A Description of a Public Health Role for Health Visitors

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Abstract

The term "public health nursing" was introduced to the UK before a definition was generally agreed. Consequently, there was confusion over the use of the term “public health” in relation to nursing as a whole and health visiting in particular. SNMAC (1995) believed that health visitors had a particular public health role because of their orientation to health promotion in relation to individual and community need. However, it was not clear whether community-focused health promotion activity could legitimately be described as a current public health role of health visitors.

Taking "public health" to mean a population perspective, the purpose of the study was to develop an understanding of health visitors' public health role by examining the practices and processes of community-based health visitors. In addition, the relevance of a community-focused health visiting role was established in relation to current practice and policy in public health, primary care, health promotion and social services.

Data were collected from health visitors who worked with community-focused remits in Scotland and England using face-to-face, semi-structured interviews within an ethnographic framework. Transcriptions of interviews were analysed by an inductive process of identifying themes, patterns, concepts, contrasts and irregularities. Reliability and validity were sought through a reflexive process whereby the researcher maintained awareness of her involvement with the data.

A model of a health visiting role was proposed that emphasised a population or community approach, and employed a range of methods of working drawn from generic health visiting, public health and community work.

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Declaration

Material contained within this thesis was written solely by the named author. No portion of this work has been submitted in support of application for another degree or qualification at this or any other university.

Signed --

Date -----30/11/98------------

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Abbreviations

The following abbreviations are used in this thesis:

CETHV	Council for Education and Training of Health Visitors
GP	General Practitioner
HFA	Global Strategy for Health For All by the Year 2000
HVA	Health Visitor's Association
NHS	National Health Service
MO(s)H	Medical Officer(s) of Health
RCN	Royal College of Nursing
SNMAC	Standing Nursing and Midwifery Advisory Committee
UKCC	United Kingdom Central Council (for nursing, midwifery and health visiting)
WHO	World Health Organisation

Note

As a starting point for collecting data, health visitors' public health work was regarded as activity relating to populations or communities rather than individuals (Billingham, 1994). However, given the confusion surrounding the use of the term "public health" in relation to nursing, health visiting activity investigated in the study was described as "community-focused" rather than "public health".

Chapter 1 Introduction

1.0 Background

My interest in studying the community-focused role of health visitors developed from attempts to find a method of evaluating the work I was doing as a health visitor and co-ordinator in a community health project (Appendix I). At that time there were no guidelines for practice relating to a community-focused health visiting role, let alone frameworks for evaluation. There was a dearth of research about any aspect of health visitors' community-focused activity and consequently there was confusion about the role; for example, there had been some debate at conferences and in the nursing press over the use of the terms "public health" and "community development" in relation to health visiting (Brown, 1994).

During my search for an evaluation framework, I began to recognise that health visitors throughout the UK were developing community-based health promotion work that focused on poverty or inequalities in health. While there appeared to be some support for this work from professional organisations, at the same time, successive primary care reforms were drawing health visitors into an increasingly medicalised model of health promotion. Despite the medical emphasis, health visitors appeared to be developing similar responses to community-identified issues despite the lack of national or local strategies for their work.

I felt that there was a need to stand back from the arguments surrounding health visitors' community-focused work and to examine the language, activities, processes and belief systems that health visitors in the UK were using to develop community health activity. By so doing, I hoped to clarify health visiting practice in relation to this activity and to identify where and how this work linked into other health and community-based services.

1.1 Purpose, aim and research questions

The overall purpose of this study was to inform the debate around the public health role of health visitors, particularly with regard to the legitimacy of the role for future health visiting development. The aim of the study was to describe the contemporary public health role of health visitors.

The study sought to answer the following questions:

1. What are health visitors' interpretations of a community-focused remit?
2. How does the community-focused role of health visitors relate to the extant principles of health visiting?
3. How does the community-focused role of health visitors relate to current Government guidelines for health promotion and community health care?

Chapter 2 Literature Review

2.0 Introduction

The contention that all nurses have a key role to play in public health was put forward by the Standing Nursing and Midwifery Advisory Committee (SNMAC) in 1995. However, SNMAC (1995) failed to address the confusion over the use of the term "public health" in relation to nursing as a whole and health visiting in particular (Craig and Smith, 1998). For example, preceding the SNMAC report, "Making it Happen" (1995) the UKCC (1994) replaced "health visiting" with the title, "health visiting-public health nursing". Two years later, the Department of Health (1996) removed "health visiting" from the title and described health visiting functions under the heading of "public health nursing". In addition, health visitors, district nurses, midwives and practice nurses were described as "all nurses working within public health" (Smith, 1997), while Caraher and McNab (1996) believed that posts labelled as "public health nursing" in the UK were no more than extended health visitor or district nurse roles.

2.1 Clarifying health visiting and public health nursing

2.1.1 Health visiting

Health visitors are registered nurses who have undertaken a post-registration course that covers the principles and practices of health visiting, sociology, psychology, social policy and social aspects of health and disease (Orr, 1993). Some health visitors have additional degrees, although data regarding nurses' higher degrees are not routinely collected (Rafferty and Traynor, 1997). However, one study found that 3.6% of 206 generic health visitors were undertaking degree studies (Porter, 1996).

Definitions of the purposes and principles of health visiting were developed in 1977 by the Council for the Education and Training of Health Visitors (CETHV) following a major reform of the NHS (CETHV, 1977). The purposes of health visiting were couched in terms of promotion of health and prevention of ill-health, focusing on individuals, social groups or communities and were to be achieved by working to four principles, as follows:

- the search for health needs;
- the stimulation of the awareness of health needs;
- the influence on policies affecting health; and
- the facilitation of health-enhancing activities (CETHV, 1977).

This framework was tested in the 1990s through a consultation process with representatives from health visiting management, practice and education in Scotland and England (Twinn and Cowley, 1992). The process included a review of health visiting research within the context of societal change and NHS reforms. Twinn and Cowley (1992) concluded from the consultation that the principles devised by the CETHV (1997) continued to be relevant to health visiting practice.

The practice of health visiting is said to be community-based and encompasses primary, secondary and tertiary prevention, as follows:

- primary - encouraging the adoption of healthy lifestyles, such as maintaining good nutrition or taking up immunisation, either with individuals or groups;
- secondary - surveillance or screening for early detection of problems; and
- tertiary - preventing deterioration of a condition; for example through rehabilitation or counselling (Roberston, 1991).

The UKCC (1992) stated that health visitors are in a position to utilise their full range of nursing and health visiting skills to determine appropriate health visiting interventions in response to identified health needs.

Health visitors are usually attached to GP practices, providing a universal outreach service with client contact established through home visits, clinics and groupwork (Orr, 1993). Despite attachment to GP practices, health visitors are managed by community nursing structures in NHS trusts (Symonds, 1997). The main focus of current health visiting practice is on the individual or family, in particular on pre-five children and their carers, and elderly people (Goodwin, 1988; Robertson, 1991; Twinn, 1991; Carney et al, 1996).

2.1.2 Confusion in health visiting

SNMAC (1995) argued that health visitors have a particular public health role because of their orientation to promoting health, which is described as follows:

> *"the unique orientation to health promotion, in terms of meeting both individual and community need, makes health visitors public health workers in the entirety of their role" (p20).*

However, it was not clear whether community-focused health promotion activity could be described accurately as the public health work of health visitors. For example, health visitors with remits for community-focused work outwith caseload responsibilities, had various job titles, including: community development health visitors (Dalziel, 1992); public health health visitors (Boyd et al, 1993); public health nurses (F Lunt, personal communication); community health workers (Swann et al, 1995); or just health visitors (Craig, 1995). In addition, the role of health visitors in meeting community need did not sit well with their orientation to GP practice, where a medically-defined role was said to prevent health visitors from focusing on communities or on populations (Barker and Percy, 1991; Symonds, 1997).

Confusion over health visiting roles is not a new phenomenon. There have been a number of conflicts since the 19th century between health visiting and other disciplines over role boundaries and professional status. For example, Davies (1988) described clashes between health visitors and sanitary inspectors during the early development of health visiting at the end of the 19th century. Further conflict followed between nursing and health visiting around the time of World War II over health visitors' training being based in further education institutions rather than in schools of nursing (White, 1985). In addition, in the 1950s and 1960s conflict arose between health visiting and social work over childcare responsibilities and professional status (Robinson, 1982). More recently, the potential for conflict between health visiting and health promotion was introduced when Stone (1996) argued that the NHS was recruiting inexperienced and untrained health promotion workers directly at the expense of health visiting.

Health visiting continues to suffer from a general lack of role clarity (Traynor, 1993). Reasons for confusion over health visiting roles were suggested as arising from a separate professional identity to that of nursing (Robinson, 1982), and from methods of working borrowed from other disciplines (Chalmers, 1990). For example, health visiting was said to have borrowed from medicine and social sciences (Hunt, 1972); sanitary inspection (Dingwall, 1977); social work and community work (Sachs, 1990); and marketing (de la Cuesta, 1994).

Attempts have been made to address the confusion over health visiting roles, such as the purposes and principles developed by the CETHV (1997). In addition, there is a growing body of research into health visitors' processes and practices (Clark, 1976; Robinson, 1982; Chalmers, 1990; Cowley, 1991; Twinn, 1991; de la

Cuesta, 1994). Despite the existence of a framework for practice and research evidence, there have been demands from outside and inside health visiting to clarify the health visiting role and prove its effectiveness (Traynor, 1993; Roberts, 1996).

2.1.3 Public health nursing

In the late 19th century, many countries developed some form of public health nursing to provide both nursing care of the sick and preventive services (Khan and Landes, 1993). Lillian Wald, the American nursing visionary, was said to have coined the term "public health nursing" in the 1890s (Frachel, 1988). Wald's vision for public health nursing was as an all-inclusive service to patients in their homes, addressing the family situation, hygienic housing and living conditions, and providing both direct care and health teaching (Boschma, 1997). The early public health nurses in America developed a specialised nursing role which incorporated an ability to relate to people, scientific knowledge and the freedom to work for the good of society (Frachel, 1988). In this way, Wald was able to use her experiences in caring for the sick poor in the New York slums to convince policymakers about the social, economic and environmental causes of ill health she encountered (Frachel, 1988).

In America, the early public health nurses worked for lay organisations, outside of the supervision of medical practitioners (Frachel, 1988). Nursing leaders were ambivalent about the increasing authority of medicine and were said to be influenced more by the progressive politics of the feminist movement and social reform (Boschma, 1997). They were able to develop an autonomous role in prevention which emphasised empowerment and advocacy for people living in poverty (Erickson, 1996).

Therefore, public health nursing in America was founded on the recognition of poverty and the need for public services to be responsive to diverse socio-economic and cultural groups (Erickson, 1996). Frachel (1988) argued that Lillian Wald's successful welding of "womanly" qualities with a scientific knowledge of epidemiology and politics gave public health nursing status and power. However, competing views on whether sick nursing and health teaching should be separate or combined impeded the development of a unified infrastructure for public health nursing in America (Boschma, 1997).

2.1.4 Confusion in public health nursing

The term "public health nursing" is apparently a source of confusion in a number of countries as well as in the UK. For example in America, contemporary public health nurses are one group of nurses within the umbrella term of "community health nursing" which is used to describe all nurses working outside of health institutions (Scruby and McKay, 1991). The main distinction between public health nurses and other community health nurses appears to be that in general, public health nurses focus on populations or communities whereas community health nurses target their services towards individuals and families (Deal, 1994).

In parts of Canada, the terms "public health nursing" and "community health nursing" are used interchangeably (King et al, 1995). For example, in Alberta in 1918, a public health nursing service based in public health departments was established to provide health education for schoolchildren and families (King et al, 1995). The term "community health nursing" was introduced in the 1970s when Alberta's public health nursing service expanded to cover nursing the sick and disabled in the community (King et al, 1993), ironically very similar to Lillian Wald's vision of public health nursing in the late nineteenth century.

In Ireland, it is "public health nursing" that is used as the umbrella term to describe all nurses working in the community (Hanafin, 1997). The present Irish public health nursing service was set up in 1956 as an amalgamation of local authority nurses concerned with public health and the voluntary district nursing service (Hanafin, 1997). In general, Irish public health nurses focus on individualised care and health promotion, mostly with children and elderly people. They work in geographical areas and have a mandate to include work at the community level, although community participation activity is often not supported by their line managers (McDonald and Chavasse, 1997).

Despite an apparent lack of consensus in terminology, Khan and Landes (1993) found that contemporary public health nurses in the UK, Finland, Sweden, Canada and the USA shared a number of common features:

- they focused on a defined community rather than individuals or families;
- there was an emphasis on disease prevention and health promotion as well as curative medicine;
- they performed an outreach function involving case finding and consultation; and
- they had professional autonomy (Khan and Landes, 1993).

Health visitors in the UK share some features of public health nursing, particularly those relating to health promotion and case finding. However, as noted in section 2.1.2, attachment to GP practices has prevented some health visitors from focusing on communities.

2.1.5 Summary

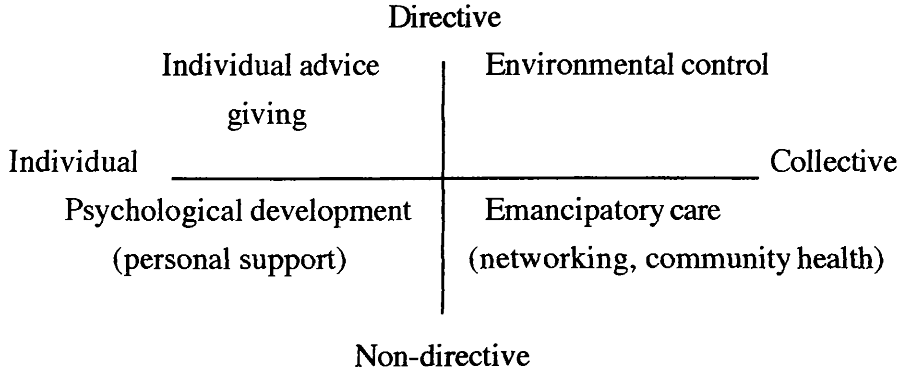
While a framework exists for health visiting in the UK to work with both individuals and communities, health visitors' main focus is on individual children or families registered with a GP practice. It is argued that the concept of public health nursing in the UK has not been clearly defined and the reasons for linking public health nursing with health visiting have not been fully justified. In addition, the relationship between a public health nursing role in the UK and public health nursing services in other countries has yet to be established. Within this climate, it is not clear what the implications of the introduction of the term "public health nursing" are for health visiting.

In the following section, the historical factors influencing the development of health visiting practice are identified in order to understand the apparent confusion over the current role. In particular, the development of community-focused activity within health visiting is traced to identify a possible relationship between health visiting and public health nursing.

2.2 The development of health visiting in the UK

Twinn (1991) identified four paradigms of practice within health visiting, which she illustrated in a diagram based on Beattie's model for health promotion (Figure 2.1).

Figure 2.1 Twinn's (1991) four paradigms of health visiting practice



Twinn (1991) believed that the four paradigms were not mutually exclusive or conflicting and, ideally, any paradigm could be adopted by a health visitor in response to a situation. Twinn's model was used as a framework for the present study to describe the historical development of health visiting. The model offered a method of providing a health visiting-centred, historical account which identified the links between health visiting and other professions, such as public health and social work. This method enabled the diverse influences on health visiting practice to be identified, including the potential sources of some of the current role confusion. The historical development of each paradigm is taken in turn, although there was some overlap between paradigms in chronology as well as influences on practice.

2.2.1 Paradigm 1: environmental control (directive/collective)

Origins of the public health movement

The epidemiological approach described in this paradigm was a significant influence in the development of health visiting (Twinn, 1991). Dingwall (1977) noted that antecedents to health visiting had been recorded as far back as 1769. However, it is widely believed that the development of current health visiting was initiated at the same time as the early development of the public health movement in the 19th century (Dingwall, 1977).

The 19th century public health movement arose in response to the need for sanitary reform which accompanied the rapid growth in British towns as a result of industrialisation (Hamilton, 1981). Employers took advantage of the lack of social controls and the large pool of unskilled labour, subjecting workers to extended working hours and inadequate nutrition, sanitary and safety arrangements (Doyal and Pennell, 1979). Consequently working class families became particularly susceptible to infectious diseases (Doyal and Pennell, 1979).

The greatest force for public health reform is often credited to the sudden high mortality rates caused by the cholera epidemics that swept through Europe in the 19th century (Hamilton, 1981). However, cholera epidemics rose and fell rapidly, while typhus, tuberculosis and childhood diseases were the main endemic causes of death in the early part of the 19th century (Webster, 1990). Typhus, known at that time as "fever", was recognised as the "poor man's disease" and was directly related to squalor, overcrowding and insanitary conditions (Flinn, 1965). From the 19th century, there have been marked differences recorded in mortality rates between poor and affluent areas; for example, in 1901 in Glasgow the overall infant mortality rate per thousand births was 149, ranging from 69 in the "best" areas to 217 in the "poorest" areas (McGregor, 1967).

In the 1800s, government took little responsibility for safeguarding the health of the population (Webster, 1993). There was only one reference to health care within 16th century Elizabethan legislation; medical care was included in the social welfare programme to support the poor (Webster, 1993). Government responsibility for health care was made more explicit in The Poor Law Amendment Act of 1834 (usually described as the New Poor Law) which replaced the Elizabethan welfare framework (Webster, 1990). However, the New Poor Law created a harsh and unpopular system that set a trend for long-stay, institutional care for vulnerable groups (Webster, 1990).

The sanitary movement, launched in the 1820s, represented the first involvement by government in disease prevention (Webster, 1993). Edwin Chadwick's radical document of 1842, "Report on the Sanitary Condition of the Labouring Population of Gt. Britain" laid the foundation for the Victorian public health movement and led to the first Public Health Act in 1848 (Flinn, 1965). This Act stimulated a steady growth in sanitary reform and increased powers for public health doctors, particularly relating to housing and sanitation (Webster, 1990). In addition, as a result of the Public Health Act (1848), Medical Officers of Health (MOsH) were created in local authorities (Webster, 1990). MOsH were eventually to oversee a number of health and social services, including health visiting.

Origins of health visiting

The UK system of health visiting towards the end of the 19th century arose from the sanitary movement's "volunteer visiting of the poor" (Webster, 1993). Volunteer visitors, known as "lady visitors", were usually middle-class women, often from temperance movements and the voluntary social work predecessor, the Charity Organisation Society (McGregor, 1967). They were said to be acting out of concern for the high mortality and dreadful living conditions of the urban poor and their aim was to promote independence and self-reliance, in line with the philosophy of the New Poor Law of 1834 (Robinson, 1982). The most frequently repeated account of the first health visitor is that of the Manchester and Salford Ladies Sanitary Reform Association who employed a "respectable" working class woman in 1867 to assist the lady volunteers (Dingwall, 1977).

In addition to the work of the women philanthropists, a major influence in the development of health visiting was women's roles in sanitary inspection. While in some areas women were employed on an equal basis with men, most female sanitary inspectors were encouraged increasingly to focus on home visiting and counselling, leaving male inspectors to deal with the higher status, legislative work (Dingwall, 1977). Davies (1988) argues that male sanitary inspectors objected to women taking on their work and effectively blocked them from achieving equal pay and employment status as sanitary inspectors. In addition, the dominant male, medical ideology in public health conspired to maintain the lower status of women and to undermine their contribution to the public health movement (Davies, 1988). However, at the same time, MOsH apparently held the supporting and counselling abilities - the "womanly" qualities - of health visitors in high esteem (Dingwall, 1977; McGregor, 1965).

Advice on health and hygiene by volunteers gradually evolved into maternal instruction on the care of infants as part of the fight against infant mortality (Davies, 1988). In 1907 the Notification of Births Act was passed as a result of lobbying of the Government by the powerful pressure group, the National Association for the Prevention of Infant Mortality (McGregor, 1967). This Act enabled a direct approach to be made to all mothers of newly born infants and, for the first time, accurate information could be gathered on all births. Under the Act, every birth had to be notified to the MOH within 36 hours and this led to the expansion of paid and voluntary family visitors (Chalmers, 1930); for example in 1908 in Glasgow (population 678,000) there were 300 voluntary helpers working with a handful of paid health visitors to visit families and give advice on infant care (Chalmers, 1930). Health visiting services were delivered across districts (Dingwall, 1997), and the early, employed health visitors were expected to live in the districts in which they worked, acting as role models for the women living around them (Davies, 1988).

Establishing the health visiting service

The numbers of employed health visitors began to increase steadily from 1908 (McGregor, 1967). Early health visitors were drawn from a range of occupations including medicine, sanitary inspection, midwifery, teaching and nursing (White, 1985). Separate training courses were soon established for nurses and for non-nurses (White, 1985). By the beginning of World War I, most large cities had some form of health visiting training in place in higher education establishments; for example, in Scotland the training course for nurses consisted of six months theory in the School of Social Study at Glasgow or Edinburgh University and practical training under the Senior Medical Officer of the Maternity and Child Welfare Department (McGregor, 1967).

By the 1920s, health visiting was an established part of the expanding public health departments within local authorities, accountable to and fully supported by MOsH (Davies, 1988). During the 1920s, health visiting gradually extended to middle class families enabling it to become a universalist, non-stigmatising service (Dingwall and Robinson, 1993).

It should be noted that health visiting in the UK developed quite separately from domiciliary nursing of the sick, despite the fact that some early health visitors were expected to care for any sick family members they encountered (Webster, 1993). District Visiting Societies emerged from the Victorian Christian practice of visiting the sick poor, preceding the trend towards home visiting at the end of the 19th century (Webster, 1993). Florence Nightingale was said to have been committed to the development of public health nursing and home care although she is usually associated with the development of hospital nursing and education in the 1860s (Baly, 1991).

Summary

The early development of health visiting was closely intertwined with the development of public health. Recognition of the extent of infant mortality and sub-standard living and working conditions helped to shape the health visiting service. Consequently, under the influence of MOsH, the main focus for health visiting became advice for mothers on the care of young infants.

2.2.2 Paradigms 2 and 3: individual advice giving and personal support

In the 1990s, the predominant approach to childcare in health visiting continued to be the provision of advice and health teaching to mothers (Twinn, 1991). However, there was increasing emphasis on a partnership approach within nursing in general which was more focused on support than advice-giving

(Salvage, 1993). The historical development of both advice giving and personal support were intertwined. Therefore, the development of both paradigms relating to individual-focused work are discussed together.

Advice and support for mothers

Towards the end of the 19th century, opinion on the causes of ill-health began to change with increasing bacteriological understanding and the development of the germ theory of disease (Webster, 1993). Public health began to move away from its environmental focus on housing and sanitation, to take on a more individualistic approach based on personal preventive services (Ashton and Seymour, 1988). Responsibility for health began to be levelled at the individual, particularly at mothers, with maternal inefficiency deemed to be a major influence on the health of the working class (Webster, 1993). Recognition of the poor physical state of young male recruits to the Boer War highlighted the need for improving general health, and this prompted the development of advice for mothers, child welfare services, ante-natal clinics and free school meals (Berridge, 1994). Public health, housed within local authorities, led the campaign to educate mothers with the development of maternal and child welfare services such as infant welfare centres and better maternity services (Lewis, 1991).

In 1867, duties of the volunteer visitors included teaching hygiene and child welfare, social support, and teaching mental and moral health (Robinson, 1982). Assisting doctors at child welfare clinics was added to the duties of health visitors at the turn of the century (McGregor, 1967). MOsH gave full support to the "mother's friend" role of health visitors as a means of addressing the high infant mortality rates (Davies, 1988). For example, an MOH for Glasgow in the 1920s, recognised that for health visitors working with mothers:

> *"time was required to create a friendly atmosphere in which to insinuate new ideas and practices and to discuss domestic difficulties, common in these years of recurring poverty and privation"* (McGregor, 1967, p 111).

While health visiting was shaped by the collectivist public health philosophies of the early 20th century, Dingwall (1977) argued that it became less political and more focused on individualism as recruits were increasingly drawn from hospital-trained nurses. Between the wars, nurses began to make up the largest group of recruits to health visiting, although entry to health visiting training remained open to non-nurses until 1962 (Robinson, 1982). This gradual shift towards individualism reflected a shift in political reforms, which began to move away from a collectivist ideology towards individual remedies for social problems such as poverty and unemployment (Dingwall, 1977).

From public health into nursing

Health visitors remained under the MOsH in local authorities until 1974 when they were taken out of public health to become accountable to hospital nurses at divisional level (Robinson, 1982). The divisional nursing structure had been created by the Salmon Report in 1966 to cope with technological developments in hospitals and was based on an industrial model of professional management (Carpenter, 1977).

Community nurses did not fit easily into the hospital management structure as their work was in carrying out direct care rather than supervising other staff, although they were of similar status to a ward sister (Carpenter, 1997). Consequently, community nurses were seen as being resistant to the bureaucracy (Carpenter, 1977). In addition, few nurse managers had community experience, leading to a lack of understanding of the preventive work of health visitors (Robinson, 1982). Health visitors had to fight to maintain both their status in relation to hospital nurses and the higher education basis for their training. By so doing, they were successful in preserving their separate identity within the main body of nursing (Robinson, 1982).

In the 1960s, health visiting began to abandon their district, or neighbourhood approach, adopting casework philosophies and selective visiting of those in proven need (Dingwall, 1977). However, health visitors have since been criticised for focusing on individualistic and victim-blaming approaches (Goodwin, 1988; Billingham, 1994), suggesting that their supportive role (section 2.2.2) had been lost over the years. However, the loss in status for caring roles appears to have affected nursing as a whole. Tudor Hart and Dieppe (1996) argue that the very fact that nursing takes place at the caring end of the health service places it at a disadvantage in the current NHS structures, where managers are compelled to ignore caring skills because they are difficult to measure.

Evaluating health visiting

Health visiting has been regarded as notoriously difficult to evaluate (Robinson 1982; Luker 1985) and has been described as an "untestable assertion" (Roberts, 1996). Campbell et al (1995) undertook a review of evaluative research concerning the effectiveness of health visiting. While there was evidence that health visiting had a positive impact on health and was valued by clients, there was no robust theoretical base from which randomised controlled trials could be conducted to assess effectiveness (Campbell et al, 1995).

Suggestions have been made as to why there are difficulties in providing scientific evidence for the effectiveness of health visiting. First, the principles underpinning health visiting are based on a positive concept of health as a value which sits uneasily within the bureaucracy of the NHS (Robinson, 1985; Barker, 1992; Symonds, 1997). Secondly, while Robinson (1985) argued that effective health visiting depended on a relationship-centred approach in order to distinguish between clients' presenting and underlying needs, health visiting activity is recorded only by contact counting (King, 1995). Consequently, there is limited information available regarding health visitors' therapeutic or public health activities(King, 1995; Smith, 1997).

Summary

Health visiting began as a supportive, advice-giving service where "womanly" qualities of building relationships were important. The relationship-building aspect of health visiting was discouraged as the NHS became increasingly technical and based on scientific principles. Health visiting was encouraged from within to move back to a relationship-centred approach, but it is argued that the demand for evidence-based practice within the NHS mitigated against this.

2.2.3 Paradigm 4: emancipatory care

Although the main focus in health visiting continued to be on the individual or family (Goodwin, 1988; Carney et al, 1996), health visitor-led, community-focused health promotion initiatives became more visible in the 1990s (Cowley, 1996). Emancipatory care was described by Twinn (1991) as a collective, non-directive approach where health visitors participated in community health initiatives, sharing their expertise and making decisions jointly with community members. While health visitors' roots in the public health movement pointed to an early background in collectivism, Dingwall (1977) argued that health visiting had become more focused on individualism by the 1920s. Therefore, the development of the community-focused role of health visitors appears to have been a more recent phenomenon.

In addition to historical, collective roots, there were three other influences on emancipatory care in health visiting. First, the CETHV (1977) stated that the purposes of health visiting included working with groups or communities as well as individuals (section 2.1.1). The second influence was the endorsement in the 1980s by both the Royal College of Nursing and the Health Visitors' Association that community work was a method of working appropriate to effective health visiting (Robinson, 1982). The third factor, also arising in the 1980s, was the development of the concept of "new nursing", which moved away from a biomedical model towards enabling patients' participation in care (Salvage, 1993).

The "new nursing" concept was adopted and developed by the World Health Organisation (WHO) who subsequently defined a role for all nurses, midwives and health visitors in Europe in the Global Strategy for Health For All by the Year 2000 (HFA) (WHO, 1981). This role was to be responsive to people's health needs rather than to the needs of the health care system (Salvage, 1993). The WHO's European policies of HFA and primary care provided the background to the principles of the HFA nurse which were described as follows:

- positive health promotion;
- participation of individuals, families and communities in care;
- working towards equity;
- collaborative working; and
- assurance of quality of care (Salvage, 1993).

Boomer (1987) argued that the principles of health visiting related closely to the principles of HFA, i.e. equity, empowerment, collaborative working, community participation and localised health care. However, it is argued that there is little evidence that the HFA nurse concept has taken hold in the UK.

Summary

Emancipatory care became more visible within health visiting in the UK in the

1990s. This approach developed in line with professional nursing organisations and appeared to conform to the WHO's vision of the HFA nurse.

2.2.4 Summary of the development of health visiting

The early development of health visiting was influenced heavily by the public health movement and focused on support and advice to mothers. Emancipatory care has been regarded as integral to health visiting practice since the late 1970s, but it is only in the 1990s that it has become more visible. Both generic and public health roles of health visiting have been criticised in the 1990s for being unable to provide scientific evidence of effectiveness.

Disciplines which have informed the development of health visiting have also continued to develop in relation to changing needs and resources within society. In order to establish the legitimacy of health visitors adopting a public health role, the relationship of health visiting to current practice within related disciplines has been examined. In particular, current health visiting practice has been appraised in relation to public health practice, primary care, health promotion and social services. The following section begins by examining the relationship of health visiting to public health.

2.3 Health visiting and public health

2.3.1 Public health departments

The administrative function of public health departments in local authorities grew in the inter-war years so that by 1939 they had a remit to provide maternal and child welfare services; school medical services; TB clinics and treatment; infectious disease, ear, nose and throat and VD services; health centres; regional cancer schemes; and to run the old Poor Law hospitals (Lewis, 1991).

In addition to their administrative duties, MOsH collected and analysed medical statistics, although figures such as mortality and birth rates had been collected since the 16th century (Webster, 1993). Up until the 1940s, a number of reports were produced by MOsH showing an association between poverty, unemployment and overcrowding with, e.g. death rates among the poor (Webster, 1993) and infant mortality (Womersley, 1987). However, public health doctors neglected to bring these issues to public notice, concentrating instead on their administrative functions (Lewis, 1991). Public health was criticised in the 1940s for not responding to the general dangers to the population of the time such as unemployment or malnutrition in depressed areas, with MOsH unwilling to challenge the dominant orthodoxies (Berridge, 1994).

There was a view that public health doctors expected to continue their administrative "empire" after the advent of the NHS in 1948, but instead found themselves considerably weakened when control of the NHS did not go to local authorities (Berridge, 1995). Consequently, public health departments lost many of their administrative functions (Lewis, 1991). McKeown (1965) has argued that the public health movement was compromised at this time because it lacked a clearly defined philosophy. Public health had been introduced initially to control infectious disease but was subsequently extended to compensate for deficiencies in other medical services (McKeown, 1965).

Attempts were made to establish a philosophy for public health through academic departments of social medicine in the 1940s, and later, the development of the concept of community medicine in the 1970s (Lewis, 1991). However, social medicine was seen as too clinical and too ready to dismiss local authority public health departments, creating divisions between academic departments and practice (Lewis, 1991). Community medicine, as a later development, comprised epidemiology and medical administration but the combined remits for management and advice were difficult to reconcile (Webster, 1993). By the 1970s, the responsibilities of MOsH were divided between the tripartite system of prevention, family practitioners and hospital services and this led to difficulties in ensuring coverage of the whole population (DoH, 1988).

Public health doctors finally became responsible for planning health services in the 1970s when public health in the form of community medicine was integrated into the NHS. However, integration into the NHS removed community medicine's contact with communities and gave it lower status in relation to the rest of the medical profession, despite the establishment of the Faculty of Community Medicine in 1972 and the broadening of public health training (Webster, 1993).

The aim of the reorganisation in the 1970s was to unify the tripartite NHS (DOH, 1988) but Lewis (1991) argues that public health doctors were unsure of their role within the NHS management structures which led to further confusion rather than successful integration. In the 1980s, the Department of Health (1988) review of public health renamed the specialty "public health medicine", couching its function in terms of prevention and promotion within the context of the WHO's definitions of public health, HFA and the Ottawa Charter for Health Promotion, as follows:

> *"the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society".*

Lewis (1991) argues that, despite the emphasis on prevention, NHS public health departments focused on the analysis of health service needs. However, other specialisms, such as environmental health, general practice, and health promotion also had a role in developing policies that prevent illness and disease (Webster, 1993). Consequently, the definition has raised conflict between public health and other health-related services (Webster, 1993).

2.3.2 Nurses, health visitors and public health

Health visitors were managed as part of local authority public health departments until public health moved into the NHS in the 1970s (Lewis, 1991). Current nursing functions within NHS public health departments were identified as needs assessment and infection control (SNMAC, 1995). In addition, public health in nursing, midwifery and health visiting was said to be about commissioning health services as well as providing care (SNMAC, 1995). However, nursing posts in public health departments in the 1990s were and are rare (SNMAC, 1995) and there are no established career pathways for nurses within commissioning and purchasing (Salvage, 1993).

In addition to needs analysis, commissioning and infection control, SNMAC (1995) included health visitors carrying out community-focused health activity as examples of public health in nursing. Health visitors carried out community-focused activity by adopting community development methods of working, using collective action and collaboration, and emphasising personal and community empowerment for promoting health and well-being (Dalziel, 1992; Boyd et al, 1993; James and Buxton, 1994; Craig, 1995; Swann et al, 1995; Gilbert and Brett, 1996). It is argued that health visitors' community-focused activity bears some resemblance to the concept of the HFA nurse discussed in section 2.2.3. HFA, along with other WHO definitions and strategies, was also said to underpin the current definition of public health (section 2.3.1). Therefore, there is a potential link between the community-focused health visiting role and public health through the principles of HFA.

2.3.3 HFA and the new public health movement

In the 1980s the Black Report (Townsend and Davidson, 1988) stimulated debate in the UK concerning health inequalities and the adverse effect of poverty on health. The perspectives of the Black Report were supported by the principles of

HFA, which also provided a platform for the "new public health movement" (Ashton and Seymour, 1988).

The "new public health movement", which originated in the 1970s, recognised health as a combination of lifestyle and the environment as well as being influenced by human biology and health care provision (Donaldson and Donaldson, 1993). The movement combined environmental change - i.e. physical, socio-economic and psychological circumstances - with personal preventive measures, eschewing a victim-blaming approach and recognising the importance of the social aspects of health problems which are linked to issues of local and national public policy (Ashton and Seymour, 1988).

In addition to the "new public health movement", HFA acted a springboard for developing the concept of health promotion. In 1986 the Ottawa Charter for Health Promotion was adopted whereby health promotion was to be based on five principles:

- build public policies which support health;
- create supportive environments;
- strengthen community action using community development;
- develop personal skills to take control over health and environment;
- reorientate health services so that individuals, communities, health professionals and governments can work together towards a health care system that contributes to "health" (Ashton and Seymour, 1988).

The Ottawa Charter and HFA provided the basis for the WHO Healthy Cities Project which was set up to develop practical structures in cities to implement the WHO health promoting policies (Curtice, 1993).

Despite the WHO's vision for nursing (section 2.2.3), nurses' activity relating to HFA principles was not integrated into either core nursing services or HFA-inspired work in the UK. For example, health visitors working with families in poverty who adopted approaches similar to those advocated by the Ottawa Charter, worked in isolation from their generic colleagues, outwith mainstream services (Blackburn, 1996). Irish public health nurses were in a similar position; they found that they did not receive support from their managers when they focused on community participation (McDonald and Chavasse, 1997). In addition, descriptions of UK activity of the European Healthy Cities Project included the perspectives of policy-makers, academics, community members and health promotion officers, but made no mention of nursing (Davies and Kelly, 1993; Curtice, 1993).

The work of health visitors in relation to the effects of poverty on health provides an example where health visitors have adopted methods of working consistent with the principles of HFA. The following section explores the roles some health visitors have developed in relation to poverty and health.

2.3.4 Poverty as a public health issue for health visitors

Since the publication of the Black report (Townsend and Davidson, 1988), research studies have shown significant differences in death rates between different socio-economic classes (Marmot et al, 1991; Wilkinson, 1992; McLoone and Boddy, 1994; Phillimore et al, 1994). Greater inequality is more likely to lead to ill-health, with the excess mortality associated with lower social status deemed to be a major health problem (Wilkinson, 1994).

Inequalities in health are said to be caused by two sets of factors: risk factors such as smoking, drinking, diet, blood pressure; and vulnerability, including pre- and post natal conditions, maternal and personal nutrition states, housing and poverty

(Forwell, 1993). The Black Report concluded that to improve health and reduce inequalities, priority must be given to reducing the number of mothers and children living in poverty; developing local and national policies in areas such as housing, employment and social services; and better co-ordination between government departments (Townsend and Davidson, 1988). As one in three children in the UK (1994 figures) is born into a family who qualifies for social fund payments (Laughlin and Black, 1995), it is argued that health visitors, with their focus on improving the health of mothers and young children, cannot avoid the need to respond to vulnerability factors that affect families' health.

Following a comprehensive review of the effects of poverty on the health of families, Blackburn (1991) identified that health visitors took action with three broad types of response, as follows:

- profiling and monitoring to gather information which can be used for planning and working for social change;
- prevention and alleviation for families coping with the material and health affects of poverty; and
- social change responses - directly challenging team, local and national policies.

Health visiting responses to families in poverty are comparable to Whitehead's (1995) findings regarding policy responses to inequalities in health. According to Whitehead (1995) effective policies act at one of the following four levels: strengthening individuals; strengthening communities; improving access to essential facilities and services; and encouraging macroeconomic and cultural change, with the most powerful focus for change being at level four. Examples of health visiting developments acting at each of the four policy levels are as follows:

1. *Strengthening individuals*

Maximising material income: in a small study of health visiting and mothers living in poverty, health visitors were found to aim to increase women's resources, for example, by helping them to claim welfare benefits (Billingham, 1994). Other methods used by health visitors to strengthen individuals were counselling, support or developing self-esteem and skills for mothers (Whitehead, 1995).

2. *Strengthening communities*

Collecting and using information at community level: for example, through community profiling (Cernik and Wearne, 1994) or use of health visitor caseload information to identify the relationship between health and material deprivation (Shepherd, 1996). In addition, a community development approach was used by health visitors to support community groups in taking action on issues raised through profiling (Boyd et al, 1993; Craig, 1995).

3. *Improving access to essential facilities and services*

Advocacy at an individual or community level for example, in pursuing adequate housing or social services (James and Buxton, 1994); and "fringe work" including providing food, clothes or money, and setting up support groups (de la Cuesta, 1994).

4. *Encouraging macro-economic and cultural change*

There were no examples found of health visitors being involved in addressing poverty at a macro-economic level. However, professional bodies provide practical resources for health visitors working at local policy level, for example in poverty profiling (Blackburn and HVA, 1992; RCN, 1996).

2.3.5 Summary of health visiting and public health

There was little evidence of a relationship identified between health visiting and public health departments within the present NHS structures. However, there are links between the community-focused role in health visiting and the definition of public health through the principles of HFA nursing and the Ottawa Charter for Health Promotion. However, despite the existence of a public health function, most health visiting work is carried out through GP practices in primary care.

2.4 Health visiting and primary care

2.4.1 Health visitors and GPs

Health visitors were drawn away from neighbourhood-based preventive work into individualised, medical models of practice by successive NHS reforms (Barker and Percy, 1991). Health visitors began to work with GPs after 1948 while they were still managed by MOsH (White, 1985). MOsH were not entirely happy with this situation and sometimes objected that "their" nurses were working with GPs who did not appear to value their services (Jeffrys, 1995). In the 1950s, GPs were criticised for their lack of co-operation with health visitors (White, 1985). However, GPs were divided in their views, as some wanted health visitors to be made redundant, while others asked for more to be employed (White, 1985).

In the 1960s some MOsH persuaded GPs to provide accommodation for health visitors, district nurses and midwives in the new health centres that were being built (Jeffrys, 1995). Attachment gradually spread and by the mid-1970s, the majority of health visitors were attached to GPs. While health visitors are now usually attached to GP practices, they are managed through community nursing structures (section 2.1.1).

There is some evidence to suggest that GPs continue to be divided in their views of health visitors. For example, in a study of GP surgeries and clinics, Symonds' (1997) found that GPs reported some suspicion regarding health visiting practice, about which they knew very little. Symonds (1997) concluded from her study that health visiting care in community clinics was very different philosophically to both general practice and to the managerial ethos of the health service. However, in a study of health visiting in two districts, Carney et al (1996) found that GPs had a good understanding of the health visitor's role, and both professional groups reported positive, collaborative relationships.

2.4.2 Policy context

The policy context until the late 1990s continues to emphasise the individualistic approach for health visiting, with 1996 NHS reforms seeking to maintain health visiting firmly within GP-led primary care service provision (DoH, 1996; Scottish Office DoH, 1996). The most recent NHS White Papers for England (DoH, 1997) and Scotland (Scottish Office DoH, 1997) suggest that health visitors and other community nurses might have the opportunity to work across primary care practice boundaries and have a greater voice in commissioning local health services. This may enable community-focused activity to take place within primary care, as follows:

> *"Primary care will be able to pool resources, work across organisational boundaries and develop shared aims and objectives" (Scottish Office DoH, p19)*

> *"Primary Care Groups will.......share expertise such as public health skills" (DoH, p38).*

In addition, there may be potential for primary care groups to adopt community development approaches, for example:

> *"Primary Care Groups....will be encouraged to play an active part in community development and improving health in its widest sense. Health visitors and health promotion professionals will have a strong contribution to make in identifying health needs and implementing the programmes that best address them" (DoH, p40).*

However, it is not yet clear as to how the new primary care reforms will affect nursing in the community.

2.4.3 Summary of health visiting and primary care

GPs and health visitors have a long history of working together, but apparently with reservations and suspicion. It is too early to understand the full implications of the most recent NHS reforms for primary care and whether barriers to collaboration between GPs and health visitors can be overcome.

It could be argued that health visiting is heading for yet another inter-disciplinary clash, this time with health promotion. In the light of the DoH's (1997) recommendation for health visiting and health promotion, and Stone's (1996) comments regarding health promotion developing at the expense of health visiting, it may be particularly important that the relationship between health visiting and health promotion is clarified.

2.5 Health visiting and health promotion

2.5.1 Defining health education

Health education began with health and hygiene advice in the early public health movement (Naidoo and Wills, 1994). Until fairly recently, the main emphasis of health education was on mass campaigns to encourage the uptake of healthy choices (Naidoo and Wills, 1994). By the 1980s, health promotion had developed and the belief was that the major killer diseases could be avoided if individuals took greater responsibility for their own health (Naidoo and Wills, 1994). In 1992, government strategies for improving health set priorities for tackling the main causes of death in the UK; i.e. coronary heart disease, cerebro-vascular disease and cancer (DoH, 1992; Scottish Office, 1992). These strategies have been criticised for focusing only on death, disease and disability and ignoring health inequalities, a major determinant of health (Seedhouse, 1997).

Health education has been defined by Naidoo and Wills (1994) as a facilitative process that allows people to make an informed choice about health. It seeks to enhance positive health and prevent ill-health by influencing beliefs, attitudes and behaviour (Downie et al, 1996). However, Seedhouse (1997) warned that those providing health education could use their own lifestyles inappropriately as models for changing others and that it was difficult for health educators to maintain a value-free stance.

2.5.2 Defining health promotion

In general, health promotion has been regarded as a wider approach than health education (Naidoo and Wills, 1994). Tones (1993) argues that health promotion was derived from different ideological positions and therefore was open to several interpretations. Seedhouse (1997) believed that this lack of core values resulted in health promotion being driven by political philosophy rather than theory.

Some attempts have been made to define health promotion. For example, health promotion has been described as an umbrella term for a range of activities which include preventive health services such as immunisation, healthy public policies and community development (Ewles and Simnett, 1992). Similarly, Downie et al (1996) believe that health promotion encompasses health education, ill-health prevention and health protection, and is a major component of HFA and public health. However, Seedhouse (1997) argues that existing definitions of health promotion was misleading, as authors have not addressed the issue of whether they believe that health promotion is value-based or evidence-based.

2.5.3 Who does health promotion?

Health promotion is often carried out by health promotion officers, who may or may not have had specific training or education (Stone, 1996). In addition, health promotion is integral to other disciplines, particularly health visiting (CETHV, 1977) as well as other types of nursing (Naidoo and Wills, 1994). Ewles and Simnett (1992) identified a list of core competencies required for carrying out health promotion, as follows:

- managing, planning and evaluating;
- communicating;
- educating;
- marketing and publicising;
- facilitating and networking; and
- influencing policy and practice.

While there are some similarities between this list and the principles of health visiting (section 2.1.1), Gallagher and Burden (1993) believe that nursing individual patients does not fit with the practice of health promotion. They argue that nursing is about developing a therapeutic relationship through assessment and negotiation, while health promotion is paternalistic, making decisions about changes on behalf of the population without consent (Gallagher and Burden, 1993).

SNMAC (1995) used health promotion at individual or community level as the justification for health visitor's public health role (section 2.1.2). However, health promotion at community level does not fit well with health visitors' attachments to GP practices. Within primary care, health promotion is usually understood to be based on a biomedical model shaped by the GP health promotion contract which has been criticised for narrowing the definition of health promotion (Russell, 1995). In line with GP health promotion contracts, health visitors carrying out health promotion activity within primary care teams are expected to focus on an individualistic, medical model of health promotion (Barker and Percy, 1991).

2.5.4 Summary of health visiting and health promotion

Reaching a consensus on definitions of health promotion is problematic. For health visitors in particular, there is conflict between an individualistic model of health promotion in primary care and a community approach that justified SNMAC's (1995) public health title. Although there was no evidence that health visitors and health promotion officers have come into conflict, it is argued that the boundaries between health visiting and health promotion have not been clarified.

2.6 Health visiting and social services

2.6.1 Social work

The relationship between health visiting and social work has been fraught since the 1940s (Robinson, 1982). For example, the Children's Act in 1948 had created children's officers with a remit for the care of deprived children who were to be educated to degree level (Robinson, 1982). These new officers not only encroached on health visitors' child welfare work, but as graduates, had higher status. The contention that health visiting was a female occupation providing a service predominantly for women compounded health visitors' low status, particularly among those controlling the welfare services (Orr, 1981).

By the 1960s, two major reviews by the Younghusband and Seebohm Committees had analysed the function of social work, and while they recognised the existence of health visiting, they failed to clarify the relationship between social work and health visiting (Sachs, 1990).

In the 1990s, social workers developed a care management role, responsible for assessing need and referring clients on to domiciliary and day care workers, usually contracted through the GP surgery (Cheetham, 1993). In a study assessing the need for health visiting, Carney et al (1996) found that health visitors and social workers demonstrated difficulties in distinguishing between health and social need and misunderstanding of respective client referral systems. Carney et al (1996) concluded that needs identification was the main area of conflict between health visitors and social workers in their study.

2.6.2 Community work

Another potential area of conflict between social work and health visiting in the 1990s, is in the overlap between community workers and health visitors carrying out community-focused activity. Community workers were employed from the 1960s as a result of the 1959 Younghusband report conceptualising community work as part of social work (Thomas, 1983). Prior to this, supported community action had been recorded as far back as the 1880s, but had not been associated with any one particular professional group (Baldock, 1980). The Younghusband report (Sachs, 1990) defined community work as:

> *"helping people within a local community to identify social needs and consider the most effective ways of meeting these .... (within) ......available resources"* .

In the 1980s, community work was endorsed as a method of working appropriate to effective health visiting by both the Royal College of Nursing and the Health

Visitor's Association (Robinson, 1982). Munday (1980) believed that other professions, including personal social services, health services and the clergy embraced community work as a way of involving non-agency personnel to cope with increasing demand on official services. Community work had links with professional groups and protest movements and was concerned primarily with improving the flow of information between communities and state organisations as they increased in size (Smith, 1980). Thus, community work was essentially educational in nature, contributing to the evolution of the democratic process (Thomas, 1983).

Community workers were generally accountable to the groups they worked with and were more likely to be influenced by the needs and perceptions of the communities they were associated with rather than by other professionals or their employing agency (Smith, 1980). This community-based approach may have led to threats around community worker's job security as local authorities began to reduce services in the 1970s and early 1980s (Thomas, 1983).

Methods of community work

The community work process started with the understanding of the problems and strengths of communities; moved on through supporting the development of local organisations and informal learning; ensured that groups were properly resourced and can collaborate with other groups or agencies; and engaged with the political process in order to ensure a community voice in decision-making (Barr et al, 1995). In an analysis of community work practice in the 1980s, Thomas (1983) identified five approaches to developing communities as follows: community action, community development, social planning, community organisation and service extension. Community workers, community members and practitioners from other disciplines used the five approaches to some extent either individually or in combination (Thomas, 1983).

One of these approaches, community development, emphasised self-help, mutual support, development of neighbourhood integration and problem-solving capacities, and the promotion of collective action to inform political decision-makers (Thomas, 1983). A community development approach corresponded to the descriptions in the literature of health visitor's community-based activity. From a study of health visiting and womens' groups, Dalziel (1992) concluded that community development and health visiting shared common beliefs, taking a holistic approach, developing action based on need, recognising the importance of social support and networks, and emphasising the individual's potential to achieve health.

Community development and health

A community development approach had been applied in UK government policy for over 100 years although community development in health developed only over the past two decades (Adams, 1991). A community development approach in health was said to have been supported by HFA and the new public health movement, with community action cited as a cornerstone in addressing inequalities in health (Farrant, 1991). Collective action by communities was said to benefit communities in a number of ways including attracting resources, tackling a major issue such as crime or poor housing, or building social networks (Whitehead, 1995).

Doyle and Thomas (1996) argued that individualistic health promotion might be more effective when it was backed up by a community development approach, particularly in deprived communities. Health visitors' community development work was focused on areas of deprivation, addressing inequalities in health and recognising the wider factors affecting health such as poverty, housing, environment, education and social networks (Boyd et al, 1993; Billingham, 1994; James and Buxton, 1994; Gilbert and Brett, 1996). However, there was a lack of evaluation and evidence of effectiveness for this activity.

Summary

Role confusion between health visitors and social workers existed in the past around childcare responsibilities. The current focus for conflict is needs identification. There is some overlap identified between health visitors and community workers in the use of community development approaches, but no evidence was identified for conflict between the two disciplines.

2.6.3 Summary of the relationship between health visitors and related disciplines

It is clear that health visiting development has been influenced by a range of professional practices and theories. There is no structured relationship between health visiting and public health within the NHS in the 1990s, although the WHO principles of HFA and health promotion underpin some of health visiting practice and public health principles. Attachment to GP practices appears to prevent health visitors from carrying out public health activity, but recent primary care reforms might prove to enable health visitors' public health role.

There has been no conflict described between health visiting and the disciplines of health promotion and community work, but it is argued that the lack of clear boundaries between health visiting and these disciplines has the potential to lead to conflict in the future. Some of the conflict between health visiting and social work regarding status appears to have disappeared. However, the difficulties in demarcating boundaries between health and social needs has given rise to further conflict between health visiting and social work in the area of needs assessment.

2.7 Summary of literature relating to health visiting

The early UK health visitors shared some of the public health concerns of the first American public health nurses. Where their underlying principles differed was that American public health nurses were said to have targeted communities in order to improve community health (Frachel, 1988), whereas health visiting aimed to educate mothers in order to reduce infant mortality (Lewis, 1991). Current health visiting practice is identified primarily with pre-five children and their carers (Twinn, 1991; Carney et al, 1996). However, there appears to have been a lack of confidence within health visiting since the 1970s regarding the child health role (Robinson, 1985; Goodwin, 1988) despite the extent of children living in poverty.

Bhopal (1993) suggested that improvements in public health would be more likely to occur if public health doctors collaborated with other health service employees to "inspire" them to analyse determinants of health and health service needs, and to carry out health promotion. It could be argued that health visitors have a remit already to work in this way through adherence to their principles and training (section 2.1.1).

The question for health visiting appears to lie in the difficulties of adopting modes of practice other than individualistic, medically-oriented activity. It appears that borrowing methods of working from other disciplines has led to conflict between health visiting and related professional groups. However, where health visitors have adopted a collective approach, their work was regarded as outside of mainstream health visiting.

A clue to the reasons for the collective, emancipatory care paradigm of practice remaining outwith the core of health visiting may be found in identifying the route for policy support for health visiting. Robinson (1982) examined health visiting practice within the social policy framework of legitimacy, feasibility and support.

She concluded that health visiting had initially achieved legitimacy through its association with the infant welfare movement; feasibility as a low cost service to disseminate health education knowledge; and support from MOsH initially with subsequent support coming from the family centred philosophy of post-war social policy.

It is argued that the emancipatory care paradigm of health visiting practice neither targets child welfare exclusively nor does it work with the individualistic focus of present-day health and welfare systems. Therefore emancipatory care does not fit into the social policy framework that currently supports the individual paradigms of health visiting practice. Consequently, community-focused health visiting activity is not reflected in mainstream health visiting monitoring systems (section 2.2.2) and the role is not recognised in purchasing and contracting processes (Goodwin, 1992; RCN, 1994; SNMAC, 1995).

A collectivist approach appeared to be gaining ground in health visiting (Cowley, 1996) despite the lack of policy support. However, describing health visitor's public health role as a community approach to health promotion ignores the fact that, at present, neither public health nor primary care structures support this approach for health visitors. For these reasons, it is argued that a definitive conclusion cannot be made on whether community-focused health promotion activity can legitimately be described as health visitors' public health work.

In order to further examine health visitors' public health role, a qualitative study to gather health visitors' perceptions of a public health role was undertaken. The starting point was to use a simple definition of public health as being a population perspective rather than an individual one (Billingham, 1994). Therefore, health visitors working with population or community-focused remits were targeted for the study.

2.8 Literature relating to the method

For the present study an ethnographic approach was adopted, using semi-structured interviews with 24 respondents interviewed individually, and two interviewed together. Observation and written information were used to provide further information about their posts. In addition, one focus group was carried out late in the study for further data collection and checking ideas and analysis. Issues of ethics, validity and reliability were taken into consideration throughout the study.

2.8.1 Introduction to qualitative research

It has been argued that the universal laws aspired to in quantitative research cannot be applied to the social world because human actions are determined by individual intentions, motives, attitudes and beliefs (Hammersley and Atkinson, 1983). Rather than producing broad comparisons, qualitative research provides in-depth detailed understanding (Patton, 1990) and is generally concerned with how the social world is interpreted, understood, experienced or produced (Mason, 1996). Silverman (1993) believes that the aim of qualitative research should be to develop a dialogue between the academic world and everyday life. In addition, qualitative analysis enriches the description of empirical findings and increases conceptual skills (Dey, 1993).

Qualitative research is usually carried out in a naturalistic setting with the researcher making no attempt to place experimental controls on the phenomenon being studied (Morse and Field, 1996). Consequently, findings produced in one setting at a particular time may not be true for other settings or for other times (Hammersley and Atkinson, 1983). The qualitative researcher's task is to move beyond primary data collection towards generalising at a more abstract level of generic concepts and formal theory (Coffey and Atkinson, 1996).

2.8.2 Qualitative methods in health services research

Pope and Mays (1995) believe that a qualitative approach should be an essential component of health services research as it can enable access to lay and professional health beliefs. However, it is clear that qualitative research has not been fully accepted by the medical profession (Jones, 1995). Biomedical research continues to dominate the medical profession, relying on methodologies derived from laboratory-based medical science and focusing on medical care, disease, individualism and researcher control (Baum, 1995). The research ethos within health services, and consequently funding, apparently continues to be biased towards the norms and expectations of biomedical research (Barker, 1996).

Since the 1980s, there has been a shift towards qualitative research in a number of disciplines including health care, despite continued biomedical domination (Miles and Huberman, 1994; Baum, 1995). Miles and Huberman (1994) suggest that practitioners, researchers and policymakers may be becoming more convinced by qualitative research because of the insight offered and also because descriptive reports are often more easily understood than pages of summarised numbers.

There is some evidence that triangulation of methodological approaches is increasingly being used in the development of health care policy (Pope and Mays, 1995; Barker, 1996). Baum (1995) attributes the shift towards qualitative approaches in health care research to the increasing acceptance of the WHO's 1947 definition of health which focuses on well-being rather than on the biomedical model of absence of disease. In addition, qualitative research has been gaining credibility in nursing since the 1980s (Morse, 1991a), reflecting the recognition of the social nature and the wide knowledge base of nursing practice (Shutz, 1994).

Qualitative methods have been used to study the process and practice of health visiting, particularly health visitor's individual and family-oriented activity (Clark, 1976; Chalmers, 1990; Cowley, 1991; De la Cuesta, 1994). Qualitative methods have also been used to establish perceptions of nursing roles in the community for: district nurses (Mackenzie, 1992); public health nurses (Reutter and Ford, 1996); and community psychiatric nurses (Hummelvoll, 1996). To date, there has been little research into the process of health visitors' community-focused activity, although, Drennan (1985) and Dalziel (1992) studied health visitors' roles with groups. In addition, Rowe (1993) evaluated clients' perceptions of outcomes from attending young mothers' support groups facilitated in part by a health visitor.

Judgements about the quality of qualitative studies are difficult to make, as reports, articles or books rarely provide enough details of the methods (Rogers et al, 1997). Rogers et al (1997) suggested that explanatory power and appropriate, flexible methodology are important in assessing quality. Therefore, it is argued that few of the above studies can be adequately judged in terms of quality without more detailed information. However, some of the results from the UK studies provide insights into processes used by community nurses which informed further research and health visiting education. For example, Chalmer's (1990), Cowley's (1991) or de la Cuesta's (1994) research studies are regularly cited in later research, such as for health visitors and child protection (Appleton, 1994); the role of health visitors in accident prevention (Ehiri and Watt, 1995); evaluating community nursing health promotion practices (Sourtzi et al, 1996); and assessment of need for health visiting (Carney et al, 1996). It is argued that while qualitative studies cited above were not generalisable across UK health visitors, they provided insight that influenced the continued development of health visiting.

2.8.3 An ethnographic approach

Qualitative research developed from a range of philosophical underpinnings and methodological techniques (Mason, 1996). "Qualitative inquiry" is described as an umbrella term for a number of widely divergent research methods including grounded theory, phenomenology, ethnography and historical and philosophical enquiry (Sandelowski, 1986). Qualitative research in nursing draws on approaches from a number of fields which have gradually become incorporated into nursing research and nurse teaching (Morse, 1991a).

The method chosen to provide the framework for the present study was ethnography, a social research method used to study beliefs and practices of a culture (Morse and Field, 1996). Ethnography was developed by pioneering anthropologists Franz Boas, B Malinowski and Margaret Mead in the 1920s as the principal method of discovering unknown facts about cultural groups (Leininger, 1985a). Ethnographers study human behaviour in its cultural context from an insider's point of view, learning from people rather than studying them objectively (Morse and Field, 1996). Participant observation is the main route for collecting data, usually through informal interviews and supplemented through observation and documentation (Boyle, 1991). The ethnographer participates in people's daily lives watching, listening and asking questions in order to find the meanings of everyday human experiences and social processes (Hammersley and Atkinson, 1983).

Within nursing research, data from an ethnographic study are used to gain new insights, to interpret behaviour or to inform policy changes (Leininger, 1985a). Melia (1982) conducted an ethnographic study of student nurses and argued that a qualitative approach was an appropriate means of investigating nursing, to access "rich" data which allowed interpretative understanding of the nursing roles. Leininger (1985a) developed the ethnographic method of "ethnonursing" which aimed to discover new nursing knowledge as perceived or experienced by nurses and their clients. It was predicted that ethnographic studies in nursing would become more common (Leininger, 1985a), and it appears that this has been an accurate prediction. Ethnography has since been applied to nursing in a number of ways, such as in studying groups of patients, groups of nurses or nursing students and for studying particular settings, such as wards or units (Williams, 1995).

An ethnographic approach offered the present study a framework for gaining an insight to an under-researched area of health visiting and interpreting the reasons behind health visitors developing community-focused activity.

2.8.4 An additional influence

While ethnography provided the conceptual framework, the present study also drew on methods developed by feminist researchers. In an examination of gender issues in nursing, Davies (1996) contends that nursing, as a female occupation, struggled for recognition within the male medical bureaucracy of the NHS. This contention echoes Harding's (1987) explanation of the lack of understanding of women's participation in social life as a result of the dominance of traditional, male-oriented theories of social science. Drawing parallels between the position of nursing within the NHS and women as a whole within wider society, it could be argued that the dominance of biomedical research in the health services has prevented the development of a true understanding of nursing.

Finch (1991) believes that women's experiences can be made visible through a systematic, detailed qualitative study, producing an understanding of the meaning of those experiences. The findings can then be made available to the group under study to be used to improve conditions (Webb, 1993). Webb (1993) suggests that feminist methodology provides a useful and appropriate model for researching nursing. Drawing from feminist methods, the present study focused on an under-represented group (i.e. nursing within the NHS) and utilised the researcher's knowledge and experience (Finch, 1991). In addition, the study emphasised a non-hierarchical relationship between researcher and informants, and proposed that findings from the study would be made available to informants for their own use (Webb, 1993).

2.8.5 Collecting data from interviews

Hammersley and Atkinson (1983) believe that all social research takes the form of participant observation and that data can be drawn from informal and formal questioning, observing actions and written material. In order to access personal interpretations of events and processes, people need to be encouraged to express their constructions in their own terms, rather than being expected to express them as isolated fragments of information on a questionnaire (Jones 1985). Consequently, interviews are the most commonly recognised form of data collection method in qualitative research (Mason, 1996). Qualitative interviews aim to go below the surface of a topic, explore people's views in as much detail as possible and uncover ideas that were not anticipated at the outset of the research (Britten, 1995). They also provide an opportunity to explore concepts that are not necessarily formed in people's minds (Mason, 1996).

In feminist research, researchers use their own experiences as a research resource (Stanley and Wise, 1983). However, Platt (1981) argues that when a researcher is interviewing their peer group, the shared community membership and continuing relationship between researcher and respondents can potentially, adversely affect the interview. With shared community membership, a researcher draws on background knowledge as well as collecting data from explicit questioning, which may create problems such as: accessing thinner data from respondents; reliance on the interviewer's interpretation of background knowledge rather than the respondent's; and difficulty in separating formal and informal interaction (Platt, 1981). In addition, shared community membership raises ethical issues, with the potential for compromising the respondent's autonomy in deciding whether or not to participate in the study (Singleton and McLaren, 1995). On the other hand, shared experience can also benefit a study in ensuring access to the respondents and gaining a deeper understanding of the topic (Platt, 1981).

In conversational interviewing the informant is given more freedom and control of the information compared with questionnaires or survey interviews (Mason, 1996). The nature of conversational interviews is such that they are structured by both the researcher and the informant (Hammersley and Atkinson, 1983). While a non-hierarchical relationship was preferred for the present study, equality between researcher and researched cannot always be assumed (Platt, 1981). For example, an assumption of equality cannot be made when middle-class researchers interview working-class subjects, or the research topic includes interviewing informants with higher status within an organisation or in society (Platt, 1981).

Interviewers are usually advised to build a rapport with their informant, which suggests a degree of manipulation by the interviewer (Hammersley and Atkinson, 1983). Platt (1981) points out that equality is violated in an interview if one party manipulates or dominates another, but reciprocity and symmetry is more likely to be achieved when researcher and informant are of equal status as in normal social interactions.

Hammersley and Atkinson (1983) distinguished between survey interviewing which uses standardised formats, and ethnographic interviewing which uses a reflexive approach. However, they argue that both types of interviewing had some structure in place. Other authors describe interviewing in qualitative research as either unstructured or semi-structured. Unstructured interviews are said to be used when the researcher has little prior knowledge of the topic (Morse and Field, 1996). Interviews can become more structured as the study progresses when the researcher wants to explore particular areas or test findings (May, 1991). Semi-structured interviews, also called focused interviews (May, 1991), range from a format that uses a prepared list of open-ended questions (Morse and Field, 1996), to interviews organised around areas of interest, allowing the respondent flexibility but maintaining a degree of consistency (May, 1991).

Questions in a semi-structured interview are designed to probe respondents' answers (Britten, 1995), and both directive and non-directive questioning are used (Hammersley and Atkinson, 1983). Rather than a prescriptive set of questions, semi-structured interviews are often guided by a prepared topic list or aide-memoire (Patton, 1990). Pre-testing in ethnographic interviewing is regarded as unecessary because interview data are collected from the perspective of the participant (Leininger, 1985b). Ethnographic interviews are carried out with single interviewees or as group interviews, which allows a number of people to be interviewed at the same time and may help to reduce strain on the interviewees (Hammersley and Atkinson, 1983).

2.8.6 The Interview Process

While interviews in qualitative research are described as "conversations with a purpose" (Hammersley and Atkinson, 1983), interviewers need a range of technical skills beyond the social skills required for more common forms of social interaction (Boulton and Fitzpatrick, 1994). Skilful interviewing depends on the extent to which the interviewer establishes rapport, elicits information without controlling the interview and records information accurately (May, 1991). The interviewer is urged to plan and prepare for the interviews but must be able to think on their feet to decide how best to ask what they really want to know (Mason, 1996).

Active listening is an important skill for the interviewer to employ in order to assess the relationship of the answers to the research focus and to plan the future course of the interview (Hammersley and Atkinson, 1983). There should be a good balance between talking and listening, and the balance is likely to be different in each situation (Mason, 1996). Morse and Field (1996) suggest that interviews should start with small talk, a description of the interview procedures and then begin by asking the demographic information before moving on to the main issues. Questions must be open-ended, sensitive, neutral and clear, starting with the easier topics, proceeding to more difficult or sensitive ones (Patton, 1990).

Most studies involving formal interviewing tape record the interviews and add information from written sources and field notes (May, 1991). At any one time during an interview, the interviewer may be listening, interpreting, deciding on appropriateness to the research topic, thinking about new ways to find out what they want to know, assessing body language or changes in demeanour, formulating a response, reflecting on something that was said earlier in the interview, keeping an eye on the time and the tape recorder, or taking notes (Mason, 1996).

2.8.7 Focus groups

The focus group interview is a data collection method that uses group interaction to explore different perceptions of a defined area of interest (Nyamathi and Shuler, 1990). The method is used to explore people's knowledge and experiences, and to examine how they think and why they think that way (Kitzinger, 1995). The technique of focused interviewing in groups was said to have been developed from social scientists' concern in the 1930s to reduce the potential domination of researchers in gathering data from individuals through structured interviews (Kreuger, 1994). Group discussions, alternatively called focused interviews or focus groups, are used extensively in market research, communications studies and to involve grass roots participation in action research (Kitzinger, 1994) and are increasingly used by public sector organisations in collecting information that is helpful to decision makers (Kreuger, 1994). It is only in the 1990s that focus groups have become popular in nursing research (Clark et al, 1996).

The relationships that develop between members of a focus group are said to help in stimulating discussion and exploration of a topic (Frey and Fontana, 1993). Focus groups are empowering for participants, particularly in action research, where participants can become an active part of the process of analysis and also when the expression of criticism is appropriate, for example in research aiming to improve services (Kitzinger, 1995). However, Parahoo (1997) believes that sharing of experiences exposes underlying conflicts that may otherwise have remained hidden.

Focus groups are used before, during and after a research study in a number of ways, including:

- *before*, to develop a questionnaire or to carry out a needs assessment;
- *during*, to collect qualitative data on perceptions of an issue or a service; and
- *after*, to evaluate a project or to explore survey results (Kreuger, 1994).

In addition, they are used at the end of a study as a source of validation for individual interview data and events observed (Frey and Fontana, 1993). Hammersley and Atkinson (1983) warn that feedback to respondents in a study should not be taken as direct validation of an observer's analysis, but should be treated as another, valuable source of data.

The limitations of focus groups listed by some authors are perceived by others as advantages; for example, Parahoo (1997) believes that a focus group is an inappropriate method for exploring personal issues due to the potential for creating discomfort amongst the group. Other researchers have found that focus groups can be used successfully in discussing many personal and emotional topics

(Morgan and Kreuger, 1993; Kitzinger 1994). Cost and time-effectiveness are also cited as advantages, with the ability to interview many people at the one time (Kreuger, 1994; Lankshear, 1993). However, the method can be costly in terms of skills required by the researcher (Kingry et al, 1990) and in the time taken to organise the groups (Clark et al, 1996).

Many of the criticisms that have been levelled against focus groups in the past appear to be similar to those used against qualitative techniques in general, such as those discussed by Clark et al (1996) which included methods used for sampling, lack of generalisablity of results and questionable validity. However, one advantage of focus groups over individual interviews is that the group interaction may stimulate the introduction of more concepts than in individual interviews (Thomas et al, 1995). In a comparison of 67 patients interviewed in focus groups and 83 patients interviewed individually, Thomas et al (1995) found that more concepts were introduced in focus group discussions, although there was no difference in the depth of discussion between the groups and the individual interviews.

The researcher's role with focus groups is to develop the questions, to facilitate the group, to document and analyse the data and to interpret the results (Kingry et al, 1990). The group facilitator must be skilled enough in groupwork techniques to prevent domination of the group by individual members and to ensure that all members have the opportunity to participate in the discussion (Thomas et al, 1995). When discussing sensitive issues the role of the facilitator is particularly important in order to encourage appropriate self-disclosure and avoid overdisclosure (Morgan and Kreuger, 1993). Facilitators are advised to have an assistant to help set up the room and recording equipment and to help in picking up cues, noting quotes and body language of participants (Kreuger, 1994; Clark et al, 1996).

There are a range of suggestions in the literature as to the ideal number of participants in a focus group. Between four and eight is recommended by Kitzinger (1995), but Frey and Fontana, (1993, p29) described a focus group as "two or more members of the population under study". Kreuger (1994) recommended an ideal number for a group being between six and 10, and Clark et al (1996) ran successful groups with up to 12 participants. The recommended number of focus groups used in a study depends on the topic and reason for the study, with fewer focus groups being required if the participants have a similar background and experience (Kreuger, 1994).

Focus group discussions are carried out with existing groups in their usual meeting place or with groups of strangers in a central location (Kitzinger, 1995). Kreuger (1994) advises that it is unwise to have mixed-sex focus groups particularly when the subject matter is experienced differently by men and women and also because there may be a tendency for either sex to perform to the other.

Participants should be invited formally to take part in the focus group, with information about the subject and format of the discussion available before the group meets (Lankshear, 1993). Clark et al (1996) recommends that it is prudent to invite more participants than needed, suggesting over-recruitment by as much as 50-100% in nursing to achieve the required number. Refreshments or food can be used to welcome participants in order to create a relaxed atmosphere (Lankshear, 1993). Opening instructions should be given to encourage participants to share their views, feelings and experiences and to encourage the group to collectively guarantee confidentiality (Clark et al, 1996). The group discussions are tape recorded, transcribed, analysed and written up in the same way as for other qualitative data, but with the added dimension of indicating the impact of the group dynamic (Kitzinger, 1995).

2.8.8 Purposive Sampling

If the aim of qualitative research is to uncover new meanings the sampling technique should ensure a rich source of data (Reed, Procter and Murray, 1996). Purposive sampling (also called purposeful sampling; Morse, 1991b) may be used in qualitative research to select informants who are articulate, reflective and appropriate to the study (Glaser and Strauss, 1967). The sample should be selected to test the researcher's argument and not only to support their theories (Mason, 1996). There are different types of purposive sampling, including snowball (also called chain) sampling with initial contacts being asked to suggest further, potential subjects who could be approached either by the informant or by the researcher (Patton, 1990). The underlying assumption of this technique is that those within the group in the study can distinguish between other "insiders" and "outsiders" of the group in question, and know who could provide the best interview (Morse, 1991b). However, a disadvantage of snowball sampling is that the researcher must rely on others' interpretations of the inclusion criteria (Morse, 1991b).

It is also important to recruit negative cases into the sample to introduce variation and reduce bias (Glaser and Strauss, 1967). Miles and Huberman (1994) stress the importance of questioning interpretations of data by following up instances of extreme cases and surprises in order to increase validity of the findings.

2.8.9 Data Analysis

The overall aim of qualitative analysis is regarded as the transcendence of factual data to theoretical ideas by finding coherent patterns of ideas, thought, utterances and beliefs (Coffey and Atkinson, 1996). Analysis includes a wide range of activities, from sorting and organising the data, to attempting broader theoretical generalisations (Mason, 1996). The process of analysis in qualitative research should inform all stages of the research including data collection and should not be seen as the last phase (Coffey and Atkinson, 1996).

There is no prescriptive system for all qualitative researchers to follow in analysing their data as the process is inductive and based on their unique study (Burnard, 1995). Mason (1996) suggests that the researcher reads textual data on three levels: literally, i.e. what is there; an interpretative reading, i.e. looking beyond the data to what you can infer from them; and a reflexive reading, i.e. locating the researcher as part of the data. Miles and Huberman (1994) provide a list of steps to guide the process of generating meaning from qualitative data, as follows:

- noting patterns and themes
- seeing plausibility but staying open to changing ideas
- clustering
- metaphors and integration between pieces of data
- counting
- making contrasts and comparisons
- partitioning variables and differentiation
- subsuming particulars into the general and developing general classes
- looking for common factors
- noting relations between variables, e.g. by using a matrix
- finding intervening variables e.g. finding out why two variables relate
- building a logical chain of evidence
- making conceptual coherence.

Coffey and Atkinson (1996) also describe a number of techniques for generating meaning, but both these authors and Miles and Huberman (1994) stress that their suggestions should not be followed prescriptively and that the researcher should be guided by the context of their study. Burnard (1995) summarised the process of analysis by identifying common characteristics shared by most qualitative approaches as follows:

- volume of the text reduced;
- categories or types of responses identified;
- similar types of responses grouped together;
- similar ideas brought together in a report; and
- attempts are made to stay true to the text.

The first step for most qualitative researchers is to break down the data by assigning codes or categories. Coding helps the researcher to sort the data and to uncover underlying meanings (Morse and Field, 1996). The important analytic work lies in establishing and thinking about the linkages between codes, data categories and concepts, and the process of coding should be seen as part of the interrogation of the data (Coffey and Atkinson, 1996). In line with the discussions above on sampling techniques and later in establishing validity, Coffey and Atkinson (1996) pointed out that contrasts and irregularities should be searched for during analysis as well as themes and patterns.

Informants' use of metaphors was described as enlightening in moving towards deeper interpretation of data (Miles and Huberman, 1994; Coffey and Atkinson, 1996). However, analysis is not about trying to find out what people might "really mean". Burnard (1995) suggests that the data collected on any one day are unique to that particular encounter; for example, people may not be able to express their thoughts clearly, or they may tell the researcher what they think s(he) might like to hear. The issue of data being valid or invalid is not as important as the inferences drawn from them by the researcher (Hammersley and Atkinson, 1983). The goal is to produce a meaningful explanation which may then lead to an understanding of why something happened (Rogers et al, 1997).

2.8.10 Use of computer software

There is a wide choice of software on the market designed to assist the qualitative analysis process. Choosing the right software depends on the task the researcher wants it to perform (Miles and Huberman, 1994). Coffey and Atkinson (1996) advise that researchers should use available resources such as word processors to the full before searching out more complicated and not necessarily better tools. There is a danger that inexperienced researchers become too involved with learning about a new programme and the mechanics of coding, consequently losing sight of their data (Morse, 1991c). As an example of simplicity versus complication in the use of computer software, Morse (1991c) described the use of Microsoft Word to analyse qualitative data in a journal article of five pages: in contrast the manual for the NUD.IST programme (Richards and Richards, 1991) ran into hundreds of pages. In the present study, NUD.IST was considered for use, but was found to be inappropriate (section 3.7.2). Microsoft Word was therefore used to support the process of data analysis.

2.8.11 Ethical Considerations

There are a number of ethical issues that must be considered when conducting qualitative research. Ethical principles should be adhered to throughout every stage in the research process, as follows: reasons for the research should be explicit at the design stage; clear boundaries should be set during data collection; and the final product should be good quality research that protects the rights of informants (Mason, 1996). Respect for the rights of individuals means that potential informants can decide whether or not to participate in research, with the researcher obliged to obtain informed consent (Singleton and McLaren, 1995). Informed consent may vary for different participants, depending on their level of understanding of the research process or their need to have consent from others, e.g. parents, teachers or managers (Mason, 1995). In addition, while informed consent may be gained for carrying out interviews, researchers often use other data sources to corroborate primary data, such as information from significant others or observation, without explicitly obtaining consent from the participant (Platt, 1981; Smith, 1992).

If research is to do no harm to participants, researchers must be appropriately qualified and must consider the potential effect of their questions on participants (Singleton and McLaren, 1995). However, questions intended for data collection may unintentionally encourage disclosure by the participant of sensitive issues requiring the researcher to compromise between the needs of the research and needs of the participant (May, 1991). Researchers must be sensitive to the fact that interviews, particularly with women, may uncover issues unrelated to the process of data collection (Smith, 1992). Consequently, they may have to justify their subsequent actions, for example in providing information about where to go for help (Smith, 1992).

There is some debate about whether the researcher should disclose personal views or opinions. For example, Smith (1992) stressed the need to remain as objective as possible, although acknowledging that this was very difficult particularly when her interviewees were obviously distressed. On the other hand, Wilde (1992) recognised that researcher intervention in the form of giving support to the interviewee had beneficial effects on the interview as it opened up additional avenues for exploration. Therefore, the researcher should plan for responding to participants appropriately, but also must be aware that they may have to take quick decisions about altering their original plan during the data collection process (Mason, 1995).

In data analysis, the researcher has an ethical responsibility to ensure that conclusions are well founded and that appropriate generalisations are made which are relevant to public concerns (Mason, 1995). In addition, researchers have an obligation to publish and disseminate results in a way that represents the group under study without distorting the group's interest (Smith, 1992). Anonymity and confidentiality must be maintained in the reporting and disseminating process, including measures taken to ensure restricted access to data; for example, preventing identifying information being logged on to a computer and maintaining locked files (Singleton and McLaren, 1996).

2.8.12 Reliability

Reliability of a research study relates to the accuracy of the research methods and techniques (Mason, 1996). Three kinds of reliability were described as follows: making the same observation from the same question; the stability of an observation over time; and the similarity of observations using different methods, for example, through triangulation (Kirk and Miller, 1986). Sandelowski (1993) warns that convergence in data may be inappropriately sought and that researchers should ensure that the methods chosen for establishing trustworthiness are relevant to their study.

In quantitative research reliability is measured by the degree of repeatability of the research tool (Sandelowski, 1986). However, qualitative methods lack the standardised tools of quantitative research and instead, the researcher is regarded as the research instrument (Hammersley and Atkinson, 1983). Reliability of a qualitative study is assessed by following the "decision trail" where the researcher clearly justifies, and describes the reasons behind, decisions taken (Sandelowski, 1986). Silverman (1993) suggests the following methods for demonstrating reliability in qualitative data from four different sources:

Observation: keeping detailed field notes, a fieldwork journal and a record of analysis and interpretation.

Texts: using inter-rater reliability where different analysts come to an agreement about data categories.

Interviews: pre-testing interview schedules and comparisons between at least two researcher's analyses of the data.

Transcripts: availability of transcripts satisfies the documentation procedure, as in observation. In addition, inter-rater comparison of analyses can also be applied.

A number of questions should be asked to judge the reliability of an analysis of qualitative data regarding the consistency of inclusion or exclusion of data, and whether the coding categories are mutually exclusive and encompass all the data (Brink, 1991). Mays and Pope (1995) add that the relation between the interpretation and the evidence should be made clear by including referenced quotations from respondents.

In the present study, reliability of data was tested by checking interview data against written reports of respondents' work where appropriate. Detailed field notes, and a record of analysis and interpretation were kept (Chapter 3). Finally, intra-rater reliability was established by re-coding early interviews at a later stage in the analysis.

2.8.13 Validity

Validity in qualitative research is defined by Morse and Field (1996, p200) as "the extent to which the research findings represent reality". The emphasis in qualitative analysis on unique interpretations by individual researchers introduces the potential for multiple sources of bias (Miles and Huberman, 1994). Therefore, there is a need to check that researchers do not verify their own preconceptions (Webb, 1993).

Sandelowski (1986) argued that in assessing the trustworthiness of qualitative research there is a tendency to evaluate qualitative methods against quantitative criteria which favoured quantitative research and failed to address the artistic nature of qualitative inquiry. For example, qualitative researchers, particularly those using a phenomenological approach, are sometimes advised to increase objectivity by "bracketing out" personal biases in order to avoid influencing the collection and interpretation of the data (Jasper, 1994). Alternatively, other qualitative approaches, for example in feminist research, actively encourage the use of the researcher's knowledge and experience (Finch, 1991).

Using one's own experience means that self-awareness can be exploited as a source of insight (Lipson, 1991). Validity in a study using an openly subjective approach is increased by the process of reflexivity, where the researcher is acknowledged as being part of the social world under study, and also part of the process of developing theory from the data (Hammersley and Atkinson, 1983). Commonsense knowledge of the world is recognised as affecting the phenomena under study but data are not treated as valid in their own terms. Instead, it is the theory drawn from the data by the researcher that is tested for validity (Hammersley and Atkinson, 1983).

There are no standard systems for assessing validity in qualitative research. A number of authors (e.g. Sandelowski, 1986; Koch, 1994; Miles and Huberman, 1994) used criteria established by Guba and Lincoln to establish trustworthiness of qualitative research, as described by Sandelowski (1986):

- truth value or credibility where the findings are credible if descriptions or interpretations of experience are recognised by people having that experience and by others;

- applicability or transferability, when the study's findings fit into contexts outside the study situation and when the audience views the findings as meaningful to their own experiences;
- auditability or dependability where the researcher leaves a decision trail about theoretical, methodological and analytic choices; and
- confirmability, the criterion for freedom from bias, where the researcher clearly shows how interpretations have been arrived at. Confirmability is established when the above three measures have been achieved.

Miles and Huberman (1994) warn that analytic bias can invalidate findings, for example, by interpreting events as more congruent than they are, or over-weighting data from articulate, high status informants. They suggest the following list of thirteen tactics for preventing researcher bias and increasing readers' confidence in findings:

1. checking for representativeness of coding categories and examples used to reduce and present the data;
2. checking for researcher effects such as stimulating behaviour in interviewees that would not have occurred under normal circumstances, e.g. posturing;
3. using triangulation of data source, method, researcher, theory or data type to determine congruence of findings;
4. weighting the evidence, for example, some settings might have been more informal than others, stronger data may be those collected later in the study, etc;
5. checking the meaning of outliers, i.e. results that do not fit with others;
6. use of extreme cases;
7. following up surprises;
8. looking for negative evidence by having someone check field notes;
9. making if-then tests;

10. ruling out spurious relations;
11. replicating a finding e.g., by testing an emerging hypothesis in another part of the case or data set, or replicating in a brand new case, saving certain subjects for later;
12. checking out rival explanations; and
13. getting feedback from informants, e.g. feedback during data collection with new or key informants or feedback after final analysis which can back it up. (Miles and Huberman, 1994).

For the present study, the criteria and tactics suggested above were taken into account throughout the study. In addition, validity of the findings was checked by the researcher presenting the study design and findings to four professional groups while carrying out the analysis (section 3.7.4).

2.8.14 Summary

Each researcher's interpretation of a set of data is unique to them. The emphasis should be on identifying the essence of a phenomenon rather than following a prescribed set of procedures (Sandelowski, 1993). There is a danger that attempting to remove the subjectivity of a researcher in qualitative research risks losing meaning by measuring qualitative research against the criteria of quantitative research (Sandelowski, 1986). Shutz (1994) believes that the personal perspective is important in nursing research in order to generate knowledge and increase understanding of experiences of nurses, patients and clients. The task for nursing academics is to find ways to accept the differing interpretations of qualitative research in order to achieve deeper understanding that advances knowledge and influences practice (Sandelowski, 1993).

The following chapter details the materials and methods employed in the main study.

Chapter 3 Materials and Methods

3.0 Research Questions

1. What are health visitors' interpretations of a community-focused remit?
2. How does the community-focused role of health visitors relate to the extant principles of health visiting?
3. How does the community-focused role of health visitors relate to Government guidelines for health promotion and community health care?

3.1 Overview of study design

Background investigations established that there was a potential for health visitors to work with a population or a community perspective through the researcher's previous experience of working in a community health project (section 1.0), a comprehensive literature review (chapter 2), and a series of informal discussions with leaders in the public health field (section 3.5.3). The study was conducted over a period of eighteen months, from May 1996 to November 1997. Data were collected between July 1996 and July 1997 from health visitors who worked with community-focused remits in Scotland and England using face-to-face, semi-structured interviews within an ethnographic framework.

Transcriptions of the interviews were analysed by an inductive process of identifying themes, patterns, concepts, contrasts and irregularities from which an understanding of the health visitor's community-focused role was developed (section 2.8.9). The health visitors' interpretations were set in context with current policy and practice in primary care and public health. This process led to the development of a description of a public health role for health visiting. Reliability (section 2.8.12) and validity (section 2.8.13) were sought through a reflexive process whereby the researcher maintained awareness of her involvement with the data and offered a description of decisions taken during the progress of the study. In addition, on completion of the interviews the interim findings were presented to a focus group for clarification (section 2.8.7).

3.2 Population

Initial investigations through professional contacts and snowball sampling established that there were too few community-focused posts in Scotland to confine the study to Scotland. In addition, the literature review revealed some health visitors with long experience of community-focused work based in England. Therefore, it was deemed necessary to extend the study outside Scotland in order to develop a greater understanding of health visitors' community-focused role.

From initial investigations it appeared that health visitors within English, Scottish and Welsh health services were developing community-focused roles in the absence of supportive policy processes. In contrast, health visitors in Northern Ireland with community development remits potentially had policy support. In Northern Ireland, health and social services departments had a Regional Strategy for Health and Wellbeing that set targets for health and encompassed community development as a method (Barr et al, 1996). The differences suggested that direct comparisons could not be made across cases from mainland UK and Northern Ireland without full consideration of both sets of policy processes. It was decided that health visitors working in Northern Ireland would be excluded on the grounds that their administration system was different than that for mainland UK. Therefore, the population from which the sample was drawn included all health visitors working in Scotland, England and Wales.

3.3 Sample

Health visitors' work of relevance to the study was deemed to be activity that related to the emancipatory care paradigm of practice as identified by Twinn (1991) (section 2.2). Other paradigms of practice identified by Twinn (1991) had recognisable public health roots and mainstream support (sections 2.2.1 and 2.2.2). In contrast, the emancipatory care paradigm (section 2.2.3) lacked a clear definition and mainstream recognition (section 2.7). Therefore, this study focused on health visiting activity that could most closely be described as emancipatory care (Twinn, 1991) and excluded activity defined by medical or public health services.

Health visitors working with community groups who had full-time generic remits were also excluded from the study. They were regarded as having less opportunity than those with explicit, community-focused remits to have established a public health role in addition to their caseload work. In order to allow full exploration of the community-focused role, health visitors were targeted who had been in community posts for some time and had dedicated, community-focused remits.

A purposive sampling framework (section 2.8.8) was adopted to ensure that health visitors with the longest and richest experience of community-focused work would be identified and invited to participate in the study. In particular, snowball sampling (section 2.8.8) was used to identify further, potential respondents. Inclusion criteria for recruiting health visitors were drawn up as follows:

- having a defined remit for one or more of the following: public health; community development or community work (including health visitors employed by or seconded to community health projects); health promotion projects; community profiling or health needs assessment (in primary care or public health);

- having worked for a minimum of one year with remit(s) as above;
- working with a community focused remit for at least two days per week;
- if not working currently in a community focused post, should have been employed as above within the last five years;
- having a community remit in Scotland, England or Wales.

The present study was funded and based in Scotland. As there had been few Scottish contributions to the health visiting/public health debate apparent in the literature review, a Scottish perspective on health visitors' community focused activity was regarded as crucial. To ensure that a Scottish perspective was represented, the study aimed to include at least eight Scottish respondents.

Some potential respondents were already known to the researcher from previous community health work, professional bodies' relevant special interest groups and national public health networks. Other respondents were identified through the established networks, by tracking down authors of relevant papers and reports and through snowball sampling. Neither the literature review nor snowball sampling revealed potential respondents in Wales. One health visitor in Wales was suggested by a professional contact unrelated to the study, but this came at too late a stage to arrange an interview. As a result, there were no respondents from Wales included in the study.

In total, 32 health visitors with specified community-focused responsibilities for some or all of their job remits were invited to participate in the study. All agreed to be interviewed. The first three interviews comprised the pilot study (section 3.6.1). A further three health visitors were unable to attend pre-arranged interviews due to illness but difficulties with time and distance mitigated against re-arranging their interviews. Consequently, the main study consisted of 26 health visitors, with nine respondents based in Scotland and 17 in England.

Time management was one factor in deciding to stop interviewing as the researcher had a limited period of funding for the study. However, the main factor was that sufficient data had been gathered to identify processes and underlying principles of the community-focused role.

3.3.1 Access to respondents

Initial contact with respondents was usually made by telephone and occasionally through personal introductions at professional meetings. On initial contact, respondents were told about the purpose, aim and method of the study and asked if they would be interested in participating in interviews. Once interest was expressed, an offer was made to approach formally the respondent's line manager for permission to organise an interview, preferably in their own workplace where possible. This offer was taken up only on a few occasions, whereupon a letter and further information was sent to the appropriate manager (Appendix II). Some respondents preferred instead to request permission from their managers in person while others were no longer working or had moved into senior positions at a level where they were self-directing. A letter confirming the interview (Appendix III) and stressing confidentiality was sent to respondents before the agreed date. Enclosed with the letter of confirmation was a summary of the study (Appendix IV) and an interview schedule (Appendix V) for their own and their manager's use if necessary.

3.3.2 Use of inclusion criteria

Efforts were made to ensure that snowball sampling resulted in recruitment of participants who were relevant to the study. In particular, clear instructions were provided about inclusion criteria to respondents who offered to help recruit further health visitors to the study. Despite this, one of the first respondents identified by snowball sampling was found at interview to be outwith the criteria. Data from this interview were believed to be limited in both breadth and depth compared to interviews with more experienced respondents. Consequently, the researcher was struck by the necessity of the inclusion criteria for future interviews in order to ensure access to rich data. The data from this interview provided limited insight into the community-focused role of health visitors. However, it added to the researcher's understanding of the research process and was therefore deemed to be of value to the study.

3.4 Ethical issues

Guidance was followed on protecting the rights of informants and taking responsibility for utilising data appropriately, as detailed in section 2.8.11.

The study did not require access to health service patients or clients. In addition, it was a multi-site study which was likely to include one respondent from each of an unpredictable number of health board or health authority areas. Consequently, line managers or respondents themselves were asked to decide on participation as appropriate. In addition, codes of confidentiality and anonymity were made explicit in order to protect respondents. Therefore, no ethics committee approval was sought.

Confidentiality and anonymity in use of quoted speech were assured by the researcher in writing, as part of the letter of confirmation sent to respondents before the interview (Appendix III). Verbal consent to tape record interviews was sought before interviews began. In addition, assurance of both confidentiality and anonymity was repeated at the beginning of each interview.

Respondents were identified only by number and date of interview on tape recordings and on the interview transcriptions. The computer database of respondents' details did not include their identifying number and information regarding respondents was used only for the research purposes in line with the Data Protection Act 1984. Typists were asked to delete transcriptions from their computer hard disks once the researcher had received her copy and recorded tapes were kept in a secure location.

3.5 Development of data collection tools

Data were collected from respondents using an interview schedule, a self-completed information sheet, field notes on observation in places of work and written reports. Development of the data collection tools was shaped by the literature review, a consultation process with local practitioners and leaders in the public health field, and the researcher's prior knowledge of the role.

3.5.1 Literature review

It was evident from the literature review that there was confusion surrounding the potential public health role of health visitors. An understanding of the underlying processes as well as practitioners' interpretations of their roles were required in order to identify any congruence in the community-focused roles. In addition, more information was needed on the conditions regarding community-focused posts, such as the health visitors' qualifications, the areas in which they worked and the management of their posts.

3.5.2 Consultations with public health practitioners

The literature review had confirmed the confusion around the use of the term "public health" and its relationship to nursing. To make sense of the conflicting views in the literature, an attempt was made to build a picture of current public health research and practice before proceeding with the study. Two groups were approached to explore current definitions of public health. The first group were participants in a seminar organised by the researcher immediately prior to the commencement of the research study. The seminar focused on the role of Glasgow's health visitors in relation to public health and community development, and included a presentation on the researcher's role as a health visitor in a community health project. It was attended by health visitors, community nurse managers, academics, health promotion officers and service planners. The researcher was able to include a short discussion between participants about definitions of public health as part of the seminar workshops. Discussions were recorded in note form and produced as a report for seminar participants (Craig, 1995b).

The second group comprised senior figures in the public health field who were invited to take part in short, informal discussions to elicit their understanding of definitions of public health and whether nurses and health visitors had a role to play. Eight Directors of Public Health, Professors of Public Health and General Practice and a Health For All Project Co-ordinator were invited to participate by letter (Appendix VI), with seven agreeing to take part. The letter was followed up by a telephone discussion or a face-to-face meeting. Enclosed with the letter of invitation was a report written by the researcher about her previous work as a community based health visitor to stimulate discussion and to ensure respondents understood the researcher's involvement in the topic.

Both consultation groups suggested that public health was about improving quality of life, focusing on populations rather than on individuals. The first group believed that methods of working for public health should include empowering communities and encouraging participation. The second group expressed similar views in that all participants stated their commitment to the WHO definitions of health and health promotion (section 2.3.3). There was concern among both groups that GPs might experience conflict between the individual and the population approaches but there was also a recognition that there was potential for nurses, and particularly health visitors, to develop a more visible role within public health.

3.5.3 Previous experience

Personal experience of a community-focused health visiting role was utilised to focus on the issues of most relevance to the topic. Specialist knowledge particularly helped the process of identifying the most appropriate study design as well as accessing the respondents most relevant to the study. The potential disadvantage of close involvement in relation to data collection was that it introduced researcher bias (section 3.6.4). This was taken into account in the development of the data collection tools by using an interview schedule in the form of an aide-memoire (Appendix V) rather than a questionnaire. Thus the interviews were designed to maximise the potential for the respondents to lead discussions. With an aide-memoire, the researcher provided the topics for discussion but did not control the interview (section 2.8.6).

3.5.4 The interview schedule

As noted in section 3.5.1, an interview schedule (Appendix V) in the form of an aide-memoire was devised in order to give respondents maximum opportunity to lead discussions during interviews. It was clear from background investigations previously described that the activities (the "what"), the processes (the "how") and the underlying reasons (the "why") of community-focused health visiting must be described in order to gain a full understanding of the role. The interview schedule split the "what", "how" and "why" into three sections as logically as possible (practice, process and personal), with the more straightforward topics coming first. The schedule was not intended as a prescriptive sequence of questions but was organised in a way that would assist the researcher in ensuring that all the topics were covered.

In addition to the interview schedule, a short, self-complete information sheet (Appendix VII) was developed to collect demographic information about the health visitors' professional profiles, the structures of their community-focused job and area characteristics. An indication of the level of need in respondents' areas of work was included in the information sheet by requesting estimates of deprivation indicators. The three indicators included were levels of unemployment, single parents and elderly people which were drawn from established deprivation indices (Morris and Carstairs, 1991). These were chosen as issues that would be of particular relevance to health visiting practice with its traditional focus on children and the elderly (Carney et al, 1996).

3.6 Data collection

3.6.1 The pilot study

The pilot study aimed to test the method of accessing respondents, to check the usefulness of the interview schedule and information sheet, to assess the researcher's interviewing skills, to practise using the tape recorder and to experiment with organising data. In addition, it was important to identify any bias created by differences in the relationships between the researcher and respondents with regard to:

- interviewing someone familiar and interviewing someone previously unknown, as some of the potential respondents were well known to the researcher;

- level of experience, as some potential respondents were less experienced than the researcher in this work and others were more experienced or had moved into promoted posts within nursing or commissioning; and
- gender, as most respondents were expected to be female with the researcher being aware of only three potential respondents who were male.

Three full interviews were conducted as the pilot study. The pilot study was designed to include a relatively inexperienced respondent who was well known to the researcher, a respondent unknown to the researcher with a high profile for community-based work and currently in a promoted post, and a male respondent, also previously unknown to the researcher. Due to illness, the interview with the male respondent had to be postponed until a later date, and a third female respondent, also previously unknown to the researcher was included in the pilot study. Two respondents were no longer working in their community posts and their interviews took place in their current workplaces. The third interview was carried out in another respondent's home.

As a result of the pilot study, one question on the self-complete information sheet was clarified. The information sheet and interview schedule appeared to elicit useful data and respondents welcomed the opportunity to see the interview schedule in advance. All three interviews were interrupted with telephone calls or someone entering the room. These interruptions had been dealt with and it was accepted that interruptions might happen wherever the location of the interviews. The pilot study also provided insight into the researcher's own interview performance, highlighting techniques that could be modified or introduced to maximise the effectiveness of the data collection process. For example, the use of anecdotes to prompt further exploration of a topic, or allowing silences for reflection were explored.

All three respondents had referred to reports that had been written by themselves or others describing their work or associated project. The researcher had been aware of two of these reports before the interviews. Reading the reports added to the researcher's understanding of the context for respondents' activities. It was decided that respondents would be asked to provide any relevant written reports of their work at the interviews. It was understood that reports would not always be available, therefore written information was treated as providing additional insight into interview data and not analysed separately.

Written information already in the public domain was acquired before interviews for fifteen respondents in the form of grey literature or papers published in professional journals. In addition, a further three respondents supplied summaries of their work or job descriptions after the interviews. The remaining eight respondents had moved out of their community posts with no written information available (n=3) or had no written reports other than loose job descriptions that were not generally in the public domain (n=5).

Data from the pilot study were used to explore different techniques of data sorting and analysis. This process also provided an early indication of the emergence of concepts that had not been identified from prior knowledge or the literature review, such as autonomy and the caseload/community interface. Therefore, the pilot study informed further questions in the main study interviews without requiring changes in the interview schedule. Pilot study data were excluded from the main study analysis.

3.6.2 The main study

A total of 26 interviews took place between August 1996 and July 1997. The researcher travelled as far north as Benbecula in the Western Isles down to Bristol and London in the south.

It was recognised that data collected later in a study might be stronger as the researcher becomes increasingly familiar with the topic (Miles and Huberman, 1994). An attempt was made to reduce the potential of skewing of the data that might have occurred if respondents were grouped, for example by interviewing all Scottish respondents first or all those with more experience after all those with less. This was avoided where possible by alternating Scottish and English respondents, and respondents with more and those with less experience. The exception to this pattern was that four of the health visitors who had published papers and reports about their community activity were deliberately interviewed last. They did not necessarily have the longest experience but had proven ability in discussing and analysing their roles. The researcher had hoped to use these final interviews to explore any issues of particular importance arising from previous interviews if necessary.

It had been intended that interviews would be carried out individually, as in the pilot study. However, two group interviews were planned to maximise the data collected in one particular town where two groups of health visitors held identical job descriptions. This situation was unique to the town as respondents from other parts of the UK tended to work in isolation. Two group interviews were arranged, each with three health visitors. However, three respondents were unable to attend due to illness; one from one group and two from the other. Consequently, one group interview was carried out with two respondents while the other respondent was interviewed alone.

3.6.3 The interview process

Interviews were arranged in respondents' community post bases (n=8) wherever possible in order to maximise the researcher's understanding of the context of the work as well as avoiding disruption to the respondent. For health visitors no longer working in their community post (n=9), or for those without access to suitable accommodation (n=9), interviews took place in new workplaces, borrowed offices or in respondents' homes. In general, accommodation posed few problems with interruptions accepted and overcome. Effort was made to become familiar with the community post bases by driving around the area and/or reading related material particularly when interviews did not take place in the respondent's community base.

As noted in section 3.5.4, the interview schedule did not provide prepared questions or prescribe the order of introduction of topics. However, every interview began with an enquiry about the development of the respondent's post. This question was expected to elicit straightforward facts with the intention of helping both respondent and researcher relax into an easy line of questioning before further exploration (section 2.8.6). Questions demanding more complex answers were introduced later in the interview. Otherwise, questions were left to be worded by the researcher during interviews in relation to the discussion that arose. This method was chosen in order to create an atmosphere akin to a discussion between peers rather than a researcher-to-subject question and answer session (section 2.8.5). Consequently, few interviews followed the order of the schedule although all topics were covered in all the interviews.

All interviews except one were tape recorded. The only interview that was not tape recorded came early in the study and was lost due to researcher error in use of the tape recorder. Field notes were written after each interview to note general observations about the conduct of the interview, reactions of the respondent and any unusual or notable event. In addition, detailed field notes were made for the interview that the researcher failed to record and these analysed along with the other data. For other interviews, field notes were treated as a tool for reflection for the researcher and for clarifying topics discussed in interviews. The field notes were particularly useful in developing the interview technique.

3.6.4 Dealing with bias in the interview process

While familiarity with the topic and being known within the field were advantageous in gaining access to respondents, the potential for researcher bias was acknowledged. This was dealt with in three ways. First, the researcher took note of the literature concerning validity in qualitative research. Platt's (1981) concerns regarding interviewing one's peers (2.8.5) were taken into consideration. In addition, Miles and Huberman's (1994) checklist for preventing researcher bias (section 2.8.13) was helpful in maintaining a systematic approach to the interviews to ensure data were not overlooked or over-weighted.

The second method of reducing bias in data collection was by developing an interview technique that maximised the respondents' views. Efforts were made to ensure that the researcher avoided asking leading questions and that researcher effects, such as the stimulation of posturing (section 2.8.13), did not affect data collection. To check for these effects, the researcher reflected on her interview technique immediately after the interviews by listening to the tapes. Particular attention was paid to her ability to encourage respondents to present their views openly. Consequently, efforts were made to ensure the researcher was aware of her interviewing technique during interviews and that open discussion was maximised.

The researcher recognised that interview conditions varied between respondents particularly with regard to availability of written information and observation in workplaces. Where little additional information was available, the researcher made efforts to draw out specific details regarding the context of activity during interviews and to visit the area described by respondents.

Finally, the researcher ensured that all the respondents were aware of and understood her agenda for the research study. The researcher was already known within professional networks as having experience in community-focused health visiting. Some respondents were found to have read about the researcher's previous work and a paper (Appendix I) had been published in a professional journal during the data collection period. Providing respondents with equal access to the same written information prior to the interview was not always possible, particularly when interviews had been arranged through snowball sampling. Therefore, explanation of the background to the study and the researcher's previous experience were given at the beginning of every interview to "recap" on or to introduce the research agenda.

3.7 Data analysis

The process of data analysis was initiated and developed during the period of data collection (section 2.8.9). This enabled data collection and analysis to be carried out as a continual developmental process with each task informing the other. For example, concepts of trading and isolation had not been considered in relation to community-focused health visitors before the researcher began data collection. Both concepts were identified in the early stages of the analysis which allowed further exploration with respondents in later interviews.

3.7.1 Organising the data

Tapes from the interviews were transcribed verbatim by two audio typists who were paid an agreed hourly rate. Interviews lasted between 40 and 70 minutes, generating between 12 and 16 pages of single spaced text per interview. Transcribing the tapes took between four and six hours but the typists were working on them outwith their daytime employment and transcriptions generally took a number of weeks to be returned to the researcher. The following format for the transcriptions was found to be most useful:

- typed in Times 12 point in the Word 6 for Macintosh word processing programme;
- researcher's comments in capitals;
- a space between researcher and respondents' speeches;
- interview number and page number in the "footer";
- wide margin on the right hand side to allow category names to be added; and
- single spacing for ease of linking comments and viewing long speech episodes on the computer screen.

Transcriptions of the interviews were received from the typists on a floppy disc and transferred onto the hard disc in the researcher's computer. The typists were asked to remove their copies of the transcriptions from their computers to maintain confidentiality (section 3.4). Transcriptions were checked by the researcher while listening to the original tape recording and amended directly on the computer to correct inaccurate interpretations of speech. Back-up copies were made of amended transcriptions onto two floppy discs and stored in separate secure locations.

Inaccuracies in the typed transcriptions were expected as interviews had been conducted in various areas of Scotland and England with respondents demonstrating a wide range of regional accents. The importance of checking carefully for inaccuracies was highlighted by the following mistakes made by one of the typists: " Yes, I got a real shock when I came out of college and they handed me the "B" forms" (Researcher, while interviewing respondent 6). This was interpreted by the typist as: "I got a real shock when I came out of college and they handed me the gun". Another example was: "There were some really inspiring health visitors" (Respondent 15), interpreted by the typist as: "There were some brilliant spy rings of health visitors". The typists were not informed about inaccuracies as a matter of course as the researcher had expected to amend the transcripts as part of the data organising process. However, one typist's level of accuracy deteriorated markedly later in the study, leading the researcher to question the efficiency of having to make extensive amendments following transcription.

Tapes from the first 17 interviews were transcribed as above by the audio typists. The final nine interviews were not transcribed as the researcher, having interviewed the participants, decided to adopt a different approach given the concerns over the quality of transcriptions. The researcher listened to each tape, taking notes on paper rather than the word processor, and transcribing selected quotes verbatim. Data were coded according to emergent categories from earlier data sorting (3.7.3). Tapes were listened to three to five times each depending on complexity of data, to ensure that no data were lost. Data from these interviews were then sorted and examined as for transcribed interviews.

3.7.2 Coding the data

In the face of the increasing availability of computer software for qualitative data analysis the use of software in the coding and categorising process was explored using data gathered for the pilot study (section 2.8.10). The NUD.IST programme was recommended by fellow students and it appeared that it might be useful in organising data (section 2.8.10). Learning about NUD.IST also offered an opportunity to further develop computer skills. Installing and learning how to use NUD.IST was not entirely straightforward, but the process was facilitated by joining a local small self-help group for other novice researchers which allowed problems to be overcome by collective effort.

The coding process using NUD.IST began after the three pilot interviews had been transcribed and the transcriptions checked for accuracy. NUD.IST was said to provide a framework for coding and categorising data by dividing text into "units" and placing linked units together in files which have been given names (Richards and Richards, 1991). Units could be phrases, lines, sentences, paragraphs or whole documents depending on the nature of the research study. The programme made use of search functions and a visual display (described as a "tree") which allowed data to be retrieved and displayed at any time.

Despite the potential benefits of using NUD.IST, splicing the data into units led to a loss of context which the researcher believed to affect adversely the understanding and interpretation of data at an early stage in the analysis. Experimentation with different sizes of units, for example using sentences or paragraphs rather than lines or phrases, did not yield better results. In addition, there was a substantial "tree" display emerging with an enormous number of categories and sub-categories at a very early stage, even before a significant amount of data had been entered. There appeared to be the potential for the system to become swamped with data in a way that hindered, rather than helped, the method of analysis chosen for the present study. Finally, there was a need to spend a considerable amount of time to enable full use of the NUD.IST programme in addition to time already spent in learning the basics. The warnings in the literature about novice researchers becoming overconcerned with the technicalities of software and losing sight of the analysis (section 2.8.10) were ringing true.

The disadvantages of NUD.IST outweighed the potential advantages to this study at an early stage. Other options for using computers to sort data were explored, and the method finally chosen was to use Word 6 on a Macintosh computer (section 2.8.10). This offered a simple and straightforward method of "cutting and pasting" sections of text from the transcribed interviews into category files. Full use of the multi-window ability was made where a large number of files can remain open and displayed on the computer screen simultaneously. This method allowed the researcher to sort the data without losing its original context in a way that was deemed to be more relevant to the chosen method of analysis.

3.7.3 Developing categories

The process of coding and categorising the data was developed from the initial exploration of the transcripts of the three pilot interviews, although data from these interviews were not included in the main study data analysis. The interview schedule (Appendix V) was initially considered as a tool for developing categories. However, it was considered inappropriate as data did not fit the headings easily without creating further categories. Instead, the researcher decided to allow categories to emerge naturally from the data by becoming familiar with the recorded interviews and transcriptions.

The amended transcripts from the first three interviews in the main study were read while listening to the tapes until a number of broad categories became evident. This process was repeated twice for each tape to check and to amend potential categories. The process was repeated using the next three interview transcripts. Broad categories were identified and named, with the intention of breaking each category down into sub-categories at a later stage. Keeping categories broad during the initial process prevented data from being lost without having to create new categories.

The first list included 18 categories, which was reduced to 15 after further sorting. The finalised list of major categories were as follows:

Access to Communities
Caseload/Community
Definitions
Facilitating Change
Health Visitor Community Activity
Reporting and Evaluation
Training
Working with Project
Aims
Collaboration
Difficulties
Framework
Needs Assessment
Support
Transition

Categories were identified from issues or concepts that "stood out" from the data for the following reasons:

- repeated during a single interview e.g. Facilitating Change;
- appearing in more than one interview e.g. Support;
- appearing as an issue of great importance to a respondent e.g. Difficulties; and
- those directly related to the researcher's questions, e.g. Aims and Definitions.

Sorting the data and developing a framework for analysis at an early stage added to the continuing process of data collection by highlighting emerging issues that could be explored in further interviews.

After the text from the first six interviews had been sorted into category files, most of the categories were fairly evenly balanced in length, apart from one, the "Difficulties" category. This had about three times as many pages of speech than the other categories. Three possible explanations for this were considered. First, the category may have been of greater importance to respondents than other categories. The second possible explanation was that the "Difficulties" category was too large a field which should have been split into three smaller categories. Finally, the explanation could have been that some of the respondents explained their difficulties by telling long, complicated stories rather than by a short explanation. It was decided that the third explanation was probably the most accurate. Therefore "Difficulties" was retained as one category as it was suspected that the descriptions of respondents' difficulties may have lost some meaning if split up in different ways.

In the final stages of the analysis some categories remained in the same format as originally designed while others were subsumed by other categories in order to link the categories and sub-categories to the main emergent themes.

3.7.4 Identifying themes

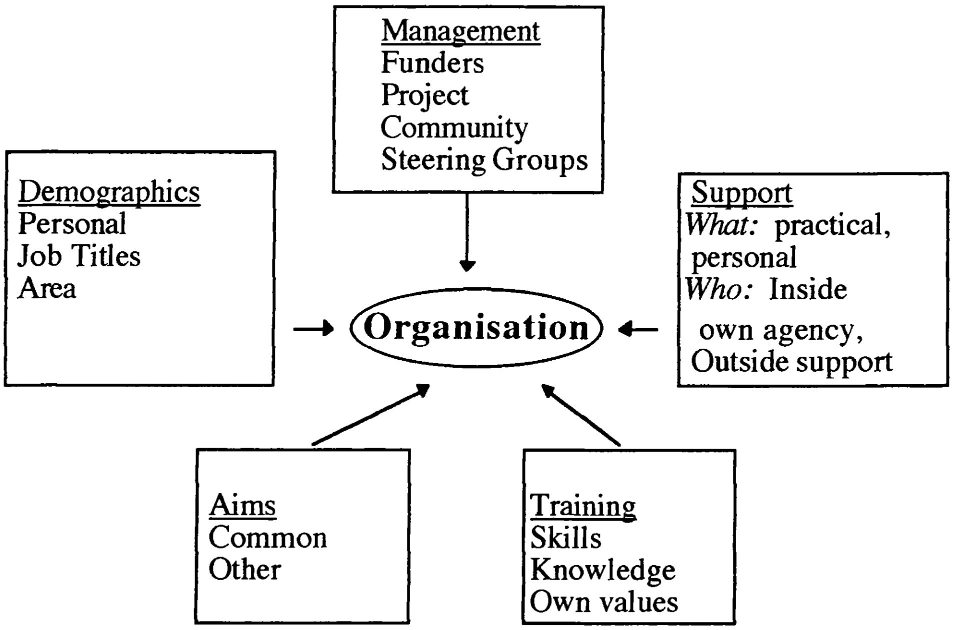
The categories described above were used to sort the data for all the main study interviews and were further examined to identify sub-categories, linkages between categories and main themes. This process was carried out in full for each of three stages: for interviews 4-10, 11-20 and 21-29, with each stage used to further explore the development of themes (interviews 1-3 were used as the pilot study). This method prevented the researcher becoming overwhelmed with too great a volume of raw data at the one time and added to the developing nature of the study where data collection and analysis informed one another (section 2.8.9). Once all three groups of interview data had been sorted and examined, the findings were brought together. The reliability of this method was checked later in the analysis process by questioning whether the same categories would be identified in the light of new knowledge, and if they remained relevant to the data (2.8.12). This was carried out by repeating the process of identifying categories for data from the first seven interviews at the time of the final stage in the analysis. The categories were found to be of continued relevance to the data as well as to the emergent themes.

A systematic process of examining emerging themes and linkages between the data was carried out making use of diagrams and flow charts. In addition, for some emerging themes, the researcher referred back to the literature to open up further lines of questioning of the data. For example, after one respondent mentioned the concept of "trading" in relation to accessing a community, the researcher explored the concepts of "marketing" (de la Cuesta, 1994) and "giving and receiving" (Chalmers, 1992) from previous generic health visiting research in order to understand the method of access to the community used by health visitors in the study. The concept of trading was then searched for in previous respondents' speech as well as in subsequent interviews.

Another factor contributing to the method of analysis was writing. During the course of carrying out the study, the researcher was required to write reports, papers and presentations for a number of different audiences on topics related to that under investigation. The process of writing about the data was found to be invaluable in the development of the final analysis as it demanded that the emerging analysis was examined in different ways. The value of writing as an integral process in analysis was initially overlooked and had not previously been considered in this way. In addition, the process of analysis was further informed by feedback from four professional audiences attending presentations carried out during the analysis process.

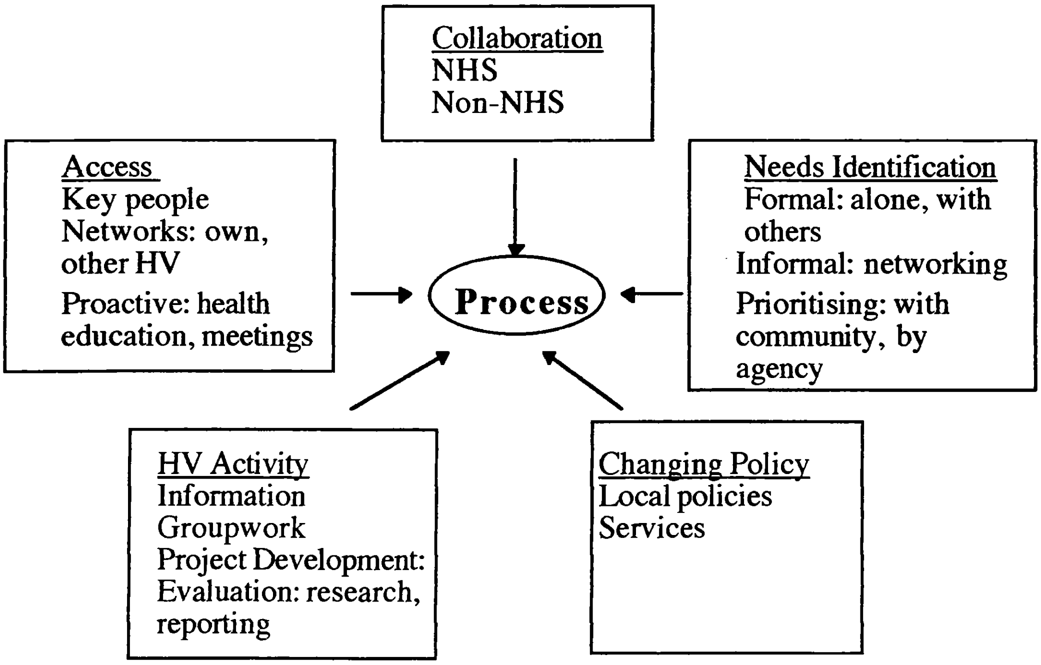
The process of analysis led to the identification of three main themes that provided a framework for describing the community-focused role in health visiting. The first theme was "Organisation of the Posts" (Figure 3.1). This theme brought together most of the information from the self-completed questionnaire as well as additional data from the following categories: Aims; Framework; Training; Support; Collaboration; Difficulties and Working with Project.

Figure 3.1 Categories and sub-categories describing organisation of the posts.



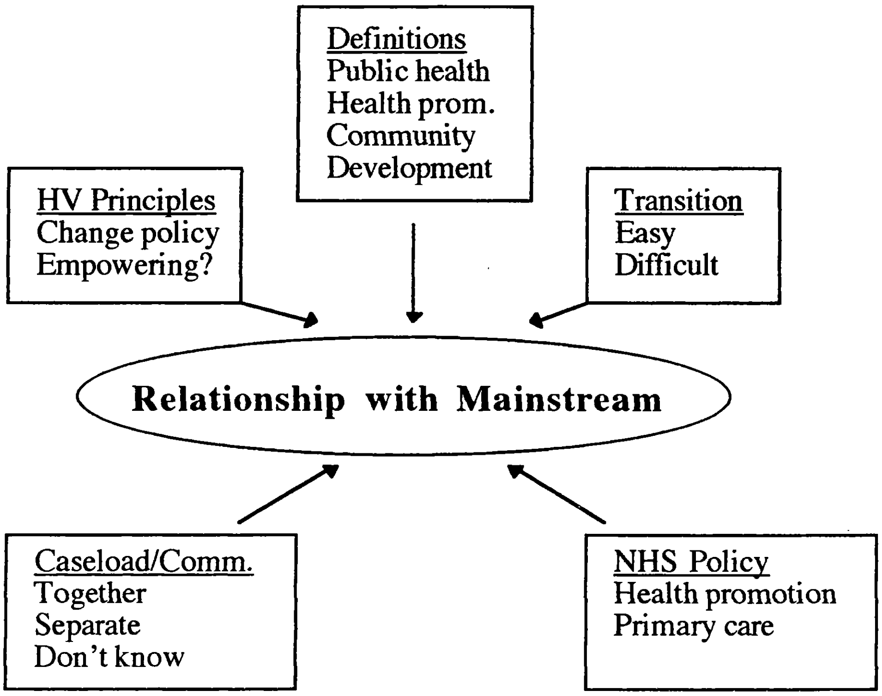
The second theme was "Process" (Figure 3.2) which brought together sub-categories from the main categories of Collaboration, Access to Communities, Needs Assessment, Definitions, Health Visitor Community Activity, Difficulties, Facilitating Change and Reporting and Evaluation.

Figure 3.2 Categories and sub-categories describing the process adopted by health visitors in community-focused posts.



Finally, the theme of Relationship with Mainstream Services (Figure 3.3) emerged from the categories of Definitions, Transition and Caseload/Community.

Figure 3.3 Categories and sub-categories describing the relationship of the community-focused role to mainstream health services and policies.



Findings relating to all three themes will be reported in full in Chapter 4.

3.8 Using a focus group

A focus group was used to explore respondents' views regarding the initial analysis, particularly relating to the theme of "Process" (Figure 3.2). The aim of the focus group was not to attempt to validate the researcher's analysis, but to enhance the interview data collected earlier (section 2.8.7). Data relating to the two themes of "Organisation of the Posts" and "Relationship to Mainstream" described in section 3.7.4 appeared to be relatively straightforward, with identifiable questions and answers producing relevant data. In contrast, the process of respondents' activities was rarely described explicitly. For example, while the researcher identified that influencing policy was an outcome for some of the respondents, few set out with this as an aim. Consequently, additional direct questions to respondents were required to inform further analysis relating to the "Process" theme.

All 26 respondents were invited by letter (Appendix VIII) to participate in a focus group in Glasgow. Overnight accommodation, and reimbursement of travelling and childcare expenses were offered. Eight respondents agreed to participate in the focus group with apologies received from 15 others: three respondents did not reply. Seven respondents were based in Scotland and one in England. Two colleagues who had not been involved in the study attended the group as assistants to take notes and observe the progress of the discussion. Both assistants had approached the researcher to express interest in attending the focus group: one was a nurse lecturer interested in observing the focus group method and the other was a generic health visitor with an interest in the study topic.

Lunch was provided at the start of the meeting in recognition of the fact that some participants had travelled long distances, as well as to create a relaxed atmosphere. It also served as an opportunity for participants to meet other health visitors with similar roles. After lunch, half an hour was set aside for the researcher to present the preliminary analysis. Quotes from interviews were included in the presentation so that respondents could be made aware of the way in which their speech may be used in reports. A diagram describing the researcher's interpretation of the process of their work (Appendix IX) was used as the basis for the focus group discussion. The main discussion lasted for one hour and was tape recorded with the group's consent.

Immediately afterwards the researcher discussed the progress and outcomes of the focus group with the two assistants. Notes taken by the researcher and the assistants were analysed along with notes taken from the taped discussion.

Following the focus group, the description of the "Process" theme was amended (cf. Appendix IX and Figure 6.1). Other points from the focus group discussion, e.g. definitions of groupwork, were also incorporated into the final analysis along with data from the individual interviews.

Findings are presented in full in the following chapter.

Chapter 4 Findings

Researcher's note: Direct quotes from respondent's speech are used throughout Chapter 4 to illustrate the findings. Quotes are attributed to respondents by their identifying numbers; for example, a quote from respondent number 6 would be labelled "R6".

As noted in the previous chapter, three main themes emerged from the data that provided a framework for describing a community-focused role in health visiting. The three themes were:

- organisation of the posts,
- process, and
- relationship with mainstream services.

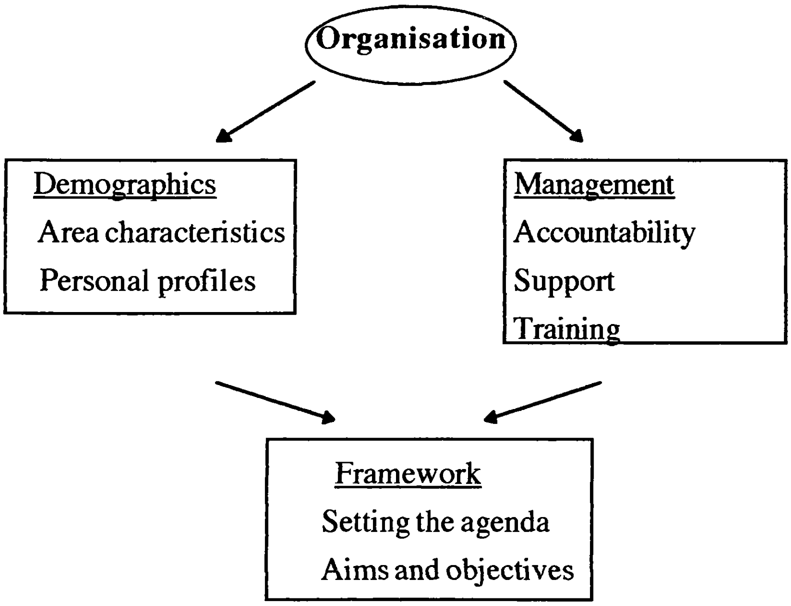
Each theme will be dealt with separately.

Theme One: Organisation of the Posts

4.0 Introduction

The sorting of sub-categories into the theme of "Organisation of the Posts" was described in section 3.7.4 and illustrated in Figure 3.1. Further analysis of this theme suggested that a relationship existed between the regrouped categories, as illustrated in Figure 4.1.

Figure 4.1 Organisation of the posts



The theme of "Organisation of the Posts" describes the structure, development and management of respondents' community-focused posts. Section 4.1 draws on the demographic data, most of which were collected from the self-completed questionnaire (Appendix VII).

4.1 Demographics

4.1.1 Geography and populations

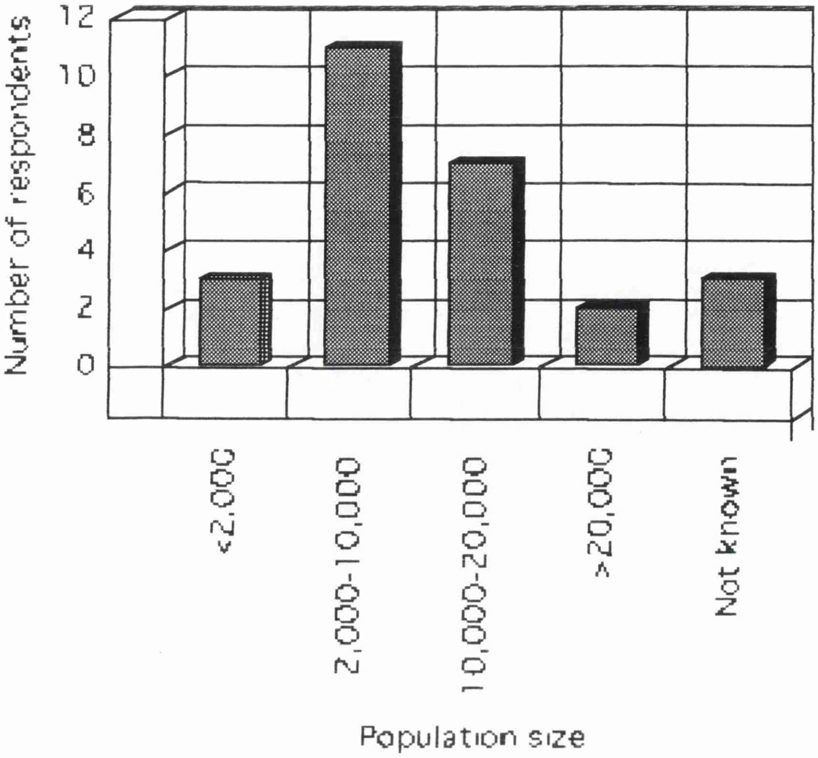
Out of a total sample size of 26, 17 respondents were based in England and nine in Scotland. Respondents were spread over seven health authority areas in England and six health board areas in Scotland. A total of 24 respondents worked in urban areas, one in a rural area and one in an area described as a mixture of urban and rural environments.

On the self-complete questionnaire, respondents were asked to estimate levels of unemployment, single parents and elderly people in their areas as proxy indicators of need (section 3.5.4). A total of 23 of the urban areas and the mixed area were reported as having high levels of unemployment and all urban areas were reported as having high numbers of single parents except one, which was regarded as having high numbers of residents from minority ethnic groups. The areas of high unemployment and single parents were reported as having either medium or low numbers of elderly people. Three urban areas were said to have high numbers of all three indicators. The rural area estimates were for medium levels of unemployment, single parents and elderly people, and only one respondent worked in an area with low levels of unemployment and single parents, although they had a high level of elderly people.

For the purposes of this study, estimates given by respondents were treated as accurate because of their population-based remits. In summary, all the urban areas and the mixed areas were reported as having high numbers of people belonging to population groups regarded as being at particular risk of poor health.

In addition, respondents were asked to estimate the population sizes of their areas on the self-completed questionnaires. Population sizes were found to vary between less than 2,000 to over 20,000, as shown in Figure 4.2.

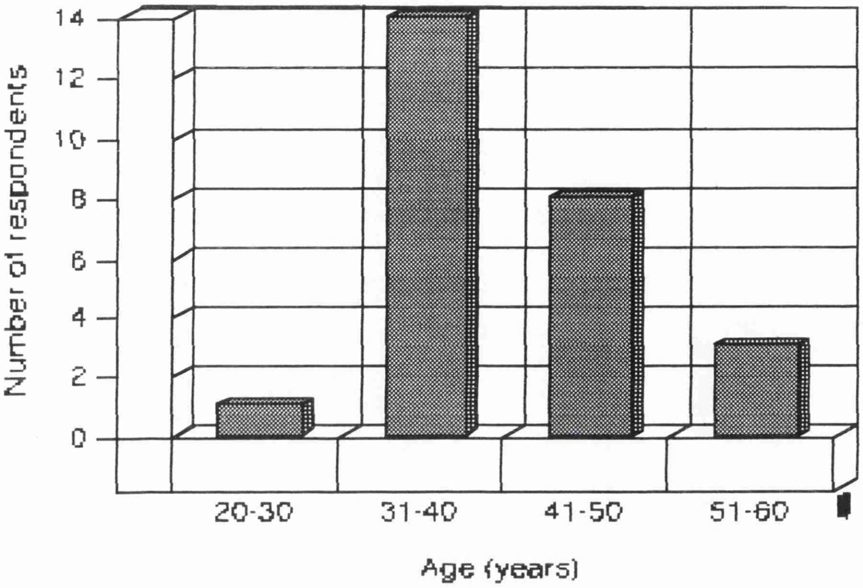
Figure 4.2 Estimated population sizes of respondents' areas.



4.1.2 Respondents' age and sex

A total of 24 of the respondents were female. As can be seen in Figure 4.3, that while there was variation in age, the majority (n=14) were aged 31-40.

Figure 4.3 Age of respondents

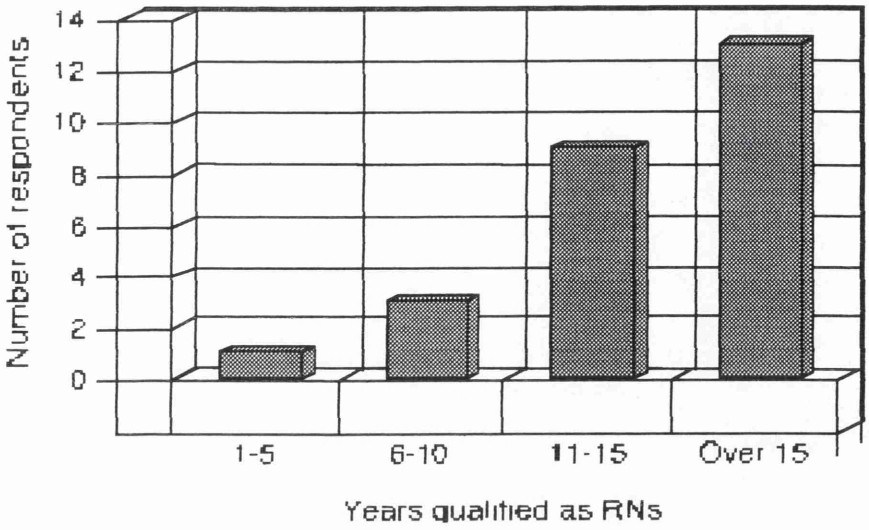


4.1.3 Respondents' qualifications

Nursing

Most respondents were registered nurses with health visiting training. Half of the respondents had been qualified nurses for over 15 years and the majority had been qualified nurses for over 10 years (n=22). The length of time respondents had been qualified as first level nurses, with either an RGN or a RN qualification is illustrated in Figure 4.4.

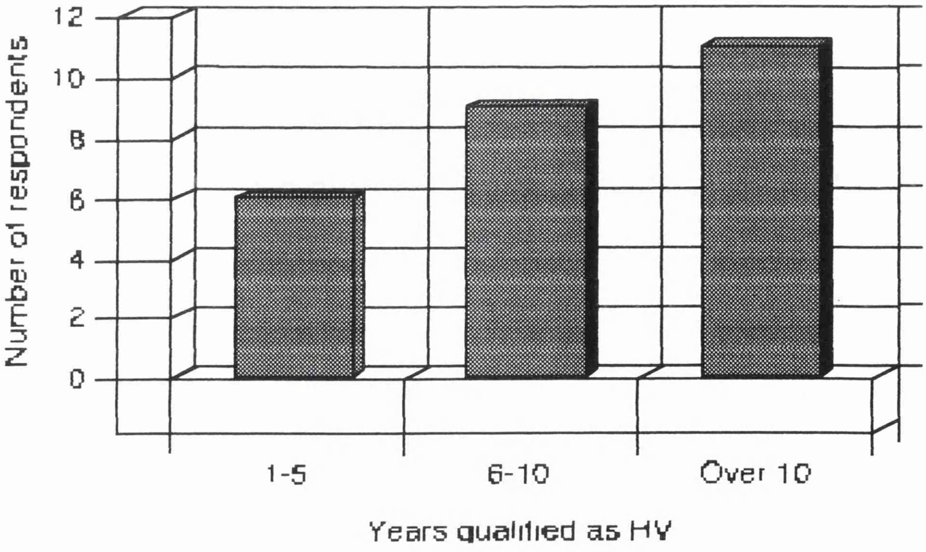
Figure 4.4 Years qualified as first level nurse.



Health visiting

Most respondents had been trained as health visitors for over five years (n=20). The number of years that respondents had been qualified as health visitors is illustrated in Figure 4.5.

Figure 4.5 Years with health visitor qualification.



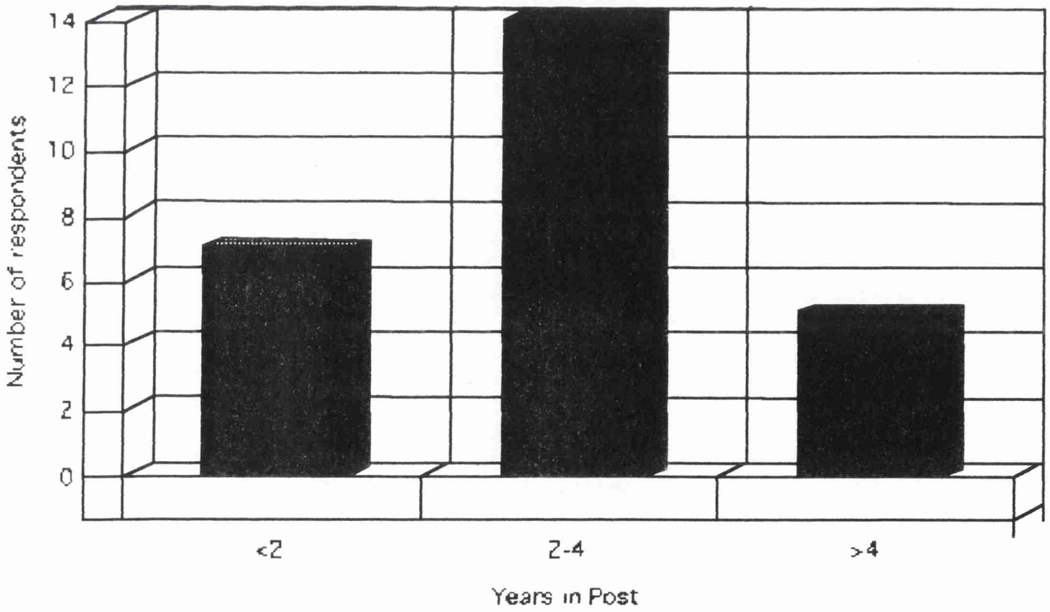
Further education

In addition to nursing and health visiting qualifications, seven respondents had qualified with Master's degrees and one was working towards a Master's degree while in her current community post. The types of Master's degrees gained or worked towards were as follows: MSc (n=4), MA (n=2), MPH (n=1) and MPhil (n=1). A further ten respondents were qualified to first degree level: BSc (n=6), BN (n=2), and BA (n=2). In addition, two respondents without degrees were qualified as nurse or fieldwork teachers.

4.1.4 Length of time in post

At the time of the interviews, seven respondents had been in their community-based posts for less than two years. Just over half of the respondents (n=14) had been in their posts between two and four years, and five respondents had been in post for over four years (Figure 4.6).

Figure 4.6 Years in community-focused post



4.2 Structure of the posts

4.2.1 Establishing the posts

The respondents' community-focused posts were developed in a variety of ways. Seven of the posts had originated from within health authorities or health boards while the others had been developed in response to proposals from sources as follows:

- from community forums or health projects (n=11);
- from health visitors or health visitor managers (n=7); and
- from a GP/nursing collaboration (n=1).

4.2.2 Employers

Most respondents were employed solely within NHS community trusts (n=19). Four respondents were employed by a combination of an NHS trust and a community health project. Three of the posts were established outwith NHS community trusts, with respondents employed by a health promotion department (n=1) or community health projects (n=2). Both community health projects had community nurse representatives on their steering groups.

Of the 23 respondents who had some or all employment within NHS trusts, five were included in a core health visiting service contract in one health authority area. The remaining 18 had project funding that was separate from core health visiting services, or were funded by underspend from other budgets. Project posts were usually funded on a short term basis, with health visitors seconded from mainstream practice.

4.2.3 Remits

Some respondents had posts that were split between a community-focused remit and a caseload (n=7) or between a community remit and health visitor training (n=1). Four of the split posts were shared equally between the two sets of responsibilities while the other four respondents worked with their community remit for one or two days per week. The remaining 18 posts were dedicated to a community remit although two of these posts were part-time.

All 26 respondents had remits for defined geographical areas. In total, 22 respondents' remits were to provide a service for the whole population within their areas. The other four respondents focused on specific groups within their geographical areas, as follows:

- women;
- families and young children;
- children between the ages of three and five; and
- young mothers.

4.2.4 Job titles

There were 13 different job titles among the 26 respondents, including public health nurse, community development health visitor, community development worker, specialist health visitor (public health) and project leader (Appendix X). Job titles appeared to be arbitrarily applied, and some respondents were unclear as to where their titles had come from:

> *"I think it's basically politic to have that title (public health nurse). It wasn't our choice of title but for whatever reason, it was what the Chief Executive thought was appropriate. And within this region, the regional nurse is trying to run with the 'Making it Happen' report which again has this public health title in it. (R 9).*

> *"They called us 'public health nurses' and that literally came out of the air. It wasn't our decision, I don't know who thought it up" (R13).*

In addition, there was no clear relationship between job titles and salary grade. Twenty-one respondents were on salary grade G in keeping with mainstream health visiting practitioners, and five were on the higher grade H.

4.3 Management of the posts

4.3.1 Lines of accountability

In general, respondents reported that they were managed separately from generic health visitors including those managed by community nurse managers. Management of the community-focused posts conformed to one of three models as follows:

1. The main funding agency controlled the direction and function of the post in line with national NHS objectives such as health needs assessment or local objectives addressing health and poverty.
2. An agency or collaboration of agencies set the framework for the post but handed responsibility for meeting the aims and objectives to a community project or to the post holder.
3. A community forum or project set the framework and maintained control over the direction and functions of the post through a local management committee.

Within these models, the way in which respondents were managed was diverse, with some having single line managers while others had more complex arrangements, as follows:

Single line managers

Fifteen respondents were managed by community nursing line management alone. A further four posts were managed by another single department or group, as follows: health promotion (n=1); public health (n=1); or a management committee (n=2).

Multiple line managers

Seven respondents had multiple line managers. One respondent who was directly employed by a community health project was managerially responsible to both the project co-ordinator and to a management committee. In addition, six of the posts were subject to particularly complex management arrangements. These posts were funded and managed between different agencies, for example, health authorities' public health departments and trusts; or trusts and community projects. Respondents in all six posts were managed by a combination of project co-ordinators and management committees, which usually included a nurse manager. One respondent had three lines of management; a community nurse manager, a project co-ordinator and a local steering group. Management committees or steering groups comprised either local people, senior officers from a variety of agencies, local workers or some combination from two or three groups.

One problem reported by respondents was that they suffered from a lack of clear management guidance, particularly where there were a number of managers wanting to control the direction of the post:

> *"We had different managers to be accountable to and the managers did not agree necessarily when you should be in the project and when you shouldn't be in the project and what the boundaries were. [..] There was always "argy-bargy" between the two managers wanting more of your time than you could give, and nothing seemed to suit either of them. The community were fine. I didn't seem to be a problem to them" (R4).*

On the other hand, some respondents found themselves with no-one taking responsibility for providing leadership, even when they had more than one manager:

> *"Management has been quite hands-off, really. Looking back on it now I would have liked to have had more direct support and supervision from somebody but the project hasn't been owned very clearly by any one manager. There are two or three managers who've got a stake in my post, and that's just within the Trust" (R9).*

Respondents without strong management input from their funding agencies used the lack of direction to work more closely with the community, for example:

> *"Consulting with the (community) management committee you could interpret the job description any way that you wanted to" (R8).*

Despite the flexibility that a "*hands-off*" (R9, R21) management style allowed, most of the respondents reported some difficulties with their management structures. In addition to problems relating to lines of accountability, most respondents remarked that they needed more support from managers.

4.3.2 Support

A manager was regarded as good if support was forthcoming:

> *"I mean, our manager's very good".*
> *"Yeah, she's brilliant, very supportive, isn't she" (R16 and R17, interviewed together).*
>
> *"We had team meetings once a week or once a fortnight and the co-ordinator was excellent, he listened to everybody in the team. [..] It was excellent support and because he had such a lot of experience in the past he was ready to let you work at your own pace. It was what you really needed and it was very, very encouraging" (R18).*

Encouragement and a listening ear were the two most common activities mentioned as support from management. However, support from management structures, particularly within nursing, was said to depend on committed individuals who understood the role. This worked well for respondents while the supportive manager was in post, but frequent re-organisations within trusts meant that these managers were often moved to other posts:

> *"The Trust kept reorganising around us and another new manager would come and ask us what we wanted" (R27).*

In general, support issues were reported in a negative way, as factors that were missing, rather than as activities that had worked. For example, many of the respondents reported that they had no budget for developing activities, or that their accommodation did not meet their needs. One of the main problems for respondents was that often managers did not appear to understand the community-focused roles or the use of a community development approach:

> *"The Trust showed no understanding of why we were doing what we were doing" (R8).*
>
> *"I think it's very hard for people to take on board what community development is. There are a lot of tensions and conflicts in that" (R10).*

When respondents did not have adequate support from their line mangers, they talked of feeling very isolated, particularly from other health visitors. Consequently, they sought out support from a diverse range of sources, usually outwith health services, and occasionally they approached inappropriate sources, for example:

> *"Personally I think I'm quite strong but it (the isolation) was actually just too much for me. I hope that nobody ever has to work in this way with that sense of isolation. I used to be using the most inappropriate people for support. I mean, people in the groups!" (R12).*

One route for support that many of the respondents explored was to take part in training. There were few training courses available that were directly relevant to community-focused posts, but respondents generally were granted time and funding to organise or participate in short, locally-run courses.

4.3.3 Training

All respondents felt that they needed some extra training for community-focused posts although many felt that their health visiting experience provided a relevant background:

> *"The general health visiting skills I think are great for this way of working, but you do need the extra community part of it" (R6).*

There were no specific courses available for the community-focused role in health visiting. However, some respondents had two or three days of training when they came into post. This training was arranged locally, sometimes by the postholders themselves. Training usually covered practical skills relating to community development methods, groupwork, evaluation, equal opportunities or project development. However, most respondents developed their skills through reading reports of similar work and community development theory. Respondents were generally granted study time by their managers for reading or visiting other similar projects. Most respondents took up the opportunity to meet with health visitors or other workers who were experienced in community health work.

Training needs were often identified in hindsight, for example:

> *"You don't realise the significance of the training until you get on with the job. [..] We've been talking about this recently, we're thinking perhaps needs assessment, certainly evaluation, discrimination awareness" (R14).*

Seven respondents studied for Master's degrees while they were in their community-focused posts (section 4.1.3). One respondent who was not studying felt that she should have been pursuing a Master's degree because of the amount of research and writing she had completed as part of her work:

> *"My Master's degree is long overdue. I feel as if I've done about three along the way!" (R28).*

For many, developing skills for the community-focused work was a case of "*learning on the job*" (R13). Most respondents felt that they had moved on in their career, having learnt new skills or new applications of existing skills through working in the community-focused post:

> *"You gain lots of new skills, sort of empowering skills, so it would be very difficult to go back into health visiting" (R16).*

Some respondents felt that being able to carry out community-focused work depended on the set of skills held by the postholder and also depended to some extent on personal values:

> *"You've got to be a certain personality, sod all the skills!" (R17).*
>
> *"It's about your own values. You've got to believe that this way works. You can see it's not about talking to individuals about making health choices but there are structures in society which limit people's choices, and we can do something about this by working in a different way" (R26).*

In summary, the background and development of the respondents' posts were subject to a variety of influences from agencies, communities and individual post-holders. Despite this variety, some common threads emerged as contributing to the framework for the posts.

4.4 Developing a framework for the posts

4.4.1 Job descriptions

In keeping with the diverse nature of the posts' backgrounds, job descriptions were drawn up by a variety of people including the current or previous postholder; a community group/project; a steering group/management committee; and a public health department. Many of the job descriptions depended on the postholders' input, for example:

> *"I virtually wrote the job description! Because really at the time there wasn't an awful lot of knowledge about what community development would involve" (R20).*

4.4.2 National health promotion targets

Some respondents based in England felt that there was pressure on them to be seen to be working towards Health of the Nation targets:

> *"Health of the Nation was incorporated into the proposal because it had just come out and it seemed a politically sensible thing to do" (R26).*

A dilemma arose for some English respondents in trying to meet targets specified by government while at the same time feeling that they should be working to a community's agenda. There was a general belief that there would be more money available to them to develop community health activities if they were seen to be working to the national targets. Scottish respondents did not report a similar pressure. While the national targets were acknowledged by Scottish respondents, many felt that they were of little relevance to the deprived areas they worked in. They felt they were justified in focusing on issues relating to poverty and health rather than individual behavioural change.

4.4.3 The community's agenda

In general, respondents were sensitive to the national health promotion targets but the targets were not perceived as the main influence in setting up the posts or in the development of aims, objectives or activities. Instead, the activities that most respondents developed were explicitly community-focused or community-led:

> *"The thing is, it just won't work if the residents don't want it"(R14).*

> *"I can honestly say it's the community that sets the agenda and because we haven't had a lot of input from steering groups or from management we've been able to let that happen" (R6).*

However, respondents reported that they were faced with barriers in ensuring their work was genuinely community-led. For instance, there was some ambiguity in allowing the community to set the boundaries and also in the ability of respondents to work to the community's agenda:

> *"The project would say that it was the community's agenda, but I felt that the agency set some of it. [..] To me, they (the employing agency) set the boundaries" (R4).*

> *"Local people were involved at every stage of the game. That was always insisted on which I found hard going at the beginning, and very slow. You just had to get the community's approval for everything or the ideas had to come from them" (R18).*

The issue of coping with the change of pace regarding working practice is reported in more detail in section 4.15.2.

The development of the job descriptions and frameworks for the posts was usually carried out by the respondents in conjunction with managers or management committees. In general, the aims set by the original funding proposals were broad, with specific objectives and operational issues developed once the postholder was in place.

4.4.4 Aims and objectives

A small number of respondents had very specific aims either in relation to assessing needs or professional development. Most respondents described their aims as being broad or vague, usually covering needs assessment, community participation and/or empowerment, for example:

> *"It was a vague aim, to encourage awareness and action on health issues using a community development approach"(R21).*

In general, the objectives reported by respondents related to their aims but were also described as vague. The main objectives were as follows: to develop and/or support community health activity based on identified needs (n=15); health needs assessment (n=10); strengthening collaboration around health issues (n=6); to set up and support groups (n=3); and evaluation of community health activity (n=2).

Objectives were usually used as a starting point for most of the respondents' activities rather than as a prescriptive list of activities. For example, while only a small number of respondents' remits specified collaboration, working with groups and evaluation, most respondents carried out activity relating to these objectives.

In addition, the objectives for all five respondents in H grade posts included, or focused on, professional development. Although one respondent on a G grade had a similar remit, professional development was the main difference between the G and H grade posts. Professional development was defined as either piloting an innovative way of working or by promoting a population perspective and/or a community development approach with other health visitors.

4.5 Summary of Theme One

Most respondents worked in areas where there were reported to be high numbers of people belonging to one or more high risk population groups. In general, health visitors in the community-focused posts were experienced nurses and health visitors and had a degree level education.

The diversity of job titles and salary grades reflected the complexity of management arrangements. Management was generally described as non-intrusive with few respondents managed alongside mainstream health visiting. Good management was described as understanding the community-focused post and providing encouragement and a listening ear.

Community-focused health visiting posts were usually directed by the community's agenda, with national health promotion targets reluctantly used when it appeared to be politically expedient. Respondents based in England appeared to be more likely to work towards national health promotion targets than those in Scotland.

Development of the posts often rested on personal commitment to working in this way from postholders, managers or funders, rather than on the fulfillment of management-led aims and objectives. Aims and objectives for the posts were usually vague and rarely reflected all the activities carried out by postholders. In general, respondents' remits included assessing health needs, developing community-based activity to meet identified needs, collaboration and groupwork. The process adopted by respondents in carrying out their remits is described in the following section.

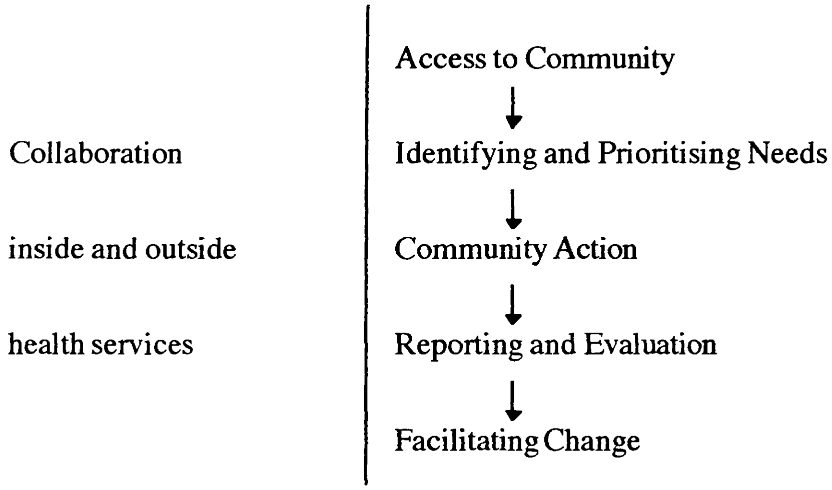
Theme Two: The Process of Community-Focused Health Visiting

4.6 Introduction

Previous research uncovered working processes adopted by health visitors in relation to individual clients (section 2.1.2). In the present study, interviews explored the processes and practices used by respondents in relation to communities rather than individuals.

Activity relating to the process of the community-focused role was illustrated in Figure 3.2 (section 3.7.4). Further sorting within the process theme enabled a relationship between sub-categories to be identified as illustrated in Figure 4.7.

Figure 4.7 Process adopted by respondents in community-focused posts.



The following sections describe the process and practice of the respondents' community-focused roles taking each category from Figure 4.2 in turn. While collaboration is described as the first step in the process, it was central to all respondents' community activities.

4.7 Collaboration

Collaboration was believed to be an important part of the process of community-focused working for all respondents, regardless of whether or not it was included in their aims and objectives. Collaborative working was described as "*crucial*" (R13) to the community-focused role and it underpinned every stage in the process of community-focused health activity.

In general, respondents collaborated with others to make allies in communities and to bring in other perspectives, for example:

> *"It's looking at a group of peoples' perspectives rather than one person's perspective on an issue, [..] to make sure that what we're trying to do is going to work. And I think for volunteers that if they're meeting up with other agencies that gives them some strength as well". (R11).*

Another reason for collaborating with other groups was to access and share scarce resources. One respondent felt that access to her project's resources was the main incentive for collaboration:

> *"The money is still crucial. In some ways it's becoming less important when the interagency working starts to work and we give time to each other, but yes, I think if they took the money away tomorrow I would have to be honest and say the project would pack up" (R13).*

4.7.1 Collaborating partners

All of the respondents described long lists of local workers and residents with whom they had good working relationships: "*We never worked in isolation*" *(R20).*

Respondents collaborated with workers inside and outside the health services. A range of 13 health services, 10 statutory social and education services and eight community or voluntary services were reported as collaborating agencies, with each respondent working with a wide range of partners.

Collaborative working often took place in formal groups, for example, strategy groups or health forums:

> *"Mine (local strategy group) consists of local schools, the councillor, some of the medical staff, some of the surgeries, some of the clinic staff, local voluntary groups, two or three churches, youth services, and the (park) rangers"(R13).*

In addition to the large groups or forums, respondents collaborated on a different level with smaller numbers of other workers to develop local initiatives:

> *"I'm working closely with the community midwife with the breastfeeding group and one other health visitor gets involved with that as well. Also with the dental health project, with the dental health educator co-ordinator. And other things like the asthma support group; we've now got good relationships with the research nurse from (the children's hospital) and the school nurse. The postnatal group as well, we work closely with the Family Resource Unit which is a social work project"(R11).*

4.7.2 Difficulties encountered with collaboration

Some employees outside and inside health services were reluctant to collaborate with respondents. Often, this reluctance was shown by individual workers rather than being attributed to the nature of the discipline in question. One example was community work, where, in general, collaboration was fruitful. However, three respondents reported difficulties in establishing relationships with individual community workers from housing, social work and community education. All three respondents felt that individual workers felt threatened, with respondents perceived as trying to take over the community workers' roles.

One discipline that demonstrated a more general reluctance to collaborate with respondents was general practice. Despite considerable efforts to involve GPs on steering groups or in developing community activities, only two respondents reported good relationships with GPs. Some respondents believed that there was too much of a difference between community health work and general practice:

> *"Personally, I didn't see the relevance of talking to a GP [..]. I suppose GPs could have one (a remit for community health) if they chose" (R14).*

Differences within the disciplines of community work and general practice could be explained by particular individuals demonstrating commitment or resistance to the respondents' remits. However, a discipline demonstrating a more complex pattern of ambivalence to collaboration was generic health visiting.

Some respondents reported that they had very good relationships with generic health visitors, particularly where they had previously worked in the same area with a caseload. However, others had received a less enthusiastic reaction:

> *"They (local health visitors) didn't give me any positive support. I mean they weren't negative, but they saw it as a separate thing. You know, 'she does that and we do the caseload work'" (R14).*

In addition, some respondents found that their generic colleagues had been openly hostile towards them, particularly at first. Respondents reported that these health visitors had demonstrated a general lack of understanding of the work, perceiving the community-focused role as separate from generic health visiting and as implied criticism of traditional health visiting activity.

4.7.3 Strategies for overcoming difficulties in collaboration

Respondents appeared to accept that there was a likelihood of difficulties arising in collaborating with others, particularly when the collaborator had a different agenda, for example:

> *"It's inevitable in any areawhere different groups are working you've not just got collaborationand co-operation, but also strife, intrigue and politics!" (R21).*

> *"You've got to be confrontational as well as collaborative to make sure your issues stay on the agenda" (R28).*

Most of the respondents experiencing hostile or other negative reactions had made attempts to develop better relationships with the group or individuals concerned. Some of these attempts had been successful and led to the development of good relationships. Where attempts to build better collaborative relationships failed, respondents by-passed the resistant individual or group to develop relationships elsewhere.

Developing or joining collaborative networks or projects was a priority for all respondents when they took up the community-focused posts. Through fruitful collaboration, they were able to gain access to the individuals, groups and agencies in a community.

4.8 Access to the community

In addition to building collaborative relationships, the initial contact with individuals, groups and agencies was often used to carry out other objectives, such as assessing needs and publicising the existence of a project or new post. This part of the process was generally regarded both as hard work and as a necessary activity:

> *"At first I thought I'm not helping anybody sitting in this office and nobody knows I'm here, but then we started getting out and introducing ourselves to community groups and community leaders and workers and finding out just what was going on in the community and what their needs were. That took at least six months" (R7).*

Some respondents were already known in the community from previous generic health visiting work. Being known usually made the initial networking easier, although residents and workers took some time to understand their new role. Known to the community or not, respondents accessed the community in three ways: first, through existing health visiting networks such as women's groups, toddler groups, elderly groups, nurseries and schools; second, by making contact with key individuals or locations in the community - the "*local vocal people*" (R13); and third, by becoming active in the community.

4.8.1 Using existing networks

Respondents often started from a point with which they were familiar:

> *"There's quite a lot of work going on with the Asian community but it's not something that I am familiar with so I stuck more with parent-toddler groups" (R9).*

From there, respondents moved on, building new links as they became more familiar with the community. This stage was generally regarded as time-consuming and a learning process. Some respondents felt that their efforts in the beginning provided limited access to community members, particularly when they focused on existing groups and professionals:

> *"To be honest I think most of the contacts and time tends to be with other agencies and other professional workers (R9).*

In addition to established groups and services, most of the respondents sought out key individuals within their community. Key individuals differed from community to community, but usually included local activists, councillors and professionals within health, social and voluntary services.

4.8.2 Accessing community members

Respondents were generally motivated to move beyond their existing networks and the "*local vocal people*" (R13) to access others in the community who might be in greater need. They felt that they were able to carry out the networking part of the process more effectively if they were able to provide something which was perceived as "useful" to the community. Some respondents felt a marked difference between providing a service as a generic health visitor and their new, less well-defined role:

> *"I had no remit to be there, not like the health visitors. [..] I had nothing to trade"(R12).*

Respondents drew on a number of ideas to ensure that they were able to act as a resource for the community. One method was to become active in the community, for example, organising open days and seminars:

> *"The idea of selling health didn't and doesn't excite people. So I had to find different inroads. I announced a few public meetings and just had open house" (R10).*

In addition, many agreed to carry out activities in response to requests from groups or individuals, such as health information sessions in schools, cooking demonstrations for women's groups or taking blood pressures. This work was generally perceived by respondents as being outwith their job remits and more akin to a traditional health education role in health visiting. However, it was justified by respondents as a route to acceptance within a community. Provision of health education fulfilled initial expectations of groups or individuals, and was usually regarded as a first step to carrying out other developmental work, for example:

> *"The youth group asked us a few times to come over and do talks. We weren't keen on doing talks, any professional could go in and do a talk. We preferred to work with people on an ongoing basis. [..] Myself and a drugs worker started up a lunch time club because that was the feedback we got from the few talks we did, that kids wanted something regular and on their own terms where the kids could be in control of what they wanted" (R18).*

Another method used for accessing the community was to carry out a needs assessment exercise. Through the process of gathering data regarding a community's health needs, respondents were able to make links with a number of individuals, groups and agencies which had the potential for developing into collaborative relationships around health.

4.9 Assessing health needs

4.9.1 Identifying needs

The focus group discussion established that respondents believed the terms "needs assessment" and "community profiling" described formal, agency-led activities requiring specific skills. Respondents felt that these terms did not reflect the community-led processes of identifying needs that most of them carried out. Instead, the informal process of identifying needs was described as a listening and hearing exercise.

Three respondents were involved in formal needs assessments using a combination of methods such as epidemiology, health visitor caseload profiles, Jarman scores, focus groups and interviews with key informants. Another two respondents carried out less formal needs assessments, using focus groups and interviews. Most of the other respondents carried out informal needs assessments through unstructured discussions with local residents or groups combined with the respondent's general knowledge of the area:

> *"Well, I don't know if it can be called a needs assessment, it was nothing formal. [..] Just basically asking people what they felt were the issues in the area"(R14).*

Informal needs assessments were often carried out as part of the initial process of establishing contacts and collaborative relationships:

> *"I carried out a needs assessment to introduce me to the area and to guide some of what I might do" (R21).*

The informal approach used for assessing needs was carried over to the process of identifying priorities for respondents' community health activity.

4.9.2 Prioritising needs

In general, prioritisation of needs was carried out in collaboration with community members or steering groups. Prioritising was carried out informally, although usually in response to a needs assessment exercise, for example:

> *"The needs assessment was never produced as a document. It was the result of going round listening to and hearing what people were saying - which was, 'our priority is not heart disease, our priority in this area is stress'. So they (the community health project workers) just took that one word to the steering group and they said, 'OK forget what we sent you there to do, do whatever you feel'" (R6, at focus group).*

> *"We waited a couple of months until we saw the sort of issues that people were asking to become involved in and the kind of things that I was coming up with" (R20).*

The main reason for prioritising an issue for most respondents was because it was found to be of particular significance to the community, for example:

> *"Recurring issues came through the project such as the need for support in parenting, childcare issues. The issues came loud and clear from the community" (R22).*

An extra incentive was when an issue could easily attract funding, for example when an issue that was important to the community was congruent with a local or national health priority:

> *"It was a question of marrying up local people's priorities with bigger targets. We ignored some Health of the Nation targets that weren't relevant to the community" (R26).*

Occasionally an issue was prioritised from the respondent's own experience but would be carried forward only if there was adequate support from the community:

> *"I thought it was a great idea (a health shop) and I started talking to people about it and they said 'that sounds smashing' and I asked 'do you think people would use it and is there a need?'. Everybody said yes and that is how they came on board but I suppose the initial idea came from me. It wasn't a true 'coming from the community' although the support that came from the community meant that it was something they wanted as well" (R12).*

In some cases respondents' posts were time-limited and they were often encouraged by management to prioritise issues that could show definite outcomes in a short space of time. This did not sit easily with respondents who were committed to developing a more community-sensitive approach:

> *"A needs assessment was on the shopping list originally but I backed off from it in the end because [..] it's a monster job and to do it properly you have to talk to local people and you have to be able to offer something at the end of it, and there is no prospect of that at all" (R9).*

Priorities identified by communities tended to relate to wider determinants of health: crime and fear of crime; housing; domestic violence; stress; isolation; child accidents; women's health (postnatal depression, breastfeeding, menopause); parenting; poverty; youth health; drugs; and alcohol.

Once a need was prioritised, respondents then worked with communities to develop community-based activities to address them, described below.

4.10 Health visitor's role in community action

4.10.1 Working with a project

A total of 21 respondents had posts that were attached to various types of community or health service projects and five worked alone. Those attached to projects found that projects usually offered professional support, access to a budget and the opportunity to work as a team, for example:

> *"I think without the project it would be quite difficult, although not impossible to continue my job. The back up is there, the administrative back up the resources back up, information for groups and things like that. And it's a central point for people to come to, to access me" (R11).*

> *"We all had our own bit of work to get on with, but everybody worked with each other for example on events. We always did work quite hard and very well together" (R18).*

Most respondents regarded working with projects as helpful. Where there were problems, such as with management committees, they generally did not affect the respondent's day-to-day work.

4.10.2 Community activity

There was little to distinguish between the activity of respondents working with projects and working alone. Once a health priority was agreed as described in section 4.9.2, respondents started to work with community members or workers to develop an appropriate response. Three distinct but related activities were identified as information, groupwork and project development.

Information

All respondents acted as a resource within communities, for community forums, networks or projects by disseminating health information and/or knowledge of the health service. Some respondents were also used as a resource by health agencies in the development of services, for example by providing reports or presentations about community health activity. Examples of methods for disseminating information into both communities and agencies included: health awareness days; health education sessions; and writing booklets, strategies, reports and funding proposals.

Activity relating to the dissemination of information was rarely carried out in isolation, but was integral to other work with a group, or as part of developing a project.

Groupwork

Respondents worked with a diverse range of groups, some of which were also described as forums or networks:

> *"I work in groups all the time. The management committee's a group, the people who come to see you about starting something, they're a group, campaign groups, and I just see everything in terms of a group. I mean they have different purposes and different structures but it is just a group of people, so I've always been working in groups" (R12).*

Respondents in the focus group were keen to differentiate between their roles in facilitating different types of group, for example, a therapeutic group and working with a number of people to plan activities:

> *"I work through and with a lot of different groups but I'm not a groupworker" (R21)*
>
> *"No, I'm not a groupworker" (R11)*
>
> *"It's to get groups of people to think of their own wider community" (R18)*
>
> *"Saying 'groups of people' allows people their own individual identity within the group, whereas 'groupwork' takes them altogether"(R20)*
>
> *"It's really 'an accumulation of people'" (R21)*
>
> *"I think it very much depends on the group, what the group is and whether they've got a wider outlook, and they're thinking of the rest of the community" (R6)*
>
> *"There's a model developing of the support groups active in my area. That is, after a support group has been meeting for a certain length of time they start to look at the wider picture" (R11).* (Discussion at focus group)

Thus, there was a strong feeling among respondents that the health visitor role was more than working only within the groups' parameters. There was an additional role of supporting the group in looking at a "bigger" picture and putting the groups' issues in context with the wider communities' health issues.

Other respondents echoed the evolution of groups from one form to another. For example, a group that started out providing support for parents of asthmatic children became a successful campaigning group for improved local specialist health services. Another example was in replacing one issue with another:

> *"I was talking to two women who were talking about the menopause and they said that they wanted to start up a menopause support group and so I thought I'd help them to do this. So they met and by the third time of meeting they were talking about all the crime on the estate and they never mentioned the menopause. It became apparent it was a stress thing rather than a menopause thing. We went on talking to lots of other women and found that lots of women in this particular age group were very stressed about a lot of things, not just the menopause. So we set up a stress group which is still running on its own and is really successful" (R17).*

Within support groups, respondents took an enabling rather than a leading role in order to encourage group members to develop their skills and confidence. Respondents' tasks often included writing up minutes and reports and making contacts with people outwith the group. Playing a supportive role was not regarded as an easy option:

> *"My role with the group? To encourage them to keep doing it..... to encourage them to keep doing it was the hardest thing" (R18).*

> *"We've motivated these people, we've kept the peace [..] we've been a friend, we've been a resource, we've been an advisor, we've been confidante and we've put them in contact with financial resources. We've done everything bar do this project and we play it down, don't we?" (R16).*

The main problem associated with groups was in maintaining continuity of community participation when respondents found that some activities were vulnerable to volunteers or participants dropping out or moving on to other activities or employment.

Respondents worked with a broad range of groups, forums and networks. They included support groups for breastfeeding, parenting, men, asthma, twins, postnatal women; campaigning groups for addressing poverty and road safety; strategy groups and forums for families, women's health and environmental issues.

Project Development

Project development often led on from respondents' information and groupwork towards longer term, sustainable health activity aimed at increasing resources for improving health in the community. Project development was occasionally initiated in the early stages of developing collaborative links in the community with ideas being introduced, discussed and refined:

> *"Networking all the time at a very grass roots level just with local workers who I am meeting all the time. Talking about new ideas, talking about ongoing projects and inviting more support for them. Just raising awareness of what we are doing and raising interest" (R14).*

Once an idea appeared to be relevant to the particular community and had adequate support, respondents started the process of identifying and accessing funding sources:

> *"I've helped to find training for them (a community group) and they're going for European funding now because they want to become a business. [..] They're doing it themselves. I help them to write their proposals and I just advise them on how groups work and how you*

> *set up your accounts and all this kind of stuff, and help to encourage them not to fight and get good groupwork skills" (R17).*

Respondents reported a total of 35 new funded developments that they had set up in collaboration with local people or other workers. Almost half of the developments (n=18) were in conjunction with local people, as follows: support groups (n=8); child safety equipment schemes (n=3); health shops (n=2); a community newspaper; a community mother's programme; and a cookery group. Other services developed in collaboration with local workers included housing clinics, a road safety campaign, research on women and violence, a poverty campaign and a condom clinic for young people. Eight of these developments were carried out with social or education services, four with other local health service employees, and three with health forums.

In addition to raising funds for activities some respondents had to focus on finding funding for their own posts or projects, as most posts were funded for short periods. All respondents funded on a short-term basis regarded their funding period to be too short to meet their aims and objectives. The process of finding funding for their own posts was generally reported as time-consuming and stressful:

> *"In February of this year we had a meeting [..] and it became crystal clear that more funding quite likely wouldn't be given to us so we started again to look at a funding strategy and at alternative ways of obtaining funds. The whole process took a lot of energy. [..] It meant we lost the focus on lots of other things" (R10).*

Summary

Respondents' community-focused work included combinations of disseminating information about health and health services, working with groups and project development. In doing so respondents utilised their community and health service experience. Linking into information dissemination, respondents often took on the task of evaluating and writing reports about the community activity.

4.11 Reporting and Evaluation

4.11.1 Recording health visiting activity

Monitoring systems for generic health visiting did not include the community-focused role for any of the respondents:

> *"There isn't any mechanism, really, of reporting back" (R6).*

In the absence of monitoring guidelines, most respondents wrote descriptive reports about their activities to report back to line managers and steering groups. Reports were written either occasionally, monthly, quarterly, biannually or annually and the frequency was usually decided by the respondents themselves. Many reported that they felt their nurse managers were ambivalent about their efforts:

> *"I used to write reports every two months, then there was a change over in management and I let it lapse for a while. [..] Now what I do is to just decide that I'll write a report again and hand it in so that at least they know I'm still there, to remind them that I'm still doing this, that I'm there" (R19).*

While most of the respondents wrote reports of their work, some felt that little notice was taken of the reports by line management, which some felt may have been due to the descriptive nature of reports. Few of the respondents were asked to provide specific information about their activity.

4.11.2 Evaluating community activity

Respondents generally regarded evaluation as being important:

> *"To keep the project going we're going to have to raise our profile and show there is proven health benefit or else we are all going to get lost with all the other projects that are coming up" (R13).*

Few respondents were given guidance on evaluation. Respondents regarded themselves as lacking in training regarding appropriate methods, time for carrying out evaluation, and lack of finance to fund evaluation advisors. Management appeared to want measureable outcomes and proof of cost effectiveness but did not provide guidance on methods of doing this, or the time to do it. Respondents and management appeared to view evaluation methods in different ways:

> *"The evaluation methodology in their (management) heads doesn't really fit in with what I'm doing" (R12).*

Management were perceived to undervalue process outcomes, which respondents felt were the most important indicators of success:

> *"People (in a community group) went through a whole growth and now they're completely self-funding. They've got computers, they've been on training courses, they want to set themselves up as a business. The whole process of what happened to these people and the benefits of that process are more important than the community newspaper they produced" (R15).*

> *"The thorny problem of how you evaluate things. My views are that if it's a community project we should be asking the community what they think of it and that should be a good enough evaluation of what's going on. But, as we know, we have to try to find the old measurable outcomes!" (R8).*

None of the respondents felt that they were able to fulfil the needs of their line management in relation to evaluation. Even when an outside evaluation advisor was employed, it was difficult to satisfy the nurse management structure, as illustrated by the experience of one respondent, outlined in Figure 4.8.

Figure 4.8 Case study: A Legitimate Evaluation?

One respondent (R28) was involved in a high-profile, centrally-funded community nursing project. The community nursing team focused on determinants of health and concluded that housing was a major issue in their community which contributed to poor health. A housing clinic was set up and evaluated, and was successful in achieving identifiable positive outcomes relating to housing problems. The evaluation satisfied the funders of the project but the work was not seen as relevant to the Community Trust who employed the nurses. Despite the evaluated project showing positive outcomes on the health of the community, the community nursing team was disbanded by the Trust.

In general, respondents were keen to find appropriate ways of evaluating their work but believed that carrying out an evaluation to satisfy line management would be difficult and time-consuming. One respondent did finally take on an evaluation of her and her colleagues' work, but found it almost overwhelming:

> *"We waited all these years for someone to be employed and brought in to do it. We couldn't wait any longer, so we decided to do it. We didn't realise it was so big. Once you start it seems to grow, it's awful" (R16).*

Some respondents working with community projects funded outwith the NHS had their work evaluated as part of the project activity. Evaluation methods used by the projects included the following: setting long and short term aims for individual pieces of work; writing short descriptive reports; feedback meetings for community members; and focus groups and/or questionnaires. These evaluations were then fed back to managers, funders and communities using printed reports, photographs, videos, presentations or exhibitions. Most respondents had some kind of written reports about their work. These reports were often used to inform and lobby key decision-makers in attempts to facilitate changes in policies regarding community health issues.

4.12 Facilitating Change

Many respondents believed that the health visiting principle of influencing policy (section 2.1.1) could be achieved more effectively in the community role:

> *"I think that there is a difference (between caseload and community-focused health visiting), and that the community side of things has a better chance of influencing policy. I think it is very difficult to influence policy at the individual level although it can happen and it does happen, but I think there is probably more of the influencing policy and more strength in it at the community level" (R4).*

For some respondents, the end point of a piece of work with a community was to stimulate changes in the way that services were provided for that community. However, a role in working at strategy or policy level was rarely included in job descriptions although some respondents had responsibility for professional development around community-focused work with other health visitors. Instead, work on strategy or policy appeared to develop as an integral part of the post:

> *"The strategy work was on top of the estate-based work. The post offers a process where you can address issues, such as high referral/low uptake of health services - it shouldn't just be more of the same, it needs to be something different, with more emphasis on health gain. The strategic role is undefined" (R28).*

> *"You just work with the barriers and try and overcome them. [..] You have to start thinking around them and thinking how you can make the changes" (R20).*

Some respondents felt that the lack of structure for their posts meant that they had limited access to decision makers and therefore to influencing policy. However, there was a feeling that they should be doing something in response to the issues they were facing:

> *"I think I was always aware that now I should be able to do something about it. This has been gnawing at me for ages really, I mean six years on I haven't done anything. I have always been aware that I would want to be this more political being, whatever that is, and also that there should be some mechanism" (R14).*

A strategic role was viewed by one respondent as an aspect of community-based work that was particularly suited to her health visiting background:

> *"The ones (community health workers) who weren't health visitors worked very hard but very much worked within the community and seemed to see their work as direct contact. So in a way I think, that's something that health visiting certainly gives you, a more strategic view of what could be going on" (R8).*

There were three main routes that respondents took to facilitate changes in policy. First, acting in an advocacy role for individuals, groups or communities, illustrated in Figure 4.9.

Figure 4.9 Case study: An advocacy role.

A respondent (R23) described how she had reacted after three children came to her project one winter, on different occasions, with scalds. On investigation, she found that the local houses did not have a separate thermostat for the central heating system and the hot water. Consequently, in order to have the water hot enough to heat up the radiators in winter, the tenants had to have their tap water at scalding temperatures. She gathered more information on this issue, including guidelines for domestic water temperatures, and intended to recommend to the council that they install separate thermometers for central heating systems and hot water tanks.

The second route for facilitating policy changes was to lobby key individuals within agencies to ensure that community health issues or community development appeared on their agenda. For example, respondents invited MPs, directors of services and other decision-makers to visit their projects. In addition, most respondents ensured that reports and recommendations about community health issues were disseminated, and many made presentations to professional bodies or decision-makers, for example:

> *"We did a lot of work trying to get community development as an issue on people's agendas so we did a lot of work on committees, you know, trying to say 'yes, but what about local people, how are you going to consult with local people?' And we did manage to get local people onto some of the groups to challenge what services were being provided" (R8).*

The third method of influencing policy decision was by proposing changes to local health visiting services, although with limited success:

> *"It was a dilemma of whether to fight for community development to be a normal part of health visiting or to say 'OK I'm in this post, and I'm a specialist'. [..] Over the years I've tried to work for this way of health visiting to be part of the norm. This project has so many contacts now, at all sorts of regional government levels that we could translate those to all areas that have the same needs, other areas that have inequalities and deprived areas. [..] This is what I've talked about and written about and given people, and had no response" (R6).*

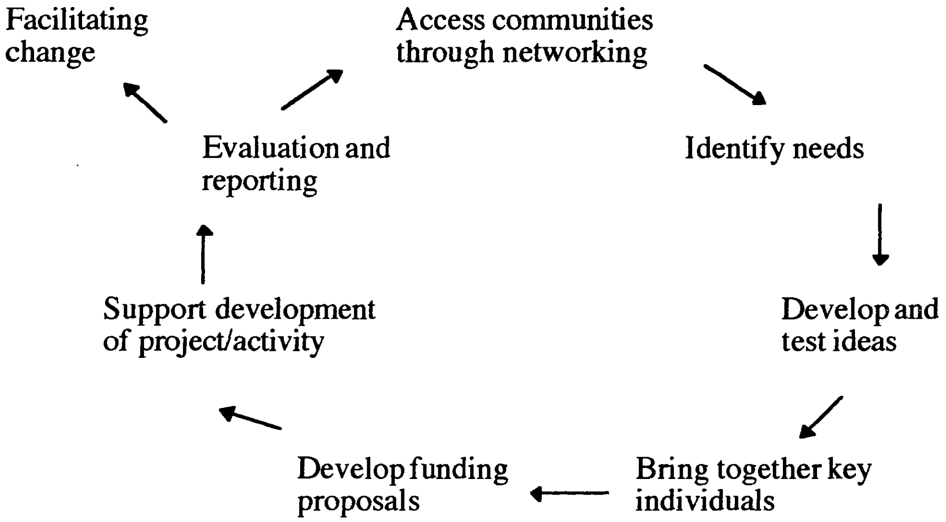
While respondents were aware of a need to influence policy, there were few examples of respondents' effecting policy change at a strategic level. However, respondents gave some examples of successes in changing policy at local level, including: developing a local childcare policy along with a community education officer; establishing a local children's outpatient clinic; and working with an economic regeneration group to increase the financial resources of a community.

4.13 Summary of Theme Two

The processes developed by health visitors in community-focused posts were very similar. All respondents started by building networks and, in collaboration with community members and other fieldworkers, they assessed and prioritised the communities' health needs. In response to community health needs, respondents worked with community members and workers to develop and test ideas. They brought together key individuals in the form of support groups, forums or networks and supported them in the tasks that were set by the group itself. For some issues, that support included linking into funding agencies and ensuring that an activity was carried through.

The process was found to be more complex than illustrated in Figure 4.7, particularly as respondents usually worked on a number of issues with many groups and networks simultaneously. Activities were often interlinked, with evaluations or needs assessments identifying new issues for respondents to further explore and develop. Therefore, it appeared to be more appropriate to depict the process as circular, rather than linear (Figure 4.10).

Figure 4.10 Health visitor's community-focused activity: a dynamic process



While Figure 4.10 provides a model for the majority of the respondents' activities it does not claim to provide a step-by-step description of every activity. Most respondents encountered difficulties with some activities, particularly in relation to collaboration (section 4.7.2), continuity of community participation (section 4.10.2), or short-term funding for their posts (section 4.2.2). Consequently, exceptions to the process being carried out as illustrated were reported, for example, when an activity was initiated at a point in the process cycle other than at networking. For example, one respondent described an activity that was initiated by funding being made available to the respondent's project for a particular local health priority. The respondent then invited key individuals to work with him, developed and tested ideas, supported the development of the activity, and moved on from there as illustrated.

Respondents' community activity usually aimed to increase local resources such as additional skills for community members or developing new services. Respondents acknowledged there was a need to evaluate their work, but little support or training was available for evaluation. Influencing policy was rarely an explicit aim for postholders, but some respondents found that they were drawn towards this as their posts developed.

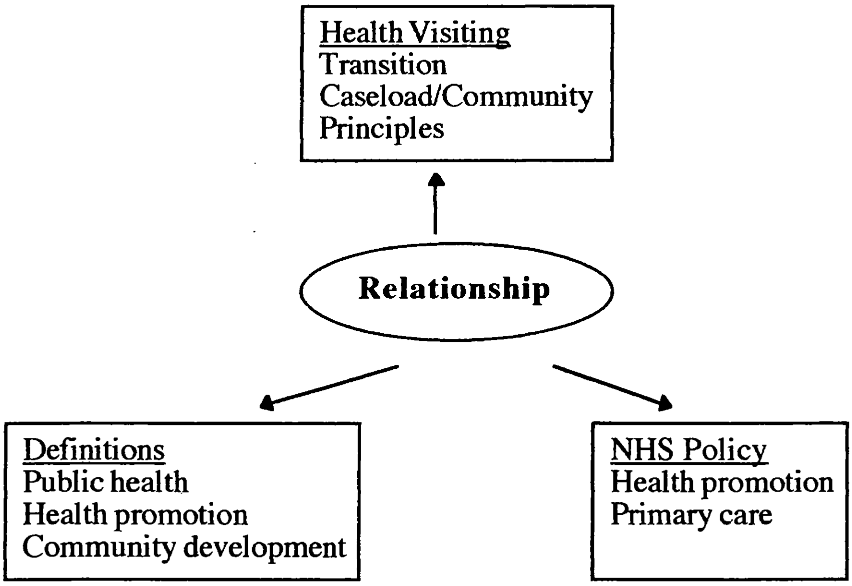
In the course of their work, respondents collaborated directly with a number of fieldworkers and decision-makers within and outside the health service. The relationship of respondents' activity to some of the principles and practice of other disciplines is explored in the following section.

Theme Three: Relationship of the Community-Focused Role to Other Disciplines

4.14 Introduction

Exploration of the organisational structures of community-focused posts (Theme One) found that the posts were often excluded from mainstream community nursing structures. However, many respondents attracted individual support from elsewhere within health services and communities (Theme Two). The availability of funding and support from within the NHS, although tenuous, suggested that there was a relationship between community-focused health visiting and mainstream health service policy and practice but it was rarely made explicit. Further exploration of the "Relationship" theme (Figure 4.11) led to identification of links between the community-focused role and generic health visiting, principles and theory underpinning other disciplines, and NHS policies.

Figure 4.11 Relationship of community-focused health visiting to other disciplines.



The following sections present respondents' views on the community-focused health visiting role in relation to mainstream health visiting, public health, health promotion, community development and current NHS policy.

4.15 Relationship with generic health visiting

4.15.1 The community focused role and the principles of health visiting

Some respondents had not considered their work in relation to the principles of health visiting (section 2.1.1) prior to being interviewed for the present study:

> *"I don't think about the principles, I just do it" (R23).*

However, most regarded the principles of health visiting as relevant to the community-focused role. In general, it was believed that the health visiting principles did not specify that health visiting had only to be carried out on an individual basis and that a community or population perspective was appropriate. The principles were regarded as actively encouraging wider activity:

> *"Health visiting starts with that one-to-one work with a family but it just must go on from that into wider activity, otherwise in a way you're not using the potential we've got as health visitors. That's where our principles are - to go on" (R14).*

Some respondents believed that the principles related more closely to community-focused work than to caseload work. However, pressures on generic health visitors from elsewhere prevented them from working to the principles:

> *"The principles fit caseload health visiting with difficulty because caseload health visiting is driven by other things, by expectations of GPs, expectations of Trusts" (R8).*

However, there was criticism of the relevance of the principles to community-focused work from two respondents. They expressed concern that the principles did not embody empowerment and believed that stimulating awareness and assessing need could be interpreted as being health visiting-led activities rather than being empowering for clients, for example:

> *"I understood it as a health visitor in training and in the early days about defining people's needs and I knew it was my job to define their needs for them. I think it's still in the body of these principles that it is the expert who knows. I remember being taught that when you go into a family you'll have some understanding of what their needs will be . That doesn't work for me any more" (R12).*

In general, an advocacy role was believed to be easier to adopt in the community-focused role than in generic health visiting. Consequently, most respondents stated that they had been able to work more effectively to the principle regarding influencing policy in the community-focused role than in generic health visiting.

4.15.2 Transition from caseload to community

In taking up a community-focused post, most reported that they had to take a different approach to working with a community than they had previously taken as a generic health visitor. This was true for respondents moving into an unfamiliar area as well as for those taking up community-focused posts in areas they knew well. All, without exception, talked about changing their pace of working. Instead of working at top speed, chasing up routine visits, dealing with crises and coping with constant demands on their time, they were forced to slow down:

> *"You've really got to listen to the residents. That's why it needs to be slow because you really need to listen to what they are saying and pick up things - which we do as health visitors, but I think it's different. You've got to really be wanting to hear what residents are saying and it's slower" (R14).*

About half the sample found the change of pace difficult at first and some reported that they felt guilty about being less obviously harassed than their generic colleagues. Guilt was particularly strong if they were engaged in activities that could be interpreted as 'fun', such as taking a community group to the swimming baths or organising a health fair.

Respondents who reported that they found the transition difficult, often took between six and 12 months to adjust to the different pace of the community-focused post. In general, respondents dealt with feeling unsure and vague at the start of their new jobs by focusing on activities such as health information sessions or groups with which they were most familiar, for example, parents of young children (section 4.8). However, some respondents reported that they had been anxious about being known in the area as a generic health visitor. There was a feeling that being known might have compromised their attempts at taking on a new community-focused role, for example:

> *"We thought that having been involved in a lot of child protection work, to attempt to do community based work would be difficult. It's very difficult to judge how much of a barrier it really was. I think at the time I didn't feel it was such a huge barrier, but nevertheless you are a health visitor. A lot of people have quite negative perceptions of what health visitors are about and that could be an obstacle" (R9).*

While most respondents felt that they were perceived in a different way as a community-focused health visitor than they had been as a generic health visitor, none had been denied access to a group or community as a result of being known as a health visitor. Changes in the community's perception of the role were recognised by one respondent when she was offered stolen goods; she believed that would not have happened while she was a generic health visitor!

Despite difficulties in the transition, most respondents welcomed the opportunity to become proactive instead of reactive, for example:

> *"Aspects (of the transition) were difficult and aspects were liberating. [..] I had this thing that I wanted to feel busy and I felt it was quite slow. But in some ways it was nice to be in a post where I had a bit more flexibility about what I could do. I didn't have the same frustrations that you have with a caseload, where you see things that you can't do anything about" (R11).*

Of those who found the transition easy, some had previous experience of similar work in the past either as a generic health visitor or in another capacity. However, for others it appeared to be the natural way for them to develop in relation to the health needs they had identified, for example:

> *"I'd had four years with a caseload and I was unhappy with my practice but I turned early to the voluntary sector, I worked with them from early on. When I started (with the community post) I hadn't done any community development or poverty work, but in health and homelessness work it was b...... obvious what had to be done!" (R28).*

In general, respondents reported that they felt restricted by generic practice. Many had been practising as generic health visitors for some time and talked about reaching "*saturation point*" (R10) or feeling that they were unable to offer appropriate services to meet the wider health problems that they identified:

> *"I was quite dissatisfied with health visiting and what I was doing, where I was going, and I didn't want to hang on to that crutch. To me it was shedding a skin and I found this work a lot more liberating, a lot more creative and a lot more rewarding and I just love it" (R16).*

> *"I just love it (community role). I found the health visiting role very restricting and wondering what we were doing, what were the benefits of this" (R14).*

While some found that the transition from caseload to community-focused work could be difficult, respondents were divided as to whether the community-focused role should be carried out with or without a caseload.

4.15.3 The caseload/community debate

There were three views expressed regarding working with or without a caseload. There were those who favoured a combined caseload/community remit, those who argued for a dedicated community remit without caseload work, and those who were undecided.

A combined caseload/community remit was favoured by some respondents for two main reasons. First they felt that the caseload gave them more confidence. The caseload provided a "*security blanket*" (R9), allowing respondents to pick up on some generic work where they could feel a small sense of achievement - particularly important when they were feeling unsure about their community remit. In addition, having a part-time caseload often gave respondents more credibility with their generic colleagues.

Second, some respondents commented on the wider picture of health that they had developed since taking on a community remit. Having a wider picture benefited their caseload work to such an extent that some felt uncomfortable about their practice in the past:

> *"Health promotion was something that health visitors did to individuals and I now feel that there is a much bigger picture. What I did as a health visitor to an individual, if that is backed up by what is happening in that individual's community, it makes life a lot easier for that person. The number of times I have given women advice and they haven't taken it. When I think about it, as a health visitor I should have recognised that how can you do it if you're on a low income or your husband smokes? We can now approach things from peculiar angles and probably have better success rates"(R13).*

> *"I remember being taught when you go into a family you'll have some understanding of what their needs will be. That's fine but it doesn't work for me any more. [..] I was a much better health visitor, I think, with my community development experience, for them, for the families, but not for the service. [..] By the time I had to hand over the caseload to another health visitor I absolutely had no idea what the immunisation status was [..] but I could have told you the status of their fruit and veg. intake and emotional and social stuff" (R12).*

The notion of utilising both approaches in order to provide a relevant and effective health visiting service to clients or communities was the main reason given in arguing for a combined remit, for example:

> *"I find it really difficult, this distinction between community development or community health and health visiting. [..] I was using a community development idea and I felt that I was doing something naughty [..] Neighbourhood work is the heart of health visiting. [..] It's really important that it's done by health visitors with a caseload. It's so important to keep the communication with other health visitors and try to encourage the whole health visiting team"(R14).*

In practice, all eight respondents working with combined remits found that they could manage their community-focused work along with a small caseload. However, demands made on them from caseloads, particularly child abuse cases, had to be dealt with immediately. Consequently, respondents felt that caseloads could be managed alongside community-focused remits as long as the caseloads remained small and relatively undemanding.

Some without caseloads worked around the problems of combining caseload and community responsibilities by working alongside a team of generic health visitors, a kind of "*casework by proxy*" (R28). This model was successful in reducing friction between community-focused and generic health visiting by recognising the value of both the individual and structuralist approaches.

There was support for community-focused work being carried out in conjunction with caseloads. However, it was acknowledged that this was not always possible as caseload responsibilities sometimes prevented respondents becoming fully involved in community-focused activity, both from the point of view of the health visitor and the community. None of the respondents who had given up caseloads to work full-time with the community-focused remit had regretted their decision.

About half of the respondents felt strongly that the community remit should be separate from generic health visiting. The main reason given was that caseload work and community health activity represented two entirely different philosophies. Caseload health visiting was regarded by many as being led by the expectations of GPs and Trusts, and was very hierarchical. In contrast, community health activity was led by communities and focused on partnership. Consequently, four respondents felt that community-focused work moved them further away from health visiting:

> *"I don't feel like a health visitor at all, and I don't feel sad about it really. I feel that the role that I'm doing isn't health visiting, it's community development work and they're not compatible. It's a totally different remit and the philosophy of the job is that you're hoping to reach those people that don't come to clinics, that don't come to parent club groups. So if you're masquerading as a health visitor, you're not going to get them anyway. So you need to distance yourself" (R16).*

> *"The more health visitors know about community development, the less satisfying the mainstream work is" (R12).*

It was clear that some health visitors were committed to working with community development approaches, but it was less obvious why health visitors should be taking on this work while it remained outside mainstream health visiting. Despite the lack of support from community nurse management, and despite the difficulties in combining caseload and community responsibilities, most respondents identified themselves as health visitors and regarded themselves to be working to the principles of health visiting.

4.15.4 Summary of relationship with generic health visiting

In general, respondents understood their community-focused role as relevant to health visiting principles. However, some respondents experienced difficulties in moving from generic health visiting into community-focused work reflecting the need to adopt a different way of working. The transition from caseload to community-focused work could be difficult but it was also seen as liberation from the constraints of caseload working with community-focused work offering a proactive, creative alternative to meeting health needs in communities. Community-focused activity was regarded as an extension of caseload activity, although in practice, working with a dual community-focused and caseload remit was difficult to organise.

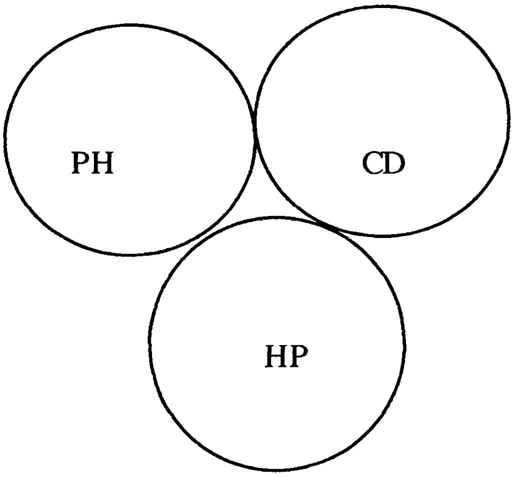
The relationship of community-focused work to other disciplines was identified by exploring respondents' definitions of public health, health promotion and community development.

4.16 Respondents' definitions

4.16.1 Public Health

"Public health" was described as *"a broad term that could be misinterpreted"* (R17). This was borne out by the appearance of two distinct, conflicting definitions. First, a small number of respondents defined public health as exclusively "top down", focusing on a medical model of health and including such topics as epidemiology and immunisation strategies. Within this definition, public health had no structure to support a community development approach or to recognise community health issues although it could work alongside health promotion or community development to improve health (Figure 4.12).

Figure 4.12 Public health (PH), health promotion (HP) and community development (CD) as separate strategies for improving health.



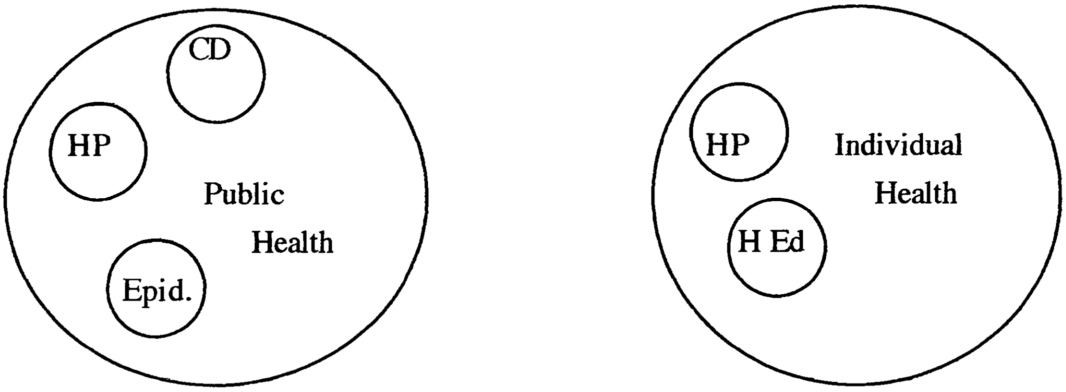
The second definition of public health, shared by more respondents than the definition above, was described as the health of people within the context of their lives. This definition was suggested by some as relating to the "new public health". Within this definition, public health included community-defined health issues, and recognised social influences on health, for example:

> *"although we work with asthma and how they use inhalers, it's not just that. It's, are they living a damp cold house? Have they got money to heat their house over winter? They're the sorts of issues that are important" (R11).*

This broad definition of public health was said to encompass health promotion and community development as well as epidemiology (Figure 4.13). Respondents subscribing to this definition of public health believed it to be an alternative to the individual way of working for health visitors:

> *"My job is a public health job because I'm looking at populations, attempting to do that, or communities or groups of people rather than just individual families.....and I think the methodology for doing public health work at local level has to be through community development with community involvement" (R9).*

Figure 4.13 Public health (encompassing community development (CD), health promotion (HP) and epidemiology (Epid.)) as distinct from individual health, which can be improved using health promotion and health education (H Ed)



4.16.2 Health promotion and health education

Most respondents regarded health education as a victim-blaming, top down, medical model, imposing health messages and focusing on individual behaviour change. Health promotion was generally regarded as having the potential for a broader, more empowering perspective. However, a small number of respondents regarded health promotion as similar to health education, i.e. as a top down model, focusing on targets set by government and ignoring the effects of poverty on health.

Despite reservations, it was generally agreed that there was a place for health education, although it had to be relevant to the targeted population:

> *"People do need to be educated about smoking, drinking, diet, but we found that the women's food poverty group knew all that and it wasn't until they began working with these issues themselves that they knew how much they knew. When they started doing the work themselves for other people there were the practicalities of not being able to get to the supermarket, and the local shops just ripping them off all the time. I mean, it's pointless the government coming down with all these big reports if practical issues like that are not seen as a priority" (R18).*

An empowering model of health promotion which usually included the use of community development methods was favoured by most respondents.

4.16.3 Community development

Some respondents believed that community development and the principles of health visiting had common goals and therefore it was appropriate for health visitors to adopt community development approaches. Community development was regarded as a method of working with the community to improve health without imposing health messages, for example:

> *"Community development is about helping people to identify and articulate their health needs" (R22).*

> *"I'm a health promoter. I'm not a nurse. I'm not a healer of the sick. I'm a health promoter and I believe that with community development you can promote health and you can make people feel better about themselves. The bottom line is making people feel better about themselves and everything else comes along after that" (R7).*

4.16.4 Summary of respondents' definitions

Definitions given revealed that respondents favoured an empowering model of health promotion that was sensitive to the needs of individuals and communities and could be carried out using a community development approach. Some believed that this model could be included within public health, while a smaller number understood an empowering approach to be separate from public health.

4.17 The community-focused role in relation to NHS policy

The two current policy areas of most relevance to health visitor's community-focused role were taken as national health promotion targets and proposals for restructuring primary care which had been published by the previous government during the time of the research study being carried out.

4.17.1 Health promotion

Most respondents were familiar with the national targets for health promotion as published in "The Health of the Nation" and "Scotland's Health: a Challenge to Us All". However, as noted in section 4.4.3, all respondents were committed to being led by the community in finding a community response to health problems. Some respondents worked with health issues that fitted with the health promotion targets but if they were not issues prioritised by the community they were not regarded as priorities for the respondents. Where the national targets did feature in respondents' work, they were used for reasons of political expediency or to ensure future funding:

> *"We incorporated Health of the Nation Targets because it had just come out and it seemed a politically sensible thing to do" (R26)*
>
> *"It's all very well being community led but if you can't get funding, you can't do it" (R22).*

As noted in section 4.4.2, respondents based in England appeared to take more notice of national health promotion targets than those based in Scotland.

4.17.2 Primary care

The White Papers setting out new primary care structures (DoH, 1996; DoH in Scotland, 1996) were released after the interviews for the study had commenced and few respondents were familiar with them. Neither documents made explicit provision for health visiting taking on community-focused or public health roles. However, the English document set out suggestions for an apparently new breed of "public health nurse" which was based on much of the current work of the health visitor but with a stated commitment to a population perspective. It was not clarified how this new form of community nursing would relate to current health visiting. The Scottish document made little reference to specific functions of nursing, but placed all community nursing firmly within the GP-led primary care team.

As noted in section 4.7.2, only two respondents reported that they had good working relationships with GPs. Many of the respondents had worked at building relationships but had been unsuccessful. Some respondents felt that the main reason for this was that community health and primary care were too different to be able to share an agenda. GPs were almost always resistant to working with respondents but some believed that primary care and community health were based on two different philosophies and there was little point in trying to work together:

> *"Personally I didn't really see the relevance of talking to a GP. I suppose GPs could have it (a remit for community health) if they chose"(R14).*

4.18 Summary of Theme Three

While the community-focused role was believed to relate directly to the principles of health visiting, the way in which it related to the practice of generic health visiting was less obvious. Difficulties were encountered by respondents in moving from a caseload to a community-focused remit and in attempting to work with both remits together. Public health and health promotion were defined in different ways by respondents, but most respondents identified their role as taking a "bottom up", community development approach rather than one that was "top down", i.e. defined by an agency or focused on individual behaviour change.

Respondents were very familiar with national health promotion targets. They were less familiar with primary care policies, although these were very new at the time of the interviews. However, national policies did not feature strongly as influences in the respondents' general activities.

Chapter 5 Discussion

5.1 Limitations to the study

5.1.1 Limitations of the sampling method

Identifying a sample was not a straightforward task as none of the relevant professional bodies held central registers of health visitors working with community-focused remits. However, some had mailing lists for public health and community development special interest groups and these were made available to the researcher.

There was a need to ensure that the sample was not merely an homogenous group of health visitors. For example, Miles and Huberman (1994) stressed the need to include negative cases in a sample in order to prevent interpreting events as more congruent than they are. Attempts were made to include health visitors who conformed to the criteria but had moved out of the community-focused posts back to caseload work (n=1), taken up other posts (n=5), or left employment altogether (n=1). This strategy proved to be useful, particularly in raising some discussions about problems associated with community-focused work. However, the researcher had little control over ensuring that respondents providing a “negative” view were included, as individuals’ attitudes to the community-focused posts were often unknown until the time of the interview.

The second problem in identifying respondents was the degree of uncertainty in ensuring that a useful sample could be recruited. For example, there were some areas where there were a number of potential respondents unexpectedly identified through snowball sampling, while inquiries in other areas yielded no respondents against expectations. Again, dependence on snowball sampling for identifying some respondents prevented the researcher having complete control over recruitment (section 2.8.8).

5.1.2 Limitations relating to other aspects

Researcher bias

The researcher was inexperienced in qualitative research methods and was carrying out the study as a research training fellow. Therefore, time was required to learn about all the stages in conducting a qualitative study in addition to carrying it through. Another consequence of being inexperienced in qualitative research was that some issues of rigour were not fully appreciated at the data collection stage. In particular, issues of concern were stringency with inclusion criteria (section 3.3.2), inconsistency in availability of written material (section 3.6.4), and an inability to carry out observation within workplaces for all respondents (3.6.4). Other areas vulnerable to bias, such as the researcher's prior knowledge and the conduct of the interviews, were acknowledged beforehand and a systematic approach was taken in order to reduce bias as far as possible (section 3.6.4).

Complexity

One of the first issues to come to light during the study was the confusion around definitions of public health and public health nursing. As a result, it became apparent that the subject matter was more complex than initially expected.

Timing

The timing of the study proved interesting as it straddled two policy changes relating to primary care; the second resulting from the changeover of political parties in government. Some of the difficulties reported by respondents were attributed to an unsympathetic policy context. However, by the time the study was completed it remained too early to determine the full implications of new NHS policies on health visitor's community-focused role.

Differences in service provision

The study was conducted over a large geographical area covering Scotland and England. While this provided a broad overview, there were inevitably differences between areas in the provision of community-based services; for example, there were community workers or health promotion officers in some areas but not in others. Effects on the health visitors' community-focused roles of the existence or absence of other local workers with similar remits were not studied.

In addition, as Scotland and England are subject to subtle differences in national policy it would be expected that there might be some cross-border differences in interpretation of the community-focused role. Only one issue raised obvious differences in attitude: the use of national health promotion targets in guiding respondents' activity. English respondents appeared to be more conscious of a need to acknowledge the national targets than those in Scotland, although respondents in both countries were equally aware of their existence. However, time did not allow for these or other potential differences between areas or countries to be investigated further.

Scale of the study

There have been few investigations into health visitors' community-focused role. Consequently, the study was necessarily broad, although it was focused on a small sample of health visitors with particular roles. As an initial investigation into this area of practice, the study raised more questions than it was able to answer. As a result, while it is hoped that the study can inform thinking about health visiting practice, the findings cannot be generalised to the wider population of generic health visitors.

5.2 Discussion of findings

5.2.1 Research questions

As described previously, the research questions were as follows:

1. What are health visitors' interpretations of a community-focused remit?
2. How does the community-focused role of health visitors relate to the extant principles of health visiting?
3. How does the community-focused role of health visitors relate to Government guidelines for health promotion and community health care?

The materials and methods chosen for the study produced data that allowed all three research questions to be answered. In order to answer question number one, the views of health visitors working with community-focused remits were sought. The interview schedule and self-completed questionnaire elicited data that provided a full picture of respondents' interpretations of their community-focused remits. In addition, observation of health visitors' bases and working practices was included to deepen understanding of the role.

Respondents discussed their roles in relation to the principles of health visiting and to theoretical concepts of public health, health promotion and community development, thus providing partial answers to the second and third research questions. The literature relating to health visiting principles and NHS policy provided further insight into the policy context of the community-focused role, and allowed questions two and three to be answered in full.

Identification of the three themes of "organisation", "process" and "relationship with mainstream services" helped to build a coherent picture of the form and function of the community-focused role of contemporary health visitors. Discussion of the findings are presented under each of the three themes with particular regard to the implications for current health visiting practice.

5.2.2 Theme One: Organisation

Profile of a typical community-focused health visitor

A typical community-focused health visitor is female, 40 years of age, qualified as a nurse for at least thirteen years and as a health visitor for at least eight years. She is likely to possess a degree, perhaps at Master's level. Her community based post is likely to be at salary grade G and managed by an NHS Community Trust. She works with a geographical remit in an area of deprivation (as measured by high levels of unemployment and single parents) with an average population size of around 10,000. She is more likely to have a full time remit for community-focused activity than have a post that is split between a caseload and a community remit, although she is seconded from a generic caseload. Her community-focused post is funded on a short-term basis, with no guarantee of continued funding.

A complete, current profile of a generic health visitor was not available for comparison although health visitors are generally employed by NHS community trusts (Orr, 1993). The main focus of generic health visiting is said to be on the individual or family, particularly on pre-five children along with their carers, and on elderly people (Goodwin, 1988; Robertson, 1991; Twinn, 1991; Carney et al, 1996). Few respondents in the present study had a remit for defined population groups. However, adults of working age appeared to be their main collaborators on community-based activity.

The number of respondents with further degrees appeared to be high, standing at 70% with a third of those degrees at Masters level (section 4.1.3). Figures regarding nurses with higher degrees are not routinely collected (Rafferty and Traynor, 1997), but one study, noted earlier, found that only 3.6% of 206 generic health visitors were undertaking degree studies (Porter, 1996). This suggests that the sample of community-focused health visitors in the present study were qualified to a higher level than would be expected of a generic health visiting workforce.

Working within an alternative framework

Health visitors are believed by SNMAC (1995) to have a public health role because of their orientation to promoting health. In general, health visitors' health promotion activity is observed to be shaped by GP health promotion contracts (Russell, 1995). These contracts were criticised in the early 1990s for their focus on death, disease and disability, and the limitations of a behaviour change model in the face of growing health inequality (Seedhouse, 1997).

In this study it was found that the national health promotion targets (DoH, 1992; Scottish Office, 1992) were incorporated into very few of the respondents' activities. It appeared that the health promotion targets were included only when respondents believed that it would be "*a politically sensible thing to do*" (R26) (section 4.4.2). Respondents explicitly shunned a behaviour change model of health promotion because the community members with whom they worked did not prioritise behaviour change over social and environmental solutions to health problems. Instead, respondents worked with an alternative approach to health promotion which corresponded to the WHO principles of HFA, primary health care and health promotion, and the new public health movement. This model was said to provide a framework for a community-led approach to improving health that aimed at participation and empowerment for community members (Ashton and Seymour, 1998), and therefore conformed to the communities' views on health priorities.

Few respondents mentioned the WHO principles and the new public health movement as providing a framework for their posts. However, it was clear that respondents adopted the approach advocated by the WHO. For example, respondents' community activity as described previously conforms to the principles underpinning the Ottawa Charter for Health Promotion of: developing personal skills to take control over health and environment; creating supportive environments; strengthening community action using community development; and creating public policies and health services which support health (Ashton and Seymour, 1988).

Respondents' interpretations of health promotion were very different from mainstream NHS expectations of health promotion practice. Rather than working to a national public health or health promotion framework, some respondents regarded themselves as working to personally-held values. For example, respondents were more likely to utilise democratic and participative methods as opposed to assuming that community members were willing or able to change their behaviour in relation to NHS expectations (section 4.9.2). This illustrates Seedhouse's (1997) belief that health promotion is driven by political philosophy of individuals or organisations rather than theory. All respondents were committed to the belief that the community agenda was, or should be, their priority. Consequently, local health issues such as those relating to crime, safety and feeling confident, were of greater significance to respondents than national targets for heart disease, cancer and stroke. Hence, respondents' health promotion activity bore little relation to the health promotion agenda within mainstream primary care.

5.2.3 Theme Two: Process

Development of a public health approach

The initial health visitors' public health role came about in the UK at the end of the 19th century through the establishment of the health visiting service alongside other developments in the public health movement such as sanitary reform and the administration of health services. Women working in sanitary inspection (Dingwall, 1977) and in volunteer visiting of the poor (Webster, 1993) had been concerned with the living and working conditions of women and children. At the same time, infant mortality was a main concern of the public health movement (Chalmers, 1930) and the development of child welfare services by MOsH together with the introduction of the 1907 Notification of Births Act helped to bring together the sanitary inspection and volunteering services to create health visiting in the early 20th century.

The early health visiting service therefore began with an understanding of poor housing, insanitary conditions, epidemiology, ill health consequences of the lack of affordable, good quality food and the constraints on women of keeping their families healthy. While health visitors in the 1990s also recognise diet and housing as priorities (CPHVA, 1998), respondents found that their managers did not generally regard health determinants, such as housing, to be the province of health visitors. For example, the community nursing team who set up a housing clinic (Figure 4.8) found that their service received no support from nurse managers after their project funding had ended, despite the clinic showing positive outcomes for housing issues. In addition, King (1995) and Smith (1997) found that community nursing recording systems were more concerned with contact counting than looking at the ability of the service to meet presenting and underlying needs.

The public health role of the early health visitors recognised determinants of health at a population level as well as individual preventative measures. Since that time, a combination of factors have conspired to remove the population focus from health visiting as it developed over the 20th century. First, MOsH support for the mother's friend role (Davies, 1988) steered health visiting in the direction of individual work, where maternal inefficiency was deemed the cause of poor health of the working class (Webster, 1993). This reflected the move in social policy in general which became more focused on individualism (Dingwall, 1977). The second set of factors came about in the 1970s, with the move of health visitors into hospital nursing management systems and GP attachment. Both of these factors resulted in health visitors being pulled further towards working to an individual-focused, medical model of practice that was said to prevent health visitors from focusing on communities or populations (Barker and Percy, 1991; Symonds, 1997).

In this study, despite respondents being employed by mainstream health services, they felt there was little understanding or support for health visitors focusing on health determinants or working at a population or community level. Individual nurse managers could not be blamed for the lack of support: for example, in this study and in others described previously (King, 1995; Smith, 1997), the systems of managing and recording health visitors' activity are geared to visiting families in their homes and clinics and not appropriate for even the most basic groupwork activity. Therefore, it is argued that the present move to increase the public health functions of nurses would require a major shift in the political and managerial structures described above.

A community approach to health promotion

In this study, respondents' health promotion activity at a community level generally included a community development approach. As described in section 4.13, respondents carried out needs assessments in collaboration with community members, brought together a group of key people to address the prioritised need, identified sources of funding or other support for the activity and oversaw the development and implementation of the chosen activity. Some respondents also took a proactive approach to changing policy using recommendations from the community activity. This approach mirrors the process of community work as reported in the literature, for example: Smith (1980) observed that community workers were more likely to be influenced by the needs and perceptions of their communities than their employing agencies; Thomas (1983) stated that community development emphasised self-help, mutual support, development of neighbourhood problem-solving capacities and collective action to inform political decision-makers; and Barr et al (1995) regarded the process of community work to be the understanding of the problems and strengths of communities, supporting the development of informal organisations and informal learning, ensure groups were resourced and could collaborate with others, and engaging with the political process to ensure a voice in decision-making.

One difference was observed in the present study between respondents' community development activity and traditional community work; that is, in the main aim of the two approaches. The aim of community workers is said to be to ensure a community voice in decision-making (Barr et al, 1995), while health visitors in this study aimed to improve the health-promoting capacity of the community. According to WHO principles of HFA and the Ottawa Charter (Ashton and Seymour, 1988), one aspect of improving health in a community includes improving community participation in decision-making. While most of the respondents in this study demonstrated that community participation was an important aspect of their roles, none of the respondents stated community participation in decision-making as an aim for their posts.

The community work approach appears to be appropriate to health visiting principles (Dalziel, 1992), with endorsement by the RCN and the HVA (Robinson, 1982). As demonstrated above, respondents in this study used a community work approach but regarded themselves as remaining loyal to the principles of health visiting (section 4.15.1). However, a community work approach did not appear to be appropriate to mainstream primary care, with GPs in particular showing little understanding of community-based health promotion activity (section 4.7.2). The policy context for primary care continues to place health visitors within GP-led primary care teams (DoH, 1997; Scottish Office DoH, 1997). Primary care did not welcome a community development approach and, as demonstrated above, worked to a very different model of health promotion than the respondents' community development approach. Therefore, it is suggested that without policy change for the public health role of health visitors, the primary care base may act as a barrier to the community-focused, preventative role of health visiting.

A dynamic role

The health visitors' community-focused work appeared to be dynamic in nature, with respondents working towards change in individuals, groups and communities and, in addition, for personal and professional development. For individual community members, many respondents in the study emphasised the aim of their work as the development of community members' confidence, self-esteem and/or skills in order to improve personal health and the strength of the community in general (section 4.10.2). In relation to working towards change in groups, respondents accepted that many of the groups they worked with might change from one type to another; for example, it was reported that a group initially set up to provide menopause support became a stress management group and a self-help group for asthma became a campaigning group. The lack of set outcomes for groups was regarded by respondents as important to the groups' development but caused problems in meeting management demands for evaluation.

In relation to change in communities, respondents' project development activity aimed to establish more sustainable resources for the communities. For example, 35 additional funded developments were reported to have been set up by respondents' projects in addition to support groups and forums (section 4.10.2). The aim for most projects was to be self-sustaining after a period of intensive funding and support. However, the short-term nature of most of the posts mitigated against respondents being able to ensure that projects would be sustainable in the long-term and also prevented the development of appropriate evaluation methods.

Some respondents also explicitly worked towards achieving change through influencing local policy. Influencing policy was regarded as being easier to do while working in the community-focused role due to increased contact with decision-makers (section 4.12). Change was attempted or successfully facilitated by making direct contact with some of the decision-makers in local health and other services, or politicians (section 4.12). By making direct contact with decision-makers, respondents were able to advocate for the communities or groups they worked with either by providing written reports, by inviting key contacts to visit the projects or communities or by writing proposals for service changes. When respondents were unable to effect change they reported frustration with the lack of structures to support their work in influencing policy.

Many respondents welcomed the opportunity to be proactive about community health problems, reporting that they felt restricted by working in generic practice (section 4.15.2). Generally, they felt they had moved on from generic practice and developed new and existing skills. This would appear to be in line with UKCC (1992) guidelines which encourage health visitors to utilise their full range of skills to determine appropriate interventions in response to identified health needs. However, as noted previously, there are few opportunities for health visitors to be employed in health service planning (Salvage, 1993; SNMAC, 1995). There was an emphasis among respondents on training and skills development (section 4.3.3) as well as on further education (section 4.1.3) and therefore it is argued that respondents appeared to be working toward change in themselves as well as in their communities.

Relevance of health visiting training and principles to community-based activity

Health visitor training continues to be based on the purposes and principles of health visiting as stated by the CETHV in 1977 and reaffirmed in the 1990s by

Twinn and Cowley (1992). All respondents in the present study were qualified health visitors. Health visiting training was regarded by most respondents to provide a relevant and useful basis for their community activity. Many believed that they had more autonomy in their community-based posts than they had had while working in generic health visiting where they felt they had to work to the expectations of GPs or Trusts rather than health visiting principles (section 4.15.1).

There was some dissent in regarding the principles as a perfect framework for the community-focused activity with the view expressed by two respondents that the principles did not include an empowering approach. However, it is argued that the principles specify neither an empowering model nor a "top-down" approach, therefore providing health visitors with the scope to choose a relevant method of working. Twinn (1991) found that health visitors used non-directive, empowering approaches in some circumstances and adopted a more directive approach in others.

In the present study, the principles appeared to provide a framework and a starting point for respondents to make sense of their roles, particularly in the absence of management support and policy guidelines. In addition to the principles of health visiting, the other common issues underpinning respondents' community-focused roles were: the focus on health inequalities, usually in relation to poverty but also to race and rural isolation for some respondents; an empowering approach, most often along with using a community development approach; and collaboration with local residents and workers. With these additional issues and methods of working, most respondents regarded health visiting training as the basis for their work but also required some extra skills and knowledge.

5.2.4 Theme three: Relationship with mainstream services

Working in isolation

The dependence of the community-focused posts in this study on project funding (section 4.2.2) resulted in the posts being developed in isolation from internal NHS policy. While the community development approach adopted by respondents was congruent with WHO principles, it did not fit into the overriding policy context of the NHS. While the WHO principles may underpin much of the theory behind preventative aspects of health care, it is clear from both this study and the literature that they have not been integrated into NHS practice. For example, as discussed earlier, Lewis (1991) argued that the definition of public health used in the 1990s emphasised prevention but NHS public health functions focused on health service delivery. Similarly, Tudor Hart and Dieppe (1996) observed that positive perspectives on health in the NHS have been marginalised through the drive towards measurable interventions.

Isolation experienced by respondents in this study echoed the experience of other nurses tackling social determinants of health. For example, as noted previously, health visitors working on poverty and health (Blackburn, 1991) and Irish public health nurses focusing on community participation issues (McDonald and Chavasse, 1997) found that they lacked support from their nurse managers. Most respondents in this study were physically isolated from generic health visitors as they were managed separately from their colleagues with no recording system for their work and an absence of other evaluation support from managers. However, respondents attached to community projects reported that they had good support and opportunities for teamworking. Therefore, isolation may also have been the result of respondents being perceived as working with different aims and methods than for generic activity.

A further example of respondents' isolation from mainstream health services was demonstrated by the difficulties encountered in developing allies within the NHS (section 4.7.2). In general, respondents reported good collaboration with a variety of workers from agencies outwith the NHS. However, within the NHS, the development of working relationships was less straightforward, particularly with GPs and generic health visitors. As noted previously, GPs did not appear to be interested in respondents' community-focused role, possibly due to their very different models of health promotion (section 4.7.2). Generic health visitors demonstrated a mixed reaction to the community-focused health visitors, with half of the respondents reporting difficulties (section 4.7.2). One problem was that generic health visitors occasionally reacted in an openly hostile manner to respondents. This was interpreted by respondents as generic health visitors feeling threatened, with the existence of the community-focused post implying criticism of traditional health visiting activity. Therefore it is perhaps not surprising that community-focused health visitors felt isolated.

Many respondents reported that they made extensive efforts to overcome misunderstandings about their role. For example, some respondents acknowledged that they developed tactics to ensure access to a community or to local primary care professionals, for example, by "trading" a service such as carrying out health education sessions for a community group, or running a stop smoking group or a child health clinic for a GP practice (section 4.8.2). The concept of trading as a basic health visiting skill was recognised by De la Cuesta (1994) in relation to generic health visitors gaining access to family homes. It should be noted that none of the respondents had difficulty in accessing a community or group although some appeared to expect to be denied access; for example having been known as a local health visitor who may have been involved in child protection issues (4.15.2).

As noted earlier, despite feeling isolated from mainstream community nursing, most respondents continued to demonstrate loyalty to the principles and purposes of health visiting. The conflict between some respondents and their generic colleagues over different ways of working reflects Twinn's (1991) findings regarding similar conflict between health visitors working within different paradigms. Twinn (1991) found that health visitors' loyalty to one or other of the four health visiting paradigms, created confusion about the purposes of health visiting. It also led to debate between health visitors about the direction that the service should be taking. In this study, the confusion and debate between health visitors working within different paradigms contributed to a climate of distrust and isolation between peers.

Confusion around the public health role

Definitions of public health medicine (Lewis, 1991; Webster, 1993) and health promotion (Tones, 1993; Seedhouse, 1997) are subject to some debate in the literature. As noted earlier, there is also some confusion around public health nursing, (Khan and Landes, 1993) and health visiting and public health (Billingham, 1995; SNMAC, 1995). With the lack of clear definitions of public health, health promotion and public health nursing, perhaps it is unsurprising that in the present study, respondents held a variety of personal definitions of public health (section 4.16.1). In a similar vein to Seedhouse's (1997) critique of health promotion, it is argued that respondents' definitions of public health depended more on personal values and political ideology than on theory-based definitions. The health visitors involved in this study perceived public health as either "top down", focusing only on a medical model of health, or encompassing health promotion and community development as well as epidemiology. Many respondents believed that while most public health initiatives conformed to a medical model, their ideal model of public health should also encompass community approaches.

"Public health nursing" was a term rarely used by respondents in this study. Only three respondents had "public health" in their job title (Appendix X) and only one was described as a public health nurse. Other respondents felt that they had moved away from nursing with their role being more like a community health worker than a nurse. As noted previously, parallels can be drawn between the first description of public health nursing, as defined by Lillian Wald in America in the 1890s (Frachel, 1988), and present day health visiting in the UK, particularly the role adopted by respondents in this study. However, current definitions of public health nursing in many countries are confused and non-conclusive (Khan and Landes, 1993; King et al, 1993; Boschma, 1997). As a result of the confusion over definitions, it was impossible to develop a clear picture of the relationship between contemporary health visiting in the UK and public health either from the literature or from this study.

In addition to differing definitions of public health, respondents reported a variety of beliefs regarding health promotion and health education. Some stated that their ideal definitions should be that public health and health promotion encompass wider health issues and a community development approach. However, respondents generally believed that neither health promotion nor public health structures were able to address wider health issues within the present climate (section 4.16.3; section 4.16.2). Consequently, neither public health nor health promotion and education were able to provide a theoretical base for the community-focused role of health visiting.

In contrast to the confusion over definitions of public health and health promotion, there was no ambiguity in respondents' definitions of community development despite their lack of formal training in community work or community development (section 4.16.3). Respondents appeared to adopt a community development process of working even when they were not familiar with the term. Most respondents described the concepts involved in a community development approach in a way that mirrored the community work process as described by Smith (1980), Thomas (1983) and Barr et al (1995) although they generally did not use the same terms.

The main problem encountered by respondents adopting a community development approach was that it did not fit into the medical model of public health that dominated community nurse management. Without a clear evidence base, as measured by methods more suited to medical interventions, community nursing structures appeared to be reluctant to include community development in core service provision. However, respondents had some support from within the NHS, often from individuals within public health departments, which allowed them to be employed in the community-focused posts. This suggests that, despite the lack of support within nursing structures, there is some scope for establishing the use of a community development approach within the NHS.

While respondents in this study appeared to have an unambiguous understanding of the process and potential outcomes of a community development approach, it is clear from the above discussions that this understanding was not shared among other NHS disciplines. Munday (1980) believed that a community development method of working was adopted by professions other than community workers in order to cope with increasing demand on official services. In the present study, there was a lack of understanding of a community development approach among community nursing line managers and other health service structures. This suggests that, should the NHS become more open to using a community development approach, there is a danger of community development being adopted as a cost-cutting measure rather than for its potential benefits to health.

5.2.5 A model for the community-focused role of health visitors

From the discussion of the findings, a model of the community-focused role of health visitors in the study is proposed. Figure 6.1 presents the model and summarises the dimensions of the community-focused role. As can be seen, the foundations of the role are the principles of health visiting. In addition to the principles, respondents' recognised a need to address issues relating to poverty and health, and inequalities of access to appropriate services. Respondents favoured a more empowering way of working than was usually possible with caseload work, and believed that collaboration with local residents and workers was central to a community-focused role.

Figure 6.1 illustrates that the process of establishing a community-based response to poor health utilises community development methods of working, although, at the same time, maintaining a link into health agencies' decision-making structures. In this way, respondents reported that they could work with both the community and the health agencies to achieve better health for community members.

Figure 6.1 A public health role for health visitors

It is not intended that the proposed model provide a step-by-step guide to a community-focused public health role for health visitors. Instead, it offers a framework for planning and describing community-focused health visiting activity, highlighting the underlying principles of this role for health visitors and illustrating the use of a community development approach to promoting health in communities.

The community-focused role emphasises a population or community approach, and employs a range of methods of working drawn in particular from generic health visiting, public health and community work. Respondents generally displayed confidence in relation to their role despite having inconsistent support, and a willingness to step out of traditional health visiting to question the dominance of a medical model in promoting health in communities. A community perspective rather than an individual approach was perceived as absent from generic health visiting but central to a community role. Consequently, the community-focused role did not fit comfortably with existing NHS structures although the principles underpinning the community-focused role were akin to WHO policies and the new public health movement. The community-focused role, as with the new public health movement, has currently little policy support in the UK and has not been integrated into NHS structures, although this may alter under current government policies.

5.2.6 Summary of discussion of findings

The community-focused health visitors in the study developed their skills and education beyond generic practice. They employed a model of health promotion that eschewed a behaviour change approach and, instead, focused on addressing social and economic factors contributing to poor health. Respondents seemed to have moved beyond individual-focused activity to adopt a community development approach that worked to health promotion principles as defined by the WHO.

While respondents believed that they remained loyal to the principles of health visiting, they found themselves isolated from mainstream health services and felt in conflict with their health visiting colleagues. Confusion about the community-focused role among respondents managers and peers was reflected in the literature, where no clear definitions of public health, health promotion or public health nursing could be found. The difficulties encountered in gaining support for health visitors' community-focused role suggested that policy change is needed for the role to become established within the NHS.

A model has been proposed for health visitors' community-focused role based on the experiences of respondents in this study which identifies the role as bridging the gap between health agencies' and communities' perspectives on improving health.

Chapter 6 Conclusion and Recommendations

6.1 Conclusion

The community-focused health visitors in the study adopted an approach which appeared to be similar to the early American public health nursing model (Frachel, 1988; Boschma, 1997) and to features identified as common to contemporary public health nurses in five countries (Khan and Landes, 1993). In addition, the approach conformed to Blackburn's (1991) framework for health visitors working with families in poverty. The term "public health nursing" has been adopted in the UK by other branches of nursing as well as health visiting (SNMAC, 1995) and did not appear to adequately describe the community-focused roles of respondents in this study.

The model of working adopted by the respondents clearly has its roots in health visiting with an added dimension of recognising the determinants of health on a population basis as well as for individuals. Therefore, the community-focused role could be described as a public health role of health visitors but there was no evidence from this study that a community-focused role could be a relevant public health role for nurses in general.

Given the range of definitions of public health reported in the literature and held by respondents, it would not be appropriate to claim that the model of community-focused health visiting presented in this study represents the public health role of health visitors. Instead, it is presented as a public health role of health visitors; a public health role that focuses specifically on community-defined health needs and the use of community-sensitive approaches to meet these needs.

While respondents believed that their community-focused roles were rooted in generic health visiting practice and training, most agreed that their posts required additional or different skills from generic practice. Specific skills identified by respondents included needs assessment, groupwork and community development, although training was not always available. In addition, many of the respondents developed research studies while in their posts, often as part of a structured course leading to a first level or Master's degree. Extension of the generic remit by adapting existing skills, developing new skills and undertaking further education suggests that respondents could be regarded as advanced practitioners, as defined by the UKCC (1992). However, far from recognition of functioning at an advanced level, there was little evidence from the findings that the community-focused remit was regarded as a valid role for health visitors within the NHS.

A further complication of the nursing/health visiting issue might present from the recent review of the Nurses, Midwives and Health Visitors Act. It has been proposed that health visitors be identified as nurses rather than as a separate occupation for the purposes of UKCC registration (Wendy Burke, personal communication). In addition, recent press releases from central government have suggested an expanded role for health visitors in new areas, such as in parenting support and in marital breakdown. However, it was beyond the scope of this study to investigate the implications of these changes on generic or community-focused health visiting.

A specific definition of public health nursing in the UK cannot yet be made, nor can a community-focused role claim to represent the only public health role of health visitors. It is clear that full integration of health visiting and public health will only take place in contemporary UK if policy support is established. Some respondents gained support at a local level from a variety of health, social and community services, and the WHO provided an international framework for the community-focused role. These routes of support must be backed up by local and national policy in order for the role to become established. Recent policy developments within the NHS, such as cross-practice working in primary care and the emphasis on health inequalities, may support the community-focused health visiting role in the future.

6.2 Recommendations

1. Further work is required to establish the relationship between the community-focused role and generic health visiting with particular regard to:

- the need for specialist skills;
- compatibility for integration; and
- recording and evaluation.

2. Dialogue should be established between health visiting and primary care in order to explore the protection and development of the preventative function of health visiting.

3. The model illustrated in Figure 6.1 should be tested for accuracy and relevance to community health issues and to other health and social services.

4. Efforts should be made to raise awareness of community development within health services decision-making structures to ensure that the approach is adopted for its potential benefits to health and not purely as a cost-cutting measure.

5. The issues raised by the description of the community-focused role are included in the consultation and development of procedures resulting from the recent publication of White and Green Papers regarding the NHS and public health respectively.

6.3 Future research and development

Following on from this study, the researcher has been successful in securing three years' funding for a primary care development in Glasgow, supported by the Scottish Office Primary Care Directorate, Greater Glasgow Health Board and the Community and Mental Health NHS Trust. The aim of the development is to increase the capacity of primary care to address health inequalities at a local level. To achieve this, training is offered to primary care teams in community development and health; resources such as consultancy and funding are made available to primary care staff carrying out community-focused health promotion activity; and monitoring and evaluation of activity are being developed. It is intended that these measures will contribute to the integration of a community development approach within primary care.

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