH, 2011) increased the health visiting workforce size. In the two research sites, HVs were under pressure to restrict the universal service to just one new birth visit, usually continuing to visit only those families in greatest need. This led to a decision to prepare two separate sets of measuring tools: one reflecting the start of a relationship on first meeting parents; and one for use once a relationship is more established, after several meetings (e.g. at 3–4 months post-birth).

The relational qualities, characteristics and skills used by parents (Bidmead et al, 2016a) and HVs (Bidmead et al, 2016b) appear similar in both situations. However, the health visiting process varies somewhat according to whether or not it is a first meeting or later, as shown in *Tables 1* and *2*, according to the purpose of the contact. Introductions and clarification of roles may be more important at the first meeting, for example, whereas exploring issues, planning strategies and working towards outcomes may assume a greater importance in subsequent meetings. While the analysis was focused on identifying observable indicators for the planned measuring tool, it also revealed the purposeful nature of a health visiting process based in relationships and partnership working (*Figure 1*).

This purposeful approach appears central to achieving positive outcomes from the health visiting service, which is important to employing organisations. Despite this, in this study, employers were not uniformly supportive of relational ways of working. This paper reports how analysis of both the interview and group data shed light on the role of organisations in either obstructing or facilitating the development of parent/HV relationships.

Organisational factors

Some key issues were identified that stemmed from organisational arrangements that lay outside the immediate control of either parents or HVs,

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Table 1. First meeting

Universal health visiting service			
Health visitor qualities and skills	**Parent qualities and skills**	**Health visiting process**	**Outcomes**
• Knowledge and experience • Friendliness • Active listening • Open questions • Silence • Encouragement • Following parental lead • Giving parent time • Observation skills • Body language • Giving information/advice • Relating to the baby/child • Calmness and gentleness • Availability and approachability • Demonstrating respect • Empathy and understanding • Genuineness, honesty • Trust in parent • Caring with motivation to help	• Friendliness • Trust in HV • Openness, genuineness, honesty • Interest	• Introductions • Putting parent at ease • Eliciting parental expectations • Ensuring clarity of roles • Explaining boundaries of confidentiality • Establishing ground rules • Exploration of health needs • Clarification and understanding	• Enables the identification of family risk and resilience factors • Encourages access by the family to the universal *Healthy Child Programme* • Encourages parenting self-confidence • Encourages contact with the health visitor should a difficulty arise

yet affected their relationships (*Figure 2*). Parents wanted continuity of care from one HV and preferred home visits above busy, often crowded clinics. HVs were also concerned about caseload sizes and the bustle of clinics, which affected their ability to provide continuity of care. They also worried about other issues, such as record-keeping and clinical supervision. The HV group added further information to the data reporting the effects of unsupportive management and working in skill-mix teams.

Continuity of care

HVs and parents valued the ability to meet each other on a regular basis. When encountering an unfamiliar HV, the parent was reticent to share real feelings, or ask questions:

'Once, when I've been, there was someone else. And that's strange because you feel less inclined to talk to someone you've not talked to before because there is a degree of relationship that's built up over the last 3 or 4 months, I suppose, and then when you're faced with someone you've never met before there's a definite element of "Yes, everything's fine". Maybe it is fine, maybe you've nothing to talk about, but I'm sure if it was someone you had known before you'd be more likely to ask.' (P2)

One parent complained about the number of different HVs who visited her (P3) and found that she could not establish a relationship with any of them. HVs, too, spoke about the importance of being able to see the same client and establish relationships with them over time. Unless this happened, work with the families suffered from an inability to raise difficult issues:

'Well, it's difficult to form relationships with clients in the [HV locality] team. Most clients are lucky to get one visit—the new birth visit—and follow-up visits have now gone, and also parents now visit a different child health clinic to the one that you work at, so in effect you may never see those clients again.' (HV Group K)

One HV suggested that to access some of the more vulnerable parents, it was important to

Table 2. An established parent/health visitor relationship

Universal Partnership and Partnership Plus levels of service			
Health visitor qualities and skills	**Parent qualities and skills**	**Health visiting process**	**Outcomes**
• Knowledge and experience • Friendliness • Active listening • Open questions • Silence • Encouragement • Following parental lead • Giving parent time • Observation skills • Body language • **Challenging as appropriate** • Giving information/advice • Relating to the baby/child • Calmness and gentleness • Availability and approachability • Demonstrating respect • Empathy and understanding • Genuineness, honesty • Trust in parent • Caring with motivation to help	• Friendliness • Trust in HV • Openness, genuineness, honesty • Interest	• Remembering • Putting parent at ease • Eliciting parental expectations • Exploration of difficulties or problems • **Clarification and understanding** • **Aims and goals** • **Strategy planning** • **Outcomes, review and endings**	• Enables the identification of family risk and resilience factors • Enables the identification of family risk and resilience factors • Encourages access by the family to the universal *Healthy Child Programme* • Encourages contact with the health visitor should further difficulties arise • Enables the working through of difficulties • Encourages uptake of other services • Trust in HV • Builds parental self-confidence

have time to keep trying to visit, even though the parent was not at home or did not answer the door. In the discussion group HVs agreed that just being persistent might be enough to help establish a relationship.

HVs described ways in which they tried to reach out to those with whom it was more difficult to establish relationships, perhaps by relating to the children, admiring babies or making positive comments to build parental confidence. One HV explained that when she and colleagues were moved to a smaller team covering one geographical ward instead of two, they found it easier to maintain relationships with parents. They used their professional autonomy to decide that each individual HV should remain linked to parents they saw at the new birth visit. There was also a greater chance of seeing the parent in clinic.

Home visiting vs busy clinics

When meeting parents, HVs preferred home visiting to establish the relationship identified as important for continuing work. It allowed them insight into how families lived and they found parents more receptive and responsive to their requests for personal information. Visits were also deemed more appropriate for dealing with sensitive issues or to help distressed parents, in contrast to the busy clinic environment:

'I think … she was really upset in the clinic, and we were in one room and I saw that I couldn't really let her go because I could see that she was on the verge of tears, actually, and I took her into another room, she had to wait a little bit for me whilst I dealt with something briefly … we had more privacy and then I remember saying to her, "I think we haven't got enough time to deal with everything here". It was a baby clinic, and "I'm happy to come home and see you."' (HV5)

HVs were more likely to home visit for problems, particularly postnatal depression. The GP surgery waiting rooms where some baby clinics were held could be unsuitable, affording little privacy or time. The majority of parents preferred home visiting as well, as they felt more able to divulge issues that were difficult:

'Because [HV 2] comes into your home to see you, you feel you're much more able to speak freely.' (P2)

However, when a parent was unable to establish a relationship with a HV due to lack of continuity

of care during home visiting, she preferred to attend clinic. In community clinics, some HVs went out of their way to make the environment as sociable as possible, helping parents to feel at ease and introducing them to each other, but parents could also find clinics difficult.

Where parents could not readily recognise HVs, or other members of staff in the clinic, they did not know who to ask about the baby's health. With the busy atmosphere of the clinic, some found it impossible to discuss their worries, even though eventually they might identify someone with whom they could relate. Parents could just be left standing, waiting:

'One time, there was quite a nice lady, but the baby was sleeping and I wanted to ask something but I forget in this moment. OK people are waiting, "So you wait there, and when you remember you can ask me later". And then I waited outside and she was talking to somebody else outside and then I just waited outside, but you can't talk like that.' (P5)

Record-keeping

HVs reported they were hampered in their efforts to relate to parents by new technology intended to help them. Computer systems used, among other things, to speed up the process of record-keeping, could intrude on parent/HV relationships, particularly in the clinic situation where HVs felt the emphasis on recording parents' attendance interfered with eye contact and the flow of conversation:

'Yeah, computerised recording system. All the babies have to go on there and comments written for attendance which takes a really long time … but I didn't really want that to interfere with the service that we provide, you know. In some places they have reduced the numbers or not doing it, but I think … if we start concentrating on that record-keeping and those kind of aspects then we lose that personal communication and that's what it's all about.' (HV 3)

Record-keeping was considered a huge pressure generally in the HV group, as a new system of computerised recording was being implemented, so a dual system of electronic and paper records was in use. The time needed for this impinged not only on their face-to-face work with parents, but also on their ability to take the breaks required for maintaining optimum mental health. Increases in record-keeping could also be due to the involvement of other agencies; for example, HVs were expected to complete forms for children's centres, which added to the time spent at a new birth visit on form-filling instead of relating to the parent.

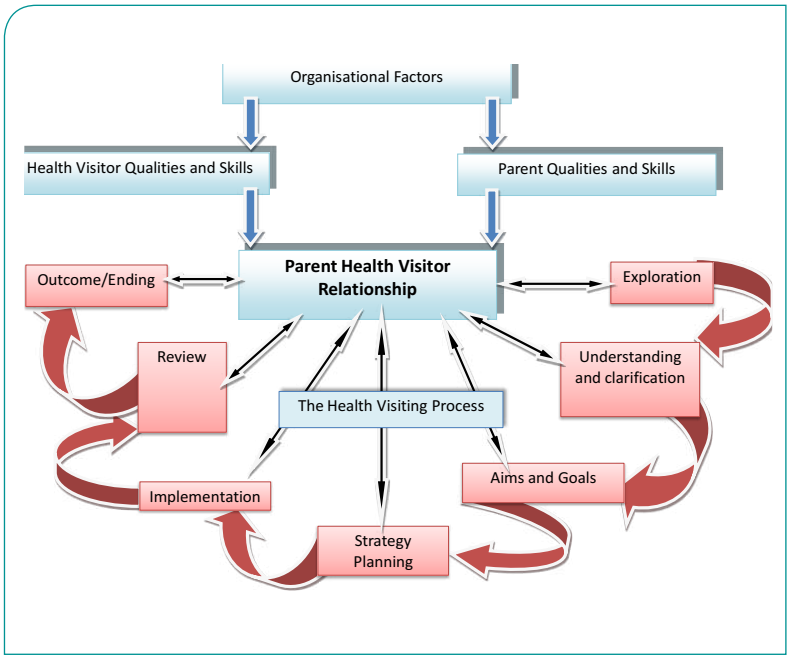

Figure 1. A model of parent/health visitor working relationships

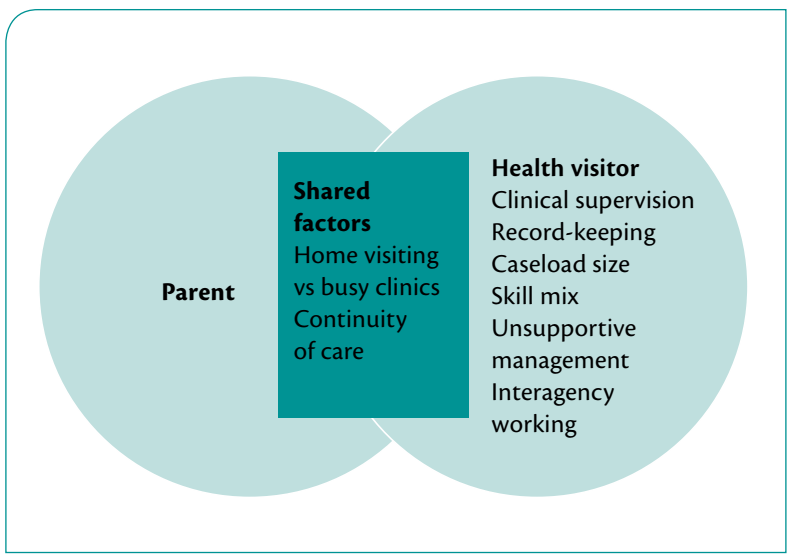

Figure 2. Organisational factors: comparison of health visitor and parent themes

Lack of management support for relationships

HVs in this study were particularly concerned about lack of management support for sufficient time to establish relationships with parents. They felt their managers undervalued this relational way of working:

Table 3. Organisational facilitators and barriers to relationship-building in health visiting

Facilitators for relationship-building	Barriers to relationship-building
Continuity of care (Russell, 2008; Van Walraven et al, 2010)	No continuity of care
Home visiting (Bull et al, 2004)	Intrusive home visiting
Clinics with staff continuity (Bowns et al, 2000)	Busy clinics (Kirkpatrick et al, 2007) with no staff continuity
Smaller caseload sizes—small teams (Bower et al, 2003)	Corporate working—large teams
Management support (Wong and Cummings, 2007)	Lack of management support
Working in partnership with other agencies (Evans and Killoran, 2000)	Fragmentation of services
Equity of service	No equity of service
Clinical supervision (individual interview data only) (Butterworth et al, 2008; Barak et al, 2009; Wallbank and Hatton, 2011)	Skill mix
	Record-keeping—dual system

'The other thing is, our managers are touting about, when you argue about relationship-building, they just say it doesn't matter ... that the client should be able to go and see a health visitor and get the same service from every health visitor—they ignore the argument.' (HV Group C)

These HVs felt their managers did not value their role by extending it into new areas. One possibly controversial example concerned the requirement of HVs to undertake 2 days' training to act as triage nurses in the local hospital in the event of a swine flu epidemic. The HVs considered that this devalued what they were already doing in the community. Of relevance to this is the way it affected the time they were able to give to their already oversized caseloads. Giving time to parents had been identified as key to building relationships with them.

Working with other agencies

The involvement of other agencies with the work traditionally done by HVs was not always seen positively; for example, the involvement of children's centre staff with more vulnerable families. They were seen as a relatively low-level intervention because they did not have the skills required to work with families that were more complex:

'I think the other thing is about the impact of children's services because, from my experience in Sure Start they were fine at low-level intervention but anything more complex was sort of out of their league, out of most people's league, and it does actually need to go to social services but I think there is a naïve expectation of some of the workers in the children's centres that they, you know, have more skills than they actually have.' (HV Group C)

Children's centres were seen as part of service fragmentation that was unhelpful for parents:

'It's not [an integrated service]; they [children's centre staff] are making decisions on behalf of the centre and we're making decisions in isolation as well, and there's confusion and fragmentation for everybody.' (HV Group K)

Other health services, also under pressure, seemed to be closing their doors. Particularly highlighted was the midwifery service, where a shortage of midwives now meant that mothers had to attend the hospital to see the midwife rather than receive home visiting postnatally. In addition, both the local and national Child and Adolescent Mental Health services (DCSF and DH, 2008) were under mounting pressure and had closed their local community service. These service

reductions were occurring at a time when families seemed to have increasingly complex needs. There was an anxiety that other services, such as social services, would not take referrals of families in need because the threshold for acceptance was set too high. HVs felt that, if they could get to know and support parents, this may have prevented referrals, but there was anxiety about health needs being missed in the 'big uncharted pool'.

Skill mix

The HVs reported that time pressures meant that their work had become restricted to dealing with safeguarding issues, rather than providing a universal preventive and health promotional service. This was now being provided by staff nurse members of the team, leaving HVs with a lack of job satisfaction and lack of continuity for parents:

'I think if you think of all the things we used to do like weaning, feeding, you know, all of those things, we're just skimming the surface now.' (HV Group N)

'One of the staff nurses here said to me this morning, we were talking about her doing her health visitor training. She said, "Oh but really, why would I, because all the things you used to do, I can do as part of my role now, that's what I really enjoy because what you're left with is safeguarding", which is very true isn't it?' (HV Group D)

Caseload sizes

In this inner-city area of urban deprivation the size of the HV caseload was a very important factor influencing the ability of HVs to establish relationships with parents. Caseloads for all the HV teams were well above the recommended levels (Cowley and Bidmead, 2009).

At the time of data collection, this was not unusual and caseload sizes were generally extremely variable and not linked to areas of deprivation (Cowley et al, 2007). HVs could not readily say how many were on their caseload as they worked in teams typically covering two wards. However, there was general agreement that the size of the caseload was unmanageable unless they had a specialist role, e.g. for the homeless, who reported:

'Our caseload is much smaller than ... the other corporate teams, because of the nature of them being in hostels and so you find that you can keep, even though we've got travel because we cover the [locality] as well, but you can make relationships ... because you have a smaller number of people ... it is quite interesting doing the corporate working, you can do it, but we have probably about a third of what the other teams have so you can do it with that number but certainly not with the sizes other people are having to work with.' (HV Group D)

» The time available for parent face-to-face contact and the availability of referrals to other resources appeared to be severely compromised in this study. «

Clinical supervision

Supervision was mentioned by one HV and not by any of the parents interviewed. The HV considered supervision very helpful but something that she had to seek out and find for herself. It appeared to confirm her in her practice and, as a result, she felt more confident in her ability to develop relationships with parents:

'I'm one person here who gets clinical supervision on a regular basis because I'm the baby in the family, whatever they say, I've only been a health visitor for 2½ years and I feel that I need regular supervision so I've found someone to supervise me and she's been a health visitor for a long time ... she says that it seems to her that … I'm doing the right thing …' (HV 6)

Discussion

The data analysis revealed HVs working under pressure. They valued their relationships with parents and tried to maintain them even though organisational constraints on their practice made this very difficult. They were keen to provide good-quality services to parents in spite of the problems. However, the way in which organisations manage services in primary care is known to affect the quality of care (Bower et al, 2003), just as there is a link between hospital organisation and the quality of patient care (West, 2001).

It is possible that there is a link between the organisation of health visiting services and outcomes for parents and children, although there is little research in this area. This is not a new idea, as Chalmers (1992: 1324) in her theory of HV practice suggested:

'The availability of referrals to resources such as health and social services, the time the HV has available for client work and material resources would influence what the HV perceived she could offer clients. When resources are limited, the HV may feel she has little to give to address clients' needs and

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clients may respond by not receiving any HV offers.'

The time available for parent face-to-face contact and the availability of referrals to other resources appeared to be severely compromised in this study. This was an ongoing source of worry and concern to HVs. Clinical supervision is recognised as an integral part of successful interventions in health visiting (Barlow et al, 2003; Brocklehurst et al, 2004; Davis and Tsiantis, 2005; Barnes et al, 2011).

A review of clinical supervision literature between 2001 and 2007 concluded that organisations had a responsibility to 'sustain and develop' clinical supervision and that there were potential benefits on patient outcomes (Butterworth et al, 2008). Such benefits have been demonstrated in psychotherapy research, where supervision has been shown to be effective for the working alliance, symptom reduction and treatment retention (Bambling et al, 2006). Yet apart from child protection supervision, regular supportive clinical supervision was often not provided. High levels of stress have been found to be amenable to sessions of restorative supervision (Wallbank and Hatton, 2011). Social services research on supervision, found that there was a significant impact on workers themselves with respect to reduced anxiety, depression, somatic complaints, burnout and turnover (Barak et al, 2009).

The ability to provide continuity of care to parents was severely hampered in this study, partly because of the large HV caseloads. The current expectation is for a 'minimum floor' population ratio of three full-time health visitors (or skill-mix teams equivalent) to 1000 families with children aged under 5 years (DH, 2015), pending advice about how these ratios should be weighted (increased) for areas of high need. However, in this study, the reported size of caseloads, team organisation and time spent on record-keeping and attending meetings meant that continuity was rarely achieved. In a survey of 6000 parents, 70% said that they would like to have one dedicated HV who knew their family, rather than being seen by different individuals from a team (Russell, 2008). Moreover, a systematic review of the association between continuity of care and outcomes found that increased provider continuity is associated with improved patient outcomes and satisfaction (Van Walraven et al, 2010).

As well as parents, HVs in this study preferred to offer continuity of care, a finding that has been repeated in more recent research (Whittaker et al, 2015). Continuity was of paramount importance and nearly all of the other factors identified influenced it by affecting the amount of time available. The study HVs regretted that, having visited parents at home, they did not see many of them again in the clinic setting so they were unable to develop relationships. Clinics were experienced by HVs and parents as busy, rushed environments where HVs did not know the parents, who in turn, could not easily identify HVs. This reflects the findings of other studies (Kirkpatrick et al, 2007; Russell, 2008).

Team sizes and task allocation in the team were issues that the HVs in this study found difficult. Griffiths (2011) warned against the introduction of skill mix in nursing without a rigorous assessment of patient needs, pointing out that a management ethos of 'faster, better, cheaper' may not always lead to positive patient outcomes. In health visiting, skill mix has sometimes been introduced without the required rigorous assessment of need or evidence of what works best for child and parent outcomes. Some survey evidence suggests that parents would prefer to have parenting support and child health advice from a trained and up-to-date health visitor (Family and Parenting Institute, 2007). The way skill mix team-working was implemented in this study meant that HVs did not always have the autonomy to maintain contact with the parent that they home visited at the new birth contact.

On a more positive note, there is evidence to suggest that the presence of nursery nurses in HV-led teams is associated with more group work, while adequate administrative support is associated with a more comprehensive and multifaceted health visiting service (Cowley et al, 2007). Where skill mix teams have been introduced, training, support and supervision by HVs have been considered essential (McIntosh and Shute, 2006). Furthermore, where HVs maintain a coordinating role and parents are able to develop relationships with at least one team member, they can have very positive experiences of services delivered through teams and children's centres (Donetto and Maben, 2014).

HVs in this study experienced their managers as unsupportive of their relational work with parents. While HVs valued the ability to establish

and maintain relationships with parents, they felt their managers did not. Effective organisations have shared values with a shared commitment to organisational goals (Murphy, 1999). Also, where organisations support HVs' values and aims, recruitment and retention is likely to be improved, along with a better service experience for parents (Whittaker et al, 2015). If managers and HVs share the view that parent/HV relationships are important to child and parent outcomes, then organisations might be experienced as supportive and thereby more effective.

The organisational issues identified by parents and HVs highlighted the need for them to have time to develop relationships in an unhurried atmosphere. They needed to be able to see parents sufficiently often and home visiting was the preferred approach. In this study, clinics were identified as rushed and often not providing the same continuity of care that was ideal for creating trusting relationships, which were the foundation for the parent to be able to convey their worries.

Table 3 shows the organisational facilitators and barriers to relationship-building in health visiting, identified in this study and from the literature. Clearly, managers and commissioners need to value relational approaches to health visiting, facilitating organisational structures that support HVs to provide a universal service built on partnership, established through trusting relationships with parents.

Organisational factors influence parent/HV relationships; they cannot be ignored and should be included in any consideration of the indicators of good relationships. HVs and parents may have good relational qualities and skills, but they need sufficient time and continuity of care to put them into practice. Without these basic requirements for relationship development, parents and HVs have little chance to exercise those same qualities and skills. Indicators of parent/HV relationships need to include organisational factors that may enhance or diminish the exercise of relational qualities and skills.

Conclusion

This study established the need for a specific measuring tool for parent/HV relationships, as instruments used for other professions' relational work omit key features of health visiting work (Bidmead et al, 2015). Subsequent papers reported a small qualitative study designed to identify observable indicators of a parent/HV relationship, taking into account the parents' (Bidmead et al, 2016a) and HVs' (Bidmead et al, 2016b) contributions. This paper has described how the qualities, characteristics and skills of parents and HVs are used in a purposeful approach, described as a health visiting process based in relationships. It has also explained how the HV's employing organisations can facilitate or obstruct this approach.

The study is limited by the small size of the sample and the changing context of health visiting practice, as the Call to Action (DH, 2011) expanded the workforce and acknowledged the importance of parent/HV relationships.

However, the transition to commissioning of HV services by local authorities means that practitioners and managers need to explain the importance of this way of working to a new audience, so the results of this analysis still seem relevant. A decision was made to incorporate the important impact of organisations into the planned measuring tool for parent/HV relationships, using the observable indicators described in this paper. The measuring tools will be discussed in the final paper in the series. JHV

Key points

- The time available for parent face-to-face contact and the availability of referrals to other resources appeared to be severely compromised in this study
- Team sizes and task allocation in the team were issues that the health visitors (HVs) in this study found difficult
- While HVs valued the ability to establish and maintain relationships with parents, they felt their managers did not
- HVs and parents may have good relational qualities and skills, but they need sufficient time and continuity of care to put them into practice
- This study established the need for a specific measuring tool for parent/HV relationships

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Correction

In the April 2016 issue of the *Journal of Health Visiting* (Volume 4, Issue 4), the article 'The health visitor contribution to the parent/health visitor relationship' by Christine Bidmead, Sarah Cowley and Patricia Grocott suggested that some health visitors had been trained in the Family Nurse Partnership (FNP) in *Table 1* (page 213). This is incorrect and should have stated that the health visitors had received Family Partnership Model training (see Davis and Day, 2010). The authors would like to apologise for any confusion caused by this error.