

This is the peer reviewed version of the following article: Astbury, R., Shepherd, A. and Cheyne, H. (2017), Working in partnership: the application of shared decision-making to health visitor practice. *J Clin Nurs*, 26: 215–224, which has been published in final form at <https://doi.org/10.1111/jocn.13480>. This article may be used for non-commercial purposes in accordance With Wiley Terms and Conditions for self-archiving.

Received Date : 20-Nov-2015

Revised Date : 06-May-2016

Accepted Date : 16-Jul-2016

Article type : Original Article

Working in partnership: the application of shared decision making to health visitor practice

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This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process, which may lead to differences between this version and the Version of Record. Please cite this article as doi: 10.1111/jocn.13480

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Helen Cheyne PhD, MSc (Med Sci), RM, RGN

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Acknowledgements

This study was completed as part of a Doctor of Nursing and would not have been possible without the support of the health visitor and parent participants within the two health board areas and their managers who generously gave their time and thoughts. Funding for expenses incurred was provided by the General Nursing Council (Education) 1983 Fund.

Abstract

Aim and objectives

To explore the processes which support shared decision making when health visitors and parents are creating plans to improve the wellbeing of babies and children.

Background

Worldwide, there is a focus on promoting children's wellbeing in order to enhance population health. Within the United Kingdom, health visitors have a key responsibility for working in partnership with parents to support this agenda. Despite evidence that the application of 'shared decision making' frameworks can increase patient participation, improve patient satisfaction, and improve health outcomes, there is limited research linking shared decision making with health visitor practice.

Design

A qualitative, descriptive study.

Methods

The study was undertaken in two phases: in Phase 1, two parent: health visitor dyads, who were planning together as part of usual care, were audio-recorded and then the participants' experiences were sought through individual questionnaires. In Phase 2 semi-structured interviews were conducted with nine health visitors and nine parents in relation to their recent experiences of planning care.

Results

Evidence of supportive processes included having a shared understanding around the issue needing to be addressed; being able to identify interventions which were accessible for the family; engaging in decision making through deep, meaningful conversations using sensitive and responsive approaches; and establishing positive relationships between health visitors and parents, significant others within the family, and other professionals.

Conclusion

Despite evidence of strong, trusting relationships between parents and health visitors, there were times when shared decision making was unable to take place due to the absence of supportive processes.

Relevance to clinical practice

Health visitors are aware that planning interventions with parents can be complex. These findings indicate the value of using a shared decision making framework to structure planning, as application of a framework identified the processes which support a collaborative approach in practice. (298 words)

Key words – health visiting, public health nursing, shared decision making, practice development

What does this paper contribute to the wider global clinical community?

- Health Visitors in the United Kingdom are in a strategic position to be able to support parents with the wellbeing of their babies and children through collaborative planning
- This research is the first to link a shared decision making framework with health visitor practice
- The study identified a number of antecedents which supported the application of shared decision making in health visitor practice

Introduction

There is recognition worldwide that the status of children's wellbeing within a community will have a direct impact on that population's future health, and consequently many developed countries ensure that there is investment in the 'Early Years'. This approach is noticeable across the United Kingdom, where the delivery of health services is devolved to each of the four countries, and where each government, or administration, invests in policies and programmes which aim to promote the wellbeing of their babies, children and young people (Northern Irish Assembly 2006, Scottish Government & COSLA 2008, Royal

College of Nursing 2011, National Assembly for Wales 2014, Department of Education

2014). Health visitors in the United Kingdom are in a strategic position to be able to support this agenda because, as registered public health nurses, they have responsibility for promoting and

safeguarding the wellbeing of babies and children as a key part of their role (Nursing & Midwifery Council 2004).

Background

Getting It Right For Every Child (GIRFEC) is a Scottish Government Programme (Scottish Government 2013a) based on the United Nations Convention on the Rights of the Child (UNCRC) (1990) and all professionals who work with children and families in Scotland are being encouraged to adopt GIRFEC principles. This ambitious programme is designed to support the wellbeing of every baby and child in Scotland and to put the 'child in the centre' of any discussions or decision-making which has an impact on them. As a direct result of implementation health visitors are starting to use the GIRFEC National Practice Model to structure their assessments, analyse their findings, and then to support their practice if they need to create plans for a baby or child (Scottish Government 2013b).

Within the UNCRC's 54 Articles there are at least 12 references to the important roles and responsibilities which parents have in relation to ensuring their child's wellbeing; as a direct result, GIRFEC principles stress the importance of professionals and parents working together to support, promote and safeguard the wellbeing of babies and children. This means that where interventions are required, to ensure a baby's or child's wellbeing, health visitors and parents should ideally work in partnership (where it is safe and in the best interests of the child to do so) in order to decide whether to implement evidence based interventions from within the health visitor team's resources or whether to make a decision to request assistance from a range of other local agencies and professionals who are available to work with families.

Shared decision making models, or frameworks, are used within a range of healthcare practice and create structure when health professionals are making decisions in partnership with patients.

Current research is beginning to identify the strengths of this in terms of increased patient satisfaction, patient engagement and improved patient outcomes (Adams & Grieder 2014). However, despite these positive results there is little evidence of shared decision making frameworks being applied within health visiting practice. In order to explore this area of practice further a research study was designed.

Aim and objectives

The overarching aim of the study was to explore:

'What processes support shared decision making when health visitors and parents are planning together to improve the wellbeing of babies and children – in the context of the Getting It Right For Every Child policy context'

This was achieved through exploring

- what was currently happening within health visitor/parent encounters when decision making was taking place and
- the perspectives of the health visitors and the parents after their encounters – in terms of their perceptions of the process and satisfaction with the final decision

Study Design

In order to address the aim and objectives a qualitative, descriptive research study was designed. This approach was taken due to the limited available published evidence in relation to health visitors sharing decision making when planning interventions with parents, and consequently a lack of understanding about the social structures, behaviours and cultures within this area of practice.

The study was divided into two phases. Phase 1 involved audio recording conversations between health visitor and parent dyads and then collecting each participant's perspective of their planning experience using a validated questionnaire. Phase 2 consisted of individual semi-structured interviews with health visitors and parents, asking them about their past experiences of planning interventions in relation to a baby's or child's wellbeing.

What is Shared Decision Making?

It is evident from the literature that shared decision making is viewed in a number of ways. For instance, there is a position supported by some academics and theorists, and cited in Siminoff and Step (2005), which identifies that the ideal shared decision making encounter is one based on normative decision making theory where two people, with equal power and the required knowledge and skills, come together to make a decision in a context where there is shared understanding of the purpose, the issue and the processes. Here all options are given equal and fair consideration and both parties have the capacity and capability to share their views, values and beliefs with each other about what should happen next. Some authors, whilst acknowledging the value of this concept, have expressed that all of these criteria are unlikely to be met in the real world of patient care (Montori *et al.* 2006). They have therefore chosen to

focus on finding ways of achieving the best possible outcomes for patients which, although still based on shared decision making theory, take a more descriptive, realistic approach. Authors, such as Charles et al (1997) and Charavel et al (2001), have focused on creating resources such as models, frameworks, decision aids, check lists and training packages which aim to improve the interactions between both parties, along with evaluations to determine the impact of the tools in practice (Gafni *et al.* 1998, Charles *et al.* 2003, Edwards & Elwyn 2006, Edwards & Elwyn 2009).

A number of Elwyn's shared decision making research studies have taken place within Primary Care where General Medical Practitioners (GPs) have been supporting patients with long term conditions, where partnerships have built up over years between patients and the GP, and where there is an acknowledgement that long term relationships can have a direct impact on the quality of the shared decision making (Elwyn *et al.* 1999). Health visitors work within a similar context as they often establish relationships with parents and carers of children in their caseloads over a number of years; and it was because of this similarity in practice that Elwyn's Framework was chosen to inform the study.

Ethical considerations

Ethical approval was given by University of Stirling, School of Health Sciences, Ethics Committee and the NHS Research Ethics Service, and permission was given to collect data in two health board areas in Scotland. Both areas had mixed demographics in relation to affluence and deprivation but one area was predominantly rural and the other predominantly urban. The researcher was not employed to work in either health board area.

Data collection

Health visitors were recruited by the researcher visiting each area, meeting with health visitors in small groups to generate interest in the study, distributing literature explaining the purpose of the study, answering questions, and then waiting for offers of participation.

Sample

The sampling approach for health visitors was purposive, with the intention of creating variation across the health visitors' caseloads. There was an ambition to ensure that, between them, the health visitor participants covered a range of caseloads, from those taken from predominantly affluent areas to those within more deprived areas. This approach was adopted in case it became apparent during the study that the demographics within caseloads were influencing the data. However, in reality all health visitors who participated described their caseloads as 'mixed' and there was no indication of any need to be selective about which health visitors to invite to participate.

The health visitors who volunteered to participate in Phase 1 had been able to recruit a parent from their caseload who was in the process of making a decision with them, and was willing to consent to participate in the study. The health visitors who volunteered to participate in Phase 2 of the study felt that they had the ability to reflect on an experience of supporting at least one parent to make a decision within the previous six months. The parents who were recruited to participate in Phase 2 had been informed about the study from their health visitor on the basis that they had made a decision about an intervention on behalf of their baby or child, in partnership with their health visitor, within the last six months, and were willing to talk about their experience.

Methods

In Phase 1 data was collected by audio recording two health visitor: parent decision making conversations, in the absence of the researcher, where decisions around planning for a baby or child were being made as part of usual care. Following the discussion each of the four participants were asked to complete an individual questionnaire based on Elwyn's OPTIONS questionnaires (Elwyn *et al.* 2013) in order to identify their perception of the experience. These questionnaires have been validated for quantitative studies in order to establish the extent to which shared decision making has taken place within encounters; however, the purpose of the questionnaire in this qualitative study was to collect the participants' interpretations of their experiences.

The nine health visitors and nine parents who offered to participate in individual semi-structured interviews, were audio recorded recalling an experience of planning around the needs of a baby or child. Each of the two semi-structured interview schedules (one designed for the health visitor and one designed for the parent) were structured around Elwyn's Shared Decision Making Framework in order to inform if, and how, any aspects of shared decision making were evident. The interviews also included open-ended questions to provide further insight into the experiences of participants when deciding which interventions to access for the baby or child.

Analysis

The twenty recordings, two from Phase 1 and eighteen from Phase 2, were transcribed *verbatim* and this data was added to the responses to the questions from the four OPTIONS questionnaires completed during Phase 1. The framework analysis method was applied to all of the data, as described by the National Centre for Social Research (Ritchie *et al.* 2014) and with the support of

NVivo 10. The analysis generated 267 different labels which were then assigned to twelve themes.

Each of these themes were presented on a framework matrix and linked directly to the corresponding data from the twenty recordings and the four questionnaire responses.

Results

In addition to the three identified themes of 'Choice Talk', 'Options Talk' and 'Decision Talk' from Elwyn's Framework, additional themes became evident. Of these, two themes stood out as being particularly important, and some of the related findings are reported here along with Elwyn's three themes.

The first additional theme, 'Identifying the Issue', was important because the quality of the discussions around the issue, in relation to the child's wellbeing, and the level of shared understanding of the importance of the issue between the health visitor and the parent, had an impact on what happened next. The second theme 'Relationships' was chosen because this theme threaded its way through every aspect of each of the other themes.

Identifying the Issue

Wood's (2013) definition of an 'issue' was applied during the interviews with the parents and health visitors, which, in the context of the Child Health Programme for Scotland, is described as anything which gets in the way of a baby's, or child's, wellbeing.

The findings indicated that where the issue was clearly defined by the health visitor or the parent, and was related to the child, there was evidence of decision making processes and a focus on resolving the issue. However, in cases where the issue wasn't clearly defined, discussions between the health visitor and parent were less focused and there was less evidence of decision making and related planning.

In addition, even if there was agreement about what the issue was, there was not always a shared understanding or agreement between the health visitor and the parent about the importance of the issue to the baby or child's wellbeing. In three examples the health visitors reported having differing views to the parents around a child's speech or behaviour, and in each of these cases there was reluctance of parents to participate in other services. In two of these cases the parents, who had unmet needs in their own lives, did not appear to have the insight to understand the extent to which their personal issues, and substance misuse, impacted on their baby or child's wellbeing.

What hindered discussions and shared understanding around the issue?

The challenges of working with parents with a range of intellectual abilities (including parents with learning disabilities) were identified, along with relating to parents from different cultures, the need to use an interpreter, and parents' lack of understanding about child development. There were occasions when the complexity of family life got in the way of clarity about what issue needed to be addressed first, as there were multiple issues and the parents' priorities were prone to change with each health visitor contact.

Their household was quite busy, so we had the two little girls, one's three and one's one and a half, both running about in the living room..... the television was on so it was quite a kind of noisy visit.....they were throwing a lot of issues at me! So, you know, 'she's not sleeping all night and her behaviour's terrible and she's not eating properly' and this and that, so there was a lot of different things

(Phase 2 HV 5)

Three health visitors described how they were unsure about how to explain 'wellbeing' to parents in language which the parents could understand – particularly when the discussion related to babies.

What supported discussions around the issue?

The use of evidence based tools and resources to assess the child's cognitive development supported health visitor findings and were found to be helpful; not only as an evidence base for their own decision making but also to support discussions with parents. However, the availability of training in the use of evidence based tools and resources varied amongst health visitors at the time of the study – although what was available appeared to make a valuable contribution to discussions and negotiations when sharing decision making with parents.

Evidence based parenting programmes and approaches, which reinforced the need for parents to understand child development in order to understand their child's behaviour in a more realistic way, were found to be helpful. Examples where managers, and professionals from other agencies, clearly understood the complexity of what the health visitors were facing, and the time it took to work alongside parents to support parental understanding, were also identified as supportive.

Elwyn's three themes

Elwyn's Shared Decision Making Framework identifies three key stages within the process (Elwyn *et al.* 2012). The first stage is where the professional identifies the opportunity to make a **choice**, the second stage takes place when **options** are identified and then once each partner in the process has put forward their views the third stage, a **decision**, is made in a collaborative way which takes both the professional's view and the patient's views and context into consideration – or else there is an

agreement to defer a decision at this point.

Choice Talk

In cases where choices were offered, and particularly if the health visitor had identified the issue during a child's cognitive development assessment, although the choice of 'doing nothing' was never offered to a parent, sometimes choice was given as to whether to delay requests for assistance to implement an intervention or not. This was to enable other strategies to be tried within the family first; however, one health visitor recognised that she only offered this choice if, in her judgement, she believed the family would follow this through.

There was evidence of choice being given to parents about which issue to address first if multiple issues were presented; however, in general terms there was only limited evidence which indicated that health visitors were explaining that there was a choice and what the choice was. It could be argued that this was appropriate because for choice to have been given between one intervention and another there would have needed to have been at least two options of interventions available – both or all with supporting evidence that they could improve the wellbeing of the baby or child. However, within the study no example was ever given where two or more options of evidence based interventions were available to address an issue and choice was offered between them. Choices which were offered to parents related more to decisions about timescales of implementing interventions.

What was interesting was that health visitors believed they were giving choice, and parents believed that they were being offered choice, when there was little evidence that this was being offered in a meaningful way. This finding was also consistent across all of the responses to Elwyn's OPTIONS questionnaires in Phase 1.

Option Talk

To be able to articulate what the options were for the parents, interviews revealed that the health visitors believed it was important that they were clear in their own minds what participation in the intervention would mean for the parents. From the nine health visitor interviews in Phase 2 it was evident that if the option of an intervention was to be delivered by another agency, the health visitors wanted to know about the appropriateness of the service, its evidence base, how to request assistance, and to know what attendance would mean for the parents, in order to encourage their participation. The health visitors also wanted to know what processes would be used by the agency for contacting the parents after the request for assistance had been made so that they could explain this to the parents beforehand.

Some of the challenges sometimes is as health visitors not absolutely 100% knowing what the service is able to offer or how it's actually going to pan out

(Phase 2 HV 5)

Seven of the health visitors also wanted to know how the agency would make contact with the health visitor to provide feedback about the child's and parent's progress and what the agency would do if the parent failed to attend the service.

INT:....the parenting programme,

HV: No you don't hear backand I had a child on the (Child Protection) Register and I didn't know whether they were attending or not.

(Phase 2 HV7)

Three parents identified that they also valued having information about other services beforehand

*It's a shame that the health visitors don't have some kind of leaflet to give out,
that would've been good*

(Phase 2 Parent 2)

In two cases where communication with other services was effective, the processes were described in a way which was streamlined, easy to explain to the parents, and less time consuming for the health visitor.

Data from two of the interviews included positive remarks in relation to creating 'Teams around the Child', based on 'Networks of Support' which consisted of a group of professionals, and the parents, meeting to support decision making around a child. They were found to be productive ways of informing parents directly what was on offer and of supporting them with their decision making during planning processes.

I think that processes have worked, you know, the liaison with everybody that's involved, you know, we have a team around the child, the parents can come to the meetings and so they've seen all the professionals who deal with the child in the community in the one place, and I think the message that that gives the parents as well is that nobody's taking decisions in a vacuum, that everybody talks to one another and they can come and talk to everybody at the one time

(Phase 2 HV3)

One health visitor spoke about the positive value she felt of having other members of the health visiting team, such as Staff Nurses and Nursery Nurses, available to implement interventions with parents. Another health visitor spoke about situations where there were no options, either from within their own team or within the community, suitable for the family, and the difficulties this created.

it eventually just lands back with usthen we've got to contain them or do something with them which can be quite tricky

(Phase 2 HV 1)

Decision Talk

In the study there were examples of deep and meaningful conversations between health visitors and parents around what they could expect from other services, and evidence that the health visitor had explored how the parents had felt about the decision to request assistance, participate in groups, or access a different service.

we talked about different situations, different children, you know, and really about gaining confidence that she'd maybe lost a bit of confidence about parenting

(Phase 2 HV 8)

There were, however, two examples which indicated that this level of discussion had only taken place *after* a parent had not taken their child to another service, as a way of establishing what the problem was and exploring what could be done to increase the likelihood of the family's future participation. Three health visitors indicated their sensitivity to the context in which parents were living and described their own range of feelings in relation to options available. For instance, two health visitors spoke about delaying before addressing one of the issues, as they recognised that the conversations could potentially be overwhelming for the parents at that time in their lives

so it was a very softly, softly saying 'I understand as much as I can where you are.....'

(Phase 2 HV 3)

Relationships

The Solihull Approach is a theoretical model which is used widely across health visiting practice in the United Kingdom (Solihull Approach 2013). It was developed by health visitors and clinical psychologists and is based on established theories from psychology and child psychotherapy.

The model takes into consideration three elements of relationships which overlap in practice; they are containment; reciprocity; and behaviour management. The ways in which these components manifested themselves within the health visitor and parent relationships was used as another layer of structure when analysing the data from both Phases 1 & 2.

Containment relates to a person's ability to receive and understand the emotional communication from another person without being overwhelmed by it (Bion 1959). In order to emotionally contain others (such as a baby or toddler) and not be overwhelmed, the parent themselves needs to be contained. There was evidence that all health visitors were containing parents (to some extent) in relation to the parents' own personal issues, feelings, and emotions, and there were descriptions from parents which reinforced the level of trusting relationships which had consequently built up between them and their health visitor.

Reciprocity was first described by Brazelton (Lewis & Rosenblum 1974) in the context of adult: infant relationships; however, it can also be used to describe the interaction which takes place in all relationships. Reciprocity describes the initiation, regulation, and termination of an interaction where both parties are actively involved in the process. There was evidence of reciprocity in the two health visitor: parent dyads, in Phase 1, where dialogue occurred back and forth and humour was used, and there was evidence of efforts to create equality in power by the health visitor through the language and tone of voice each used.

Behaviour management is based on learning theory and behaviourism (Skinner 1988) and refers to the attention and reward behaviours which one person can use to influence the behaviour of another. Behaviour management is less likely to be as effective if containment and reciprocity

are lacking in a relationship so it was informative that, in the study, there was evidence of health visitors providing direction around behaviour management, and ideas being accepted and tried by parents.

In addition to evidence of strong trusting relationships between the health visitors and parents, there were indications that other family relationships were important too, and could potentially influence decision making about the child, in addition to those decisions made between health visitors and parents; predominantly (but not exclusively) the mother.

It became apparent that although health visitors were often aware of internal disputes in families between parents, grandparents and other family members, links between the impact of these relationships on decision making were sometimes missed – which in one case created a negative outcome.

their speech was delayed, their eye contact – there was concerns about their development.

We at that point referred these children to Pre 5 Assessment Team and mum agreed with the referral, but when we went to the referral meeting, dad arrived and at that point mum told everybody at the meeting that she hadn't consented to the referral and that she'd felt quite pressured into it

(Phase 2 HV8)

Although there were examples of health visitors endeavouring to meet fathers and grandparents this was not common practice and it was rare for them to be actively included in decision making.

The Solihull Approach is useful for health visitors to support analysis of their interactions with parents and children and it ensures that they are using well established theories from psychology and psychotherapy within their practice (Douglas 2010) . There was evidence that, where health visitors had been trained in using this model, it gave them the language to

describe what was happening and insight into why they needed clinical supervision to support them in their practice.

Discussion

In this study there was an indication that identifying the issue which needed to be addressed, in order to improve the wellbeing of the child in a clear understandable, shared way, was a prerequisite for shared decision making, but it did not always appear to take place. It is not unusual for health visitors, in other areas of their practice, to need to come to a consensus with a parent around the details of what requires addressing, as this structured approach is used when applying behaviour management strategies, motivational interviewing techniques and health behaviour change models. A consistent theme when implementing these approaches, is that it is the norm to be applying frameworks or models to create structure to the conversations. This raises the possibility that development of a shared decision making framework, which includes the need to be clear about the issue, could support health visitor practice when planning in partnership with parents. A framework could also help the health visitors to determine whether there are a range of options available in the first place, and then whether the options are physically and psychologically accessible to parents; also whether the systems and processes surrounding the interventions are clear and understood by health visitors, and if there are enough options to justify a choice.

The health visitors' and parents' perceptions were that more choice was being given by the health visitor than was actually the case, and that more choice was being received by the parent than was evident from the conversations; this finding is consistent with Towle et al's (2006) study. This raises a question as to why this should be, and the potential implications of parents believing that they are being given a choice between options when this is not the case. Health visitors are educated to empower parents and to support them to make choices where they can

as they are aware that parents have a significant role in the care of their children and are more likely to participate in services if they have actively been involved in the decision making processes. The advantages of health visitors reframing the conversation in order to imply a choice is clear; however, if parents believe that they have been given more choice than is actually available, there is the risk that, through lack of clarity, they misunderstand the need for implementing any intervention, and choose to do nothing. Agreement about the impact of the issue on the child's wellbeing, the role of the intervention, and clarity around the importance of participating, may however reduce this misunderstanding.

Deep and meaningful conversations, with a sensitive and responsive approach, which supports shared decision making to take place requires health visitors to constantly reflect on their behaviours and continually increase their self-awareness as promoted by programmes such as Compassionate Connections (NHS Education Scotland 2013). Dewar and Nolan (2013) promote the concept that nurses need to be 'curious', 'courageous', and 'connecting with people' at an emotional level in order to provide patients with the individual support they need within a personalised service.

In order to build on health visiting planning skills and working collaboratively with parents, an understanding about decision making theories has the potential to support the process (Thompson *et al.* 2013). If promoted in this context this would enable health visitors to differentiate between when choice and shared decision making is appropriate, and when other psychological and practical responses are more applicable. Understanding decision making theories also enables health visitors to support parents with their role in the shared decision making processes.

As part of the assessment of the child and their family, evidence from the study would indicate that children benefit if health visitors not only know about the Network of Support which is available **for** a child, but also know about the Network of Influence which exists **around** the

child. This knowledge will increase the health visitors' understanding about family dynamics and is consistent with the scope of the GIRFEC National Practice Model. Increased understanding about the context within which a child lives will potentially improve the quality of shared decision making, as appropriate adults will be able to be included in the process; which in turn may increase parental acceptability of interventions designed to improve the wellbeing of their baby or child.

Conclusion

In summary, despite evidence of strong, trusting relationships between parents and health visitors, this study has shown that where supportive processes were absent shared decision making was challenging. For shared decision making to be effective consistently there needed to be structure to the conversations; clarification, and agreement about the issue which was having an impact on the wellbeing of the child; accessible and acceptable interventions available; deep meaningful conversations to enable increased understanding about the dynamics within relationships in the families; and positive working relationships between health visitors and other professionals, and agencies, which were available to provide interventions for families (Figure 1).

Limitations of the study

There were limitations to this study, for instance the sample size was small, particularly for Phase 1. The health visitors and parents in Phase 1 were also aware of the purpose of the study which may have influenced their conversations. It was evident throughout that the parents in Phase 2 had a positive relationship with their health visitor which could have influenced the findings. Despite an open invitation to involve fathers in addition to mothers, only one father volunteered and then, for logistical reasons, he was unable to meet with the researcher. This may have detracted from the

scope of the findings. It is acknowledged that retrospective reporting is always going to be influenced by the passage of time and the participants' abilities to recall; however, in this study the perception of the decision making experience was an important factor.

Relevance to clinical practice

Health visitors are aware that planning interventions in partnership with parents can be complex. These findings have identified the value of using a shared decision making framework to structure planning in collaboration with parents. The findings have also highlighted a number of areas where there are opportunities for improving the systems and processes within organisations, and across partner agencies, where health visitors work.

There is every indication that, as with other areas of health practitioner practice, if shared decision making is supported in health visitor practice this will increase parental participation in decision making, and improve wellbeing outcomes for babies and children.

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Figure 1

Processes which were identified as supporting shared decision making when health visitors were planning in collaboration with parents:

1. A shared understanding, between the health visitor and the parent, of what the 'issue' was and how it related to the child's wellbeing
2. Evidence based interventions which were physically and psychologically accessible for the family - if required
3. Deep, meaningful conversations using sensitive and responsive approaches
4. Positive trusting relationships between health visitors and
 - a. parents
 - b. other significant family members and
 - c. other professionals