



Final Report
to the
Greater Glasgow Health Board

**Starting Well
Health Visiting
Practice Guides**
An Independent Audit

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Introduction

This report presents findings from a small study of the use of the health visiting practice guides developed as part of the Starting Well National Demonstration project. The views of twenty-one health visitors, based in two teams located within the Greater Glasgow Health Board area, were elicited via in-depth semi-structured interviews.

The fieldwork was undertaken in November 2003, three years after the establishment of the Project. The aim of the study was to investigate what the health visitors thought about the process involved in drawing up the guides, the purpose behind their development, and the extent to which the health visitors were using the guides in their current practice. The intention was to interview all the health visitors currently working in the two Starting Well teams, based in South and East respectively, together with a small number of health visitors working generically, i.e. those not attached to Starting Well and managing a 'traditional'-style case load.

Background

In 2000 the Scottish Executive facilitated four national health demonstration projects, one of which, the Starting Well Health Demonstration Project, was based in Glasgow and administered by the Greater Glasgow Health Board. Starting Well is concerned with providing intensive family support to families living in vulnerable communities.

In 2001 the Greater Glasgow Primary Care NHS Trust and the Starting Well Health Demonstration Project (Greater Glasgow Health Board) commissioned the Centre of Gerontology and Health Studies at the University of Paisley to review the evidence base for health visitor practice. As part of this project the Centre produced source documents containing literature reviews of research related to particular aspects of health visiting practice of interest to the Starting Well Health Demonstration Project. The review of the literature provided the evidence base for the development by the health visitors of practice guides for the Starting Well Project. One of the intentions involved in the decision to develop the guides was that by giving the HVs themselves the responsibility for producing them, a common approach to practice would be engendered based on evidence-based good practice. It is the use of these practice guides, and the health visitors' views of them, that are the subject of the study reported here.

The rationale for the production of the guides stemmed from the overall purpose of the national demonstration projects, namely, moving international evidence-based practice into local practice. Some of it already existed in conventional health visiting practice but not usually assembled in a user-friendly format. The Starting Well Project wished to develop a standardised approach common across the sites that could then be consolidated into a series of guides. The process of developing the guides started in August 2001 with the latest version being introduced in February 2003.

Aims

The aim of this audit study was to conduct a formative (process) evaluation of the practice guides produced by and for health visitors participating in the Starting Well Demonstration Project. It sought to determine the participants' subjective experiences of using the practice guides, with a view to providing information for improvement or modification of the practice guides, together with information on how best to utilise them.

In particular the following questions were posed:

1. Did the health visitors feel sufficiently involved in the process of the development of the practice guides?
2. To what extent do the health visitors consult the practice guides produced for the Starting Well Health Demonstration Project?
3. To what extent have the practice guides altered practice?
4. Are there any specific problems or difficulties in understanding or using the practice guides?
5. To what extent do the health visitors consult the 'source documents' (the folders containing the evidence base) for the practice guides?
6. To what extent do the health visitors value the practice guides?
7. To what extent do the health visitors feel that the material in the practice guides needs to be updated?

The study did not aim to evaluate the impact of the *use* of the practice guides on child development or the extent to which the practice guides may have been beneficial for the parents in the Starting Well project.

Method

Procedure

Data were gathered via in-depth interviews. Notes were taken during the interviews and field notes were written after the interviews. The data were analysed qualitatively. In all, 21 health visitors were interviewed.

The sample

The sample consisted of 10 health visitors based in East (out of a total of 12 + the HV coordinator) and 11 based in South (out of a total of 16 + HV coordinator). It was not possible to interview all the Starting Well (SWell) HVs because of difficulties in timetabling interviews, sick leave and (in the case of a small number of individuals) reluctance to be interviewed. All except one were female. Three health visitors in the South group were not attached to the Starting Well team and were currently working generically (although two of them had previously been part of the Starting Well team in South).

Experience

For the majority of the East HVs (eight out of ten), it was their first job after qualifying; among the South HVs, fewer than half came to Starting Well as their first HV job. More HVs at East had been with Starting Well since its inception than at South and more of the HVs at South were newcomers (working for less than a year with Starting Well) than at East. This latter detail confirms information provided prior to the start of fieldwork that there had been a greater turnover of staff at South than at East.

Table 1 -Length of time qualified

Years qualified	East	South	All
< 1 year	1	1	2
1<2	1	2	3
2<3	3	2	5
3<4	3	3	6
4<5		1	1
5<6		1	1
6<7		1	1
7<8	1		1
8	1		1

Table 2 - Years with Starting Well*

Years	East	South	All
<1	1	4	5
1<2	3	2	5
2<3	3	3	6
3	3	1	4

* The two HVs now working generically but previously working with Starting Well are included.

Most of the South HVs had had experience of generic working (N=7) while only a small proportion of those at East had worked generically (N=2).

Results

(1) Did the health visitors feel sufficiently involved in the process of the development of the practice guides?

In all, four of the ten East HVs reported that they had been involved in the development of the practice guides. Three South HVs reported that they had been involved at the outset and a further two said they had commented on later drafts.

Table 4 - Involvement with developing the practice guides

East	South	All
4	3 (+ 2)	9

The process of developing the practice guides

As noted in the introduction, one of the intentions involved in the decision to develop the guides was that by giving the HVs themselves the responsibility for producing them, a common approach to practice would be engendered based on evidence-based good practice. This would in turn contribute to the developing ethos of the programme. Some of the HVs were aware of and approved of, this intention. One said that there was a widespread view that HVs 'out there' were 'busy doing their own thing' and that individual HVs had their own prescriptive views of what was appropriate advice to give to clients. This was muddling for clients (they were getting conflicting messages from different HVs) and for new HVs coming into practice straight from training. Others, however, were unclear as to the provenance of the guides or the rationale for their production. Most HVs did not know how the gathering of the research into the evidence base had taken place. A few mentioned the involvement of Paisley University – one questioned whether it was appropriate to bring outside researchers who were not HVs themselves into the process because they could not know the field as well as HVs

themselves. Another said she was not sure when or why Paisley was involved but it had been useful and cut down the amount of work it would have involved for the HVs.

The HVs who had been involved in the process, or remembered it happening, described the way it had developed. One said that team members had been involved in deciding what topics should be developed. Another said that the idea had first been suggested at a meeting with managers (Project and local) who had said that the intention was to develop a general framework based on best practice for everyone in Starting Well to work from. There was general agreement that team members had been invited to participate in developing the guides if they wanted to. A number had expressed an interest in particular topics and had been allocated these, although most reported that they had been reluctant to volunteer because of the work that it might entail. Some said they had tried to avoid being involved. Drafts had been prepared and then circulated to colleagues for comment. They had also been sent to experts at that stage for further comment.

Issues to do with the process

In the end, however, for most of the study participants it had been a matter of HVs 'being volunteered' and expected to find time to do the work. The degree to which the work had had to be fitted into their existing workload seems to have varied. Some said they had only commented on the drafts, or at the updating stages, neither of which activity had taken up much time. Those who had been involved had generally enjoyed the process, although one HV said that it was a big task to take on at the beginning of the (Starting Well) project, just when they were having to get used to the new way of working. Another said that they had not been given enough time in which to do the work and a colleague felt, on reflection, that they should have been given protected time in which to do the work.

One HV expressed a view that the process could have been undertaken more collaboratively. She thought that generic HVs could have been involved and that it would have been helpful to have had a specialist linked to each specific topic as the work was being done. She would have liked to have been able to manage the process of consultation and incorporate the comments herself. Another HV felt that some initial preparation and agreement about format and style would have been helpful. As it was, she said, first drafts had to be altered in the light of later discussion about these aspects. For some, the process of producing the guides had been opaque, with a burst of activity followed by a period where nothing seemed to be happening and then with the guides suddenly appearing ready for circulation. One HV talked about having been on maternity leave and coming back to find a series of coloured cards on her desk. One of the HVs who had been involved at the beginning felt she had not had a chance to keep involved during the comment and final drafting stages. Another had felt that her work had been criticised in some of the comments made by colleagues.

There seemed to be some confusion as to the history and status of the guides among some of the HVs – mostly those who had joined Starting Well some time after its inception. Some thought that the guides published in February 2003 were new, revised versions, others thought they were the final versions of the first drafts. One or two study participants talked about a series of stages in the development of the guides with some topics being started early on in the project and others only being started later.

(2) To what extent do the health visitors consult the practice guides?

The practice guides were designed for practical use and the central focus of this study was to discover the extent to which the guides are used by HVs in their daily work. Eight of the East staff and nine of the South staff (including the generic HVs) said that they use or have used the guides. However, this positive response masks a degree of variation in type of use. Some HVs said they made extensive use of them while others said they had used them only very occasionally.

Table 5 - Extent of use

Use	South	East
No use made	2	2
Limited	3	2
Regular	6	6
Total all using guides	9	8

Many of the HVs consulted the guides to crosscheck and confirm their own approaches. Two HVs mentioned that they had found the sleep management information extremely useful and had photocopied sections on it for the families involved. One of the two, like some others, had also consulted the guide on domestic violence several times. Others said that they consulted the guides when they were looking for additional tips and ideas when confronting difficult situations. Additionally, the guides provided an opportunity for the HVs to reflect on their usual practice. They also appreciated the resource sections at the end of the documents. Some said they had found that the actual act of drawing up the guides had proved useful to everyday practice – so although they might not consult the guides now, their knowledge base had been increased and consolidated through being involved in the production of the guides. One HV said that they provided authoritative backing to her own judgement and that it was useful (in a protective sense) to be able to write 'I have given advice as per the guides' in the case records. Another HV, no longer with SWell, said that she found the guides extremely useful in providing up-to-date evidence-based information to the already well-informed, articulate client group in the more affluent area that now formed part of her practice. She found that the guides gave her a certain amount of protection in enabling her to tell her families that she was working within accepted guidelines.

While many HVs said they used the guides to help them deal with problems that they encountered in their daily work, they also stressed the importance of consulting with colleagues in these situations. Most felt that this was more important than resorting to the printed word. Several mentioned the importance of peer support, team meetings and supervision although there seemed to be more organised support of this nature in East than in South. (One South HV said that although they were supposed to meet regularly they 'tend to *not* meet rather than *do* meet'). Reliance on colleagues more than on the printed word also related to the way in which HVs kept themselves informed and up-to-date. Partly it was through talking with colleagues but it was also through reading journal articles that came through to them from time to time (one suggested a journal club would be helpful) and through study days. Several people mentioned the additional training that was made available to them through being part of the SWell project. They regarded this as a great benefit.

Of those who did not use the guides, one health visitor said she never used them and that they were still in the envelope in which they had been sent to her. She did, however, acknowledge that she might use them if she were asked a question about a specific topic and she wanted to check on the evidence. Another said that she didn't use them because there was nothing in them that she didn't know already. Others said that they had used them from time to time if they wanted to check on particular topics. Two of the health visitors said they had found them extremely useful when they had had to do presentations on particular topics for students. A view expressed more than once was that HVs involved in Starting Well knew the topics inside out in any case (and so did not need to consult the guides) – the topics dealt with were, after all, the very stuff of what the project was about and that finding solutions was part and parcel of their jobs in SWell.

Asked whether they thought their colleagues used the guides, one HV said she thought that other HVs did use them – she herself had given them to newly qualified HVs when they joined the team – but she thought that the more experienced generic HVs would probably be resistant to using them. They tended to be confirmed in traditional ways of working and as a result were resistant to change and less flexible than the SWell HVs.

She felt that many generic HVs did not like the SWell community development-type approach which involved getting out into the community and visiting parents frequently, nor did they see the importance of the modern consistent, evidence-based approach that SWell favoured. In her view this approach was essential – it gave legal protection to their practice.

Apart from a small number of HVs who thought their SWell colleagues did make use of the guides, about half of the rest felt unable to say whether their colleagues made use of them or not. Of the remainder, some were reasonably certain that they did not – one talked about 'blank faces' were the guides to be mentioned. Others suggested that their colleagues probably used them from time to time in much the same way as they did themselves (to check and confirm, to reflect, to assist parents) and a few said that because a lot of them had been involved in producing them everyone was so well-versed in the subject matter that there was no continuing need to refer to them. Those who said they themselves or their colleagues rarely used them did not necessarily under-rate their value – they felt the guides would be useful for students, newly qualified staff and people new to the localities. There was the occasional reference to the fact that their managers seemed not to have mentioned the guides to new staff. One HV suggested that if managers ensured that the guides were put in recognisable folders and shelved prominently more attention might be paid to them – rather like the child protection guidance which was well-known and used. As it was, she said that each HV had been given a set of guides which then tended to get buried under piles of paper on people's desks. Other HVs however expressed the opposite view saying they preferred to have their own personal copies ready at hand for easy reference.

(3) To what extent have the guides altered or influenced practice?

Just over half of those interviewed (12 out of 21; 6 in each location) said they felt that the guides had confirmed, altered or influenced their practice. Of these twelve only two said that they had actually *altered* the way they worked (as opposed to confirming or influencing). One health visitor who had been involved in drawing the guides up said that she had found the experience of doing so had changed her practice. As a student she had worked with a very traditional HV who knew 'what worked' from her long experience (rather than any evidence base – and, indeed, contrary to the evidence base). The guides had given her the reason to break away from that approach. One said that she was now much more observant when visiting families, looking out for signs of drug misuse or neglect and being more confident in making decisions to refer cases to social work in relation to child protection. Another had found the guide on domestic violence had changed her way of asking questions in cases of suspected violence. For another, one of the guides had been useful in helping her offer alternative strategies on sleep management. More specifically, another HV said she now gave clearer advice and explanation about staying on stage 1 formula rather than moving on to stage 2 inappropriately. A colleague also commended the nutrition guides saying that they were very helpful in providing a rationale for advising parents on weaning which she had not been aware of before.

The remainder said that they had made no difference. Most of these said that they did not add anything that they did not know already. Several who were not long out of training said that what they had been taught at university had been similar to what was in the guides. Others said that the guides were the summation of what Starting Well stood for and so their practice was already consonant with what was in the guides. No-one felt that they disagreed with the approach set out in the guides (although there were some who disagreed with some elements in the guides – usually to do with breast feeding).

(4) Are there any specific problems or difficulties in understanding or using the practice guides?

All those who said they had seen the guides (one HV said she had not seen them) thought the style and format of the guides was appropriate. The style was 'user-friendly' and not 'too busy' or patronising (although one HV said that she thought some of the older HVs might – they would think 'we don't need to be told how to do the job'). A few thought that they were too detailed – linking this to their view that HVs had too much written material to wade through in any case. On the other hand, several thought some of them needed more detail – one HV saying 'they have to be meaty with advice on what to do in problematic situations' and cited the problem of over- or under-weight babies. Several felt they were extremely useful for working with students. One HV said that if that became the norm they would need to keep them in special folders to make sure they were accessible with lots of summarising and changes in layout (a bit like the core visiting schedule) if they were going to be used as working documents.

In terms of the content, several HVs thought that they should have been extended to cover other topics as well. The existing ones covered the 'bread and butter' health visiting topics and it would have been useful to cover other more problematic topics. Immunisation, depression, skill mix (using different types of support staff) and 'how to motivate people' were all mentioned. One HV also suggested a guide for GPs to use. Another suggested a 'comprehensive library' of guides.

There were divided views about the format – most being satisfied with the existing format but some saying either that the guides could be smaller, laminated and hand-bag sized or that summaries could be produced for ready handling in the form of 'tips' sheets or information cards.

(5) To what extent do the health visitors consult the 'source documents' for the practice guides?

A tiny number (2 out of 21) said they had gone back to the source documentation that contained the research evidence on which the guides were based. One of these said she did so to test the evidence base – for example by checking the sample size in one of the studies cited in the guides. The other said she sometimes went back to the evidence base in order to keep herself up to date and informed.

The rest of the HVs said that they had not gone back to the source documentation. There were broadly two reasons for this. First, many said they simply did not have the time to do so. It was difficult enough to find the time to read the guides let alone the background material on which they were based. One said that they suffered from information overload and to go back to source documents would be impossible (although HVs involved in training might do so). The other main reason was based on the view that one of the main reasons for drawing up the guides was to make it unnecessary for practitioners to have to go back to the evidence source. They were ready to accept the findings of experts because 'that was what experts were there for'. One HV said that she was prepared to accept expert opinion, but, if information was not produced by experts, she liked to see the research herself.

Additionally, several who had been involved in drawing up the guides said they had consulted the research evidence during that process and therefore did not need to go back to it subsequently. One who had trained recently said it would be too much like going back to university to consult the research.

(6) To what extent do the health visitors value the guides?

All but one HV thought the guides were valuable to their practice. The exception, although a member of the Starting Well project, was largely hostile to its approach for a variety of reasons. She also felt that there was already a great deal of information available before the guides were produced and so the exercise of developing them had not been necessary. She did not, however, criticise the factual information within the guides and agreed that they were useful for 'back-up and reference' although she did say that they could be 'dangerous in the hands of the wrong person' (giving the example of talking about drugs to someone with a medical problem). Nevertheless, apart from this one critic, the other HVs were largely positive about the guides' value although varying in the degree to which they said they made use of them themselves.

Those who had started with the project relatively recently as newly qualified HVs, for example, were particularly favourable. One said it had been beneficial to have all the evidence set out at her fingertips. Many of the HVs agreed that the guides would be useful for students and newcomers to both health visiting and local circumstances.

Views about the value of the guides fell into three broad categories: (1) as a support and confirmation of the individual's own practice; (2) as providing an authoritative validation and protection of their work; and (3) as a foundation and evidence base for the ethos and philosophy underpinning the Starting Well project.

As confirmation

Many of those interviewed said the guides provided welcome confirmation of their own practice. While some of those who were not long out of training felt they knew most of what was in the guides, they still felt that they provided reassurance and validation of what they did from day to day.

As protection

As noted earlier, several HVs valued the guides as being able to provide implicit protection to them. Being able to say that they were working in accordance with practice laid down in the guides meant, they felt, that they would be protected if their advice was ever challenged. One said she made a point of writing this down in case records (see above).

As a unifying statement of good practice

Several health visitors mentioned the importance of the guides as a means of setting out the baseline for practice in Starting Well. In explaining how the guides had come about in the first place, one HV said that in a demonstration project such as Starting Well 'there was a need to be seen – and it was a good thing – to have such things at the start of the project. It was a good idea to have a standardised approach otherwise they could be criticised for not having good practice standards in a project like this.' Similarly, another HV argued that health visitors must have standards of practice – especially in relation to things they were not familiar with (because colleagues were not always there to discuss problems with). One of her colleagues expanded this view, saying that HVs wanted their practice to be evidence-based. It was essential to give uniform advice (although 'taking account of clients' individuality'). This was a theme that kept cropping up. Two HVs who had previously worked as midwives pointed out that other professions were already used to working to guidelines and agreed that it was important that health visiting adopted the same approach. One HV described how important the guides had been in establishing the Starting Well way of working. This had been passed on over the years as staff had come and gone. Their role in providing continuity over time was mentioned by other HVs who said that the guides were valuable because of staff turnover. They were particularly important for people coming into the profession or into the area for the first time or coming back after a break.

However, it was not always quite so straightforward. One HV, while approving of the guides, also felt that 'the guides are black and white and health visiting isn't black and

white'. Another said that written guides could not really deal with the 'real life' problems encountered in the field. She felt the emphasis that the guides placed on breast-feeding was in stark contrast to the daily reality which they encountered where it was difficult to keep mothers from weaning babies from formula too soon and breast feeding had never even figured as a possibility. (This was, however, countered by another HV who said that in her view not enough emphasis was placed on breast-feeding). There seemed to be a tension between, on the one hand, wanting clear guidance which was evidence based and which provided HVs with a consistent baseline for practice thus enabling them to give out uniform messages and, on the other, stressing the need for HVs to be responsive to clients' needs and individuality in circumstances where no two situations were the same or in circumstances which were just too far away from the ideal set out in the guides.

(7) To what extent do the health visitors feel that the material in the practice guides needs to be updated?

Almost all the HVs felt that the guides needed to be updated regularly and for most this meant doing it on an annual basis at least. One HV felt that if there was going to be a reliance on written guides then they obviously had to be kept up-to-date but there was a danger in such reliance because updating might not always be done. Some said they needed to be checked continuously and updated as required. A number of them felt this was happening anyway and that one of the managers was responsible for this being done.

Opinions varied as to who should do the updating. Several people suggested forming a working group to monitor the guides on a continuous basis, updating as necessary. A number felt that the HVs who had been involved at the outset ought to be able to remain involved and take on the role themselves if they wished. Some felt that it would give the guides additional credibility if experts were involved in their development right from the outset of any future updating.

Discussion

While almost all the HVs interviewed held positive views about the guides, and many of them had found them useful, very few gave them enthusiastic or overwhelming support. Perhaps, at best, most were politely favourable towards them. On reflection, this is perhaps not surprising. The guides did not occupy centre stage in the HVs daily concerns. For most HVs, getting on with the job was what was most important, especially in circumstances, as they perceived them, where demands on them were high and caseloads complex. HVs saw themselves essentially as 'doers', often burdened by documents to read and paper work. Practice guides (and the process of developing them) for many of them were part of the burden.

This is not to deny, however, that on occasions the guides were of practical value and that the HVs were ready to acknowledge this. There were numerous examples of individual HVs successfully turning to the guides for direction and information. Nevertheless, in spite of their proven value on such occasions, views about the guides remain somewhat ambivalent. There are perhaps several reasons for this.

There was a general acceptance that the guides represented statements of good practice that SWell HVs were expected to work by. But there does not seem to be any authoritative commitment on the part of the Project to this. One HV raised the question of their status in the following way – 'they are good practice but not best practice'; another said 'they are not cast in stone – except where they include things like UKCC guidance'. Criticisms were voiced about the fact that they did not clarify the 'grey areas' of practice, i.e. they did not come down on one side or the other on contentious issues.

Some HVs said that they would like the guides to address specific problem areas instead of focusing on the bread-and-butter topics.

There were other HVs, of course, who were less keen on this urge for clarity and prescription – closer perhaps to the tradition of generic working where the emphasis was on individual professional judgement, whether evidence-based or not. These HVs wanted to retain some scope for following their own instincts.

Beyond these reservations however was a general view that the guides would be useful over time – for people who were new to the Project and its ways of working or to long-qualified HVs coming back to work after a career break. But set against this, was a widespread acknowledgement that the greatest resistance to the guides, and the Starting Well way of working, lay with those who were long qualified – the traditional, generic HV.

Concluding Comments

The aim of this study was to evaluate the way in which the practice guides had been developed and were being used by the Starting Well teams in East and South with a view to suggesting, if appropriate, what improvements or modifications might be made and how best the guides could be utilised.

Given the complex context in which the guides are being used, it is perhaps not surprising that they seem to inhabit ambiguous space. The interviews revealed a mixed understanding of both their purpose and their importance. For the future, it will be necessary to clarify their purpose. This might include addressing the following issues:

- Are the guides statements of Project philosophy and embodiments of its culture?
- Are the guides working documents which set out ways of working and ways of tackling both common and extraordinary problems?
- Do the guides confer (legal) protection on those adhering to them?
- Do the guides set out basic levels of practice which must be adhered to, against which professional appraisal or contract compliance can be assessed?
- Do the guides constitute a 'collective knowledge store' or 'knowledge base' on which the health visiting should be based?
- Are the guides codifications of this knowledge or something which can be modified at will without general agreement?

Some of these issues raise the immediate question of how far is health visiting amenable to the imposition of a guideline- or professional standards-based approach or how far should its practice be left to the exercise of individual professional judgement (which is how some of the SWell HVs described the approach of traditional health visiting). Is there something special about health visiting which makes it different from other health and social care professions which increasingly are adopting a standards-based approach?

A number of other matters arise, some depending on the resolution of these issues. If the guides are to be used as working documents (for everyday consultation and for training purposes) then the format may need to be reconsidered. Various suggestions were made about, on the one hand, summaries being made and, on the other hand,

more detailed but uniformly laid out and robustly produced versions being produced. If they are to be seen as standard health visiting 'ways of proceeding', then it could be argued that they will need to have endorsement from the wider health visiting community; perhaps the national Starting Well roadshow which one health visitor mentioned will provide the start of this process. It is clear that most health visitors think the guides are a valuable asset to their work.

This suggests that there is an important role for management and the leaders of the Project in consolidating the impact of the guides. This could be done by ensuring that the guides are updated as frequently as necessary, possibly by having a rolling programme of monitoring and review. In addition, encouraging their use by health visitors could be a role of management, for example, by broadcasting the existence of the guides to new staff.

Ultimately, however, the future of the guides may depend on the outcomes flowing from the evaluation of the Starting Well Demonstration Project as a whole. If the Project is found to have achieved or partially achieved its goals, then the guides themselves will be valued for their role in this. Backing, no doubt, will be forthcoming to address and resolve the issues outlined above.

Recommendations

The following practical recommendations, based on the comments made by the participants in this study, can be made:

- The guides should be circulated to new team members as part of their induction process and HV co-ordinators should draw teams' attention to them regularly.
- Arrangements should be made to update the guides on a regular basis either annually or a continuous 'watching brief' basis.
- The range of topics should be reviewed periodically in consultation with health visitors.
- Team members should be consulted on appropriate format.
- Dedicated time should be provided to those involved in reviewing and updating the guides.
- The guides should be made available for training purposes.

APPENDIX

Topic Guide Used to Structure the Interviews

1. To determine if the health visitors felt sufficiently involved in the process of the development of the practice guides.

Do you think health visitors were sufficiently involved in the production of the practice guides? Were you yourself involved?

Was the process satisfactory?

If the process of involvement was not satisfactory what could have been done to make the process more inclusive?

2. To determine the extent to which the health visitors consult the practice guides produced for the Starting Well Health Demonstration Project.

How often do you read and consult the practice guides?

Are you aware of how many of the health visitors involved in the Starting Well project have consulted the practice guides?

Which guides are consulted most often (by you or by other HVs)?

Are there particular aspects of the practice guides that are consulted more often than others?

If the practice guides are rarely consulted, why not (by you and by others)?

3. To determine the extent to which the practice guides have altered practice.

In what way, if any, have the practice guides changed the ways that you practice and give advice?

How long have you been practising as an HV?

Do you think experience is a factor in whether or not you (and other HVs) have been more or less likely to change your practice?

4. To determine if there are any specific problems or difficulties in understanding or using the practice guides.

Have you (or other HVs) experienced any difficulty in understanding or using the practice guides? If so, what were the difficulties?

Is the current format of the practice guides sufficiently user-friendly?

Are the practice guides too detailed to be used effectively?

Or, alternatively, do the practice guides contain insufficient information to be beneficial in practice?

Are there instances of what appears to be conflicting advice?

5. To determine the extent to which the health visitors consult the 'source documents' (the folders containing the evidence base) for the practice guides.

How often have you (or other health visitors) consulted the source documents?

Which topics are most often examined in relation to the evidence base?

If the source documents are rarely or never consulted, why?

6. To determine the views of the health visitors as to the value of the practice guides.

In what ways are the practice guides produced for the Starting Well project useful above and beyond practice guides/guidelines that were already available?

7. To determine if changes in the practice guides would be perceived as beneficial.

What changes would you like to see being made to the practice guides?

Is there anything that would make you more likely to consult and use the practice guides?

Do you (or other HVs) feel that the material in the practice guides need to be updated?