
Paper:

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Do targeted child health promotion services meet the needs of the most disadvantaged? A qualitative study of the views of health visitors working in inner-city and urban areas on child health promotion policy implementation in England.

ABSTRACT

Aim: To explore health visitors' views on the effects of policy change on the services they offer to pre-school children in areas of high health inequalities in England.
Background: Child health promotion services are offered throughout the world in order to maintain and improve children's health. It is not known how the policy shift to a more overtly targeted service, which has occurred in some countries, has affected child health promotion practice in areas of deprivation.
Methods: An in-depth telephone interview study was conducted between October 2006 and January 2007. All participants (n = 25) were registered health visitors who had taken part in a 2005 National Survey of Child Health Promotion Practice and were delivering health promotion services to pre-school children in inner-city and urban areas.
Results: Despite high levels of need, some children who would have benefited from an enhanced health visiting service were offered only the core programme. Local interpretation of national policy is a key factor in determining the level of service offered, and the extent of targeting.
Conclusion: This study illustrates the importance of exploring the effects of national policy change from the perspective of practitioners, in order to identify unintended outcomes. Reductions in the core child health promotion programme can lead to difficulties in monitoring and improving children's health outcomes in areas of deprivation.

Keywords: child health promotion, health policy, health visiting, preventive health services, public health nursing

What is already known about this topic

A national policy shift in England has resulted in a more highly targeted child health promotion programme
Policy reform does not inevitably lead to changes in health professionals' practice
The child health promotion programme has been inconsistently implemented in England

What this paper adds

Factors at the local organisational level contribute to diversity in service delivery
Staffing and resource issues can influence the threshold at which children are targeted
Health visitors experience difficulties in maintaining an ongoing relationship with children and families without routine health promotion contacts

Implications for policy and practice

It is important to evaluate whether policy reform has met its implicit objectives
Exploring practitioners' views can give insights into how policy is implemented
The role of local health organisations in modifying national policy merits further research

Introduction

The child health promotion programme is the primary means by which preventive health care is delivered to children in England (Department of Health [DH]/DSCF 2009), with health visitors (specialist public health nurses) taking a lead role in ensuring that children's health and developmental needs are met (DH 2004, 2008). The National Service Framework for Children, Young People and Maternity Services (DH 2004) included a national Child Health Promotion Programme as part of a ten year strategy to improve the health and wellbeing of children. The national policy was to be put into action by local health organisations, which in England are called primary care trusts (PCTS) (Pollock 2005). The intention in defining a core child health promotion programme was to set a standard for children's preventive health services, which could be extended for children with complex health needs (DH 2004).

National Service Frameworks are intended to be a 'blueprint' for the way services are provided in the National Health Service (Talbot-Smith & Pollock, 2006). However, analysts of health policy have questioned the efficacy of national guidelines in bringing about change in practice (Hudson & Lowe 2004). Renfrew *et al.* (2008) suggest that successful policy implementation relies upon collaboration between a range of people, including practitioners, service commissioners and service users. The quantitative arm of this study (Condon 2008) provided evidence that implementation of child health promotion policy reform has been inconsistent within the UK. This nested qualitative study examines the implementation of this policy from the perspective of health visitors delivering the programme in areas of high health needs.

Background

There is little standardisation of programmes of well-child care between developed countries, and programmes vary in terms of which health professional delivers the programme, the extent to which preventive child health services are integrated with curative services, and whether the programme focuses on the individual child or takes a community approach (Kuo *et al*. 2006). It has been suggested that these differences reflect national assumptions about what well-child care consists of and how it should be delivered (Court 1976, Mayall 1996). In Australia and England national programmes of well-child care have been influenced by 'landmark reports' which have questioned the efficiency of routine surveillance and have instead proposed increased targeting of child health promotion to those with the greatest health needs (Kuo *et al*. 2006). This represents a radical shift away from a traditional focus within community preventive services on children's universal developmental needs (Bradbury-Jones & Bates 2005).

Increased targeting of child health promotion has taken place against a background of widespread debate regarding the desirable extent of universal services. Under the New Labour government the direction of health policy has been towards redressing health inequalities (Wanless 2004). It has been recognised that within a social gradient of health which is linked to lifestyle choices, universal interventions can increase health inequalities (Kelly *et al*. 2007). This has resulted in a new impetus to direct services at those experiencing the greatest societal disadvantage and the poorest health status (Marmot 2004). 'Every Child Matters' (DH 2003), the policy initiative driving the development of services for children, also advocates directing health promotion to the most deprived communities. Increasingly new child health promotion initiatives in community nursing in the United Kingdom, such as the Family Nurse Partnership (Olds 2006) and Starting Well (Wright *et al.* 2009), are targeted to children within families identified as at risk of social exclusion (Cabinet Office 2006, Cabinet Office 2007).

The reform of child health promotion within England has rarely been examined from a policy process perspective. The policy process is a series of consecutive stages and functions which act as a theoretical model for developing knowledge about policy generation and implementation (Hudson and Lowe 2004). Green and Thorogood (1998) present a clear and accessible policy process framework, which is used here to explore child health promotion policy reform in England. It can be seen from Box 1 that when a problem comes to the forefront of government and public attention (Stage 1), legitimate groups propose solutions (Stage 2). Concern about the evidence-base for child health surveillance arose from the 1970s (Hutchison 1973, Bain 1974, Hendrickse 1982) and led to the formation of a joint working party to address the identified problem. The ensuing report (Hall 1989) proposed a core programme of surveillance consisting of activities for which scientific justification could be found. The necessity for clinical evidence was the dominant consideration in defining the level of preventive health service for children, subordinating other potentially influential factors such as considerations of social need, or even children's rights.

The medical profession is unique among health professions in its ability to influence national health policy development (Elston 1991, Buse *et al.* 2005). The reform of child health promotion has been successful in rationalising practice, to the extent that there is now an acknowledged national programme for England (DH 2004); this means that the previous lack of medical consensus has been replaced by clarity about the programme's content. However, there has been little attempt to evaluate the policy change either from the perspective of practitioners or from service users. Throughout this process the views of child health practitioners such as health visitors have largely remained unexplored, despite their central role in delivering the programme. From a feminist perspective Nielsen (1990) suggests that the views of less powerful actors should not be neglected because, as a result of their less elevated position, they may have a more complete view of social reality. In order to gain a fuller picture of the implementation and outcomes of this policy reform it is important to examine the views of the practitioners charged with putting it into practice.

The national survey which forms the quantitative arm of this study (Condon 2008) provided evidence that local practice does not consistently reflect the recommendations of national policy. This nested qualitative study is designed to enable and facilitate further exploration of questions raised by the national survey, which could not be answered by quantitative means. These questions include the factors influencing the structure and content of the programme delivered, how targeting is implemented, and the impact of reduced universal contacts on related services offered by health visitors, such as child protection. Following Green and Thorogood's (1998) theoretical policy process framework, this qualitative study aims to explore how policy has been put into practice at different levels, and whether the child health promotion policy reform has met its implicit objectives (Stages 3 and 4). Mixed methods are noted for their ability to provide a highly nuanced picture of the phenomenon under investigation, with the potential to influence policy and practice (Dixon-Woods *et al.* 2005). The qualitative study contributes to a contextual understanding of child health promotion policy reform from the perspective of practitioners.

Aims

The study aim is to explore health visitors' views on the effects of policy change on the services they offer to pre-school children in areas of high health inequalities in England. The focus is on practice in areas of high need, in order to examine whether the increasingly targeted programme has benefited the most disadvantaged children.

Design

The nested interview study forms the qualitative arm of a mixed methods study designed to explore child health promotion policy implementation from the perspective of health visitors.

Participants

Participants were recruited from those who responded to the national survey in 2005 (Condon 2008). Sampling was purposive, with health visitors selected who were delivering the child health promotion programme in urban and inner cities areas of high health inequalities. A letter or email was sent to all survey participants who had provided the researcher with contact details (see Figure 1), inviting those who met the inclusion criteria to take part in a telephone interview. Sufficient numbers were recruited from this one invitation, as samples in qualitative research must be relatively small in order to do justice to the richness of the data, and make intensive analysis feasible (Ritchie *et al.* 2003).

Data collection

Semi-structured telephone interviews were carried out between October 2006 and January 2007. A topic guide was utilised which was devised from the survey findings, the researcher's knowledge and experience and known current policy concerns (see Box 2). Interview questions were open-ended and prompts were used to stimulate response where necessary. This method was successful in keeping the focus on the topic but allowing new ideas to be generated which had not been anticipated by the researcher. Most interviews lasted over one hour (range 30-90 minutes). All interviews were audiotaped and transcribed.

Ethical considerations

The study was approved by the appropriate health service and university ethics committees. At the request of the health service ethics committee, agreement was sought and obtained from the Nursing and Midwifery Council for the researcher to use the contact details voluntarily provided by survey participants. Permission to audiotape the interview, and directly quote from the transcript was sought at the start of the telephone interview. Participants were informed that names would not be attached to transcripts and that names would be changed when reporting findings to ensure confidentiality.

Data analysis

Ritchie & Spencer's (1994) qualitative analysis framework was used to sort data by a process of iterative analytical summary and synthesis. The initial thematic categories were identified by the lead researcher and an independent fellow health visitor and researcher, following reading and re-reading of the verbatim transcripts. Resulting themes were then reviewed and consensus achieved, before codes were developed and the data sorted to focus on each conceptual subject area in turn. Mason (1994) describes this traditional thematic approach, as the most familiar technique used by qualitative researchers to engage with the data systematically. A consciously constructivist approach was taken in interpreting the data, which acknowledged that data and analysis are created from the shared experience of researcher and participants (Charmaz 2002).

Validity and reliability

A survey sample is known to be an effective sampling frame for a qualitative study as it is likely to provide comprehensiveness, diversity and lack of bias (Ritchie *et al*. 2003). A qualitative sample does not need to be representative of the wider study population for the study to be considered valid, but there should be evidence of diversity within the sample (Barbour 2008). Here participants were interviewed from different geographical areas of England and health visitors with contrasting ideas about policy reform were included. Methodological rigour was sought by utilising a systematic and transparent process of data analysis, with a clear audit trail from the raw data to the conceptual framework.

Results

All interviewees were practicing health visitors, but some had additional or specialised roles (see table 1). One fifth of interviewees had caseloads of 500 or more children, putting them in the top 20% highest health visitor caseloads in England (Family and Parenting Institute 2009).

From the data a central theme emerged of the child health promotion programme and how national and local policy impact upon service delivery. Subsidiary to this over-arching theme were three themes relating to the factors which participants identified as influencing the way in which they deliver services to children and families. These were: meeting clients' needs, organisational change and resource allocation. In this paper are presented the findings which relate to the central theme of how health visitors working in areas of high health needs have translated policy into practice. The subsidiary themes inform the account, providing an underpinning for the analysis of the relationship between policy and practice. The theme of meeting clients' needs services is particularly dominant in dictating the form of services provided for children with high health needs. Results are presented in three sections which relate pragmatically to delivery of the child health promotion programme:

- What child health promotion programme was delivered and why

- Who gets a targeted service?
- The implications of policy reform for children with high health needs

What child health promotion programme was delivered and why

Health visitors described themselves as delivering a variety of Child Health Promotion Programmes. These ranged from a sole new birth visit, to a routine two year review for all children, and in one case a universal three year face-to-face contact. A curious picture was therefore drawn of variety in practice, with some health visitors offering more universal contacts than recommended in the National Service Framework, and some less. Almost all interviewees stated that the main reason for delivering a particular programme was that this was prescribed in local policy. Examples of the most commonly cited reasons for local policy taking its current form are given in Box 3. The quotations do not illustrate regional trends in child health promotion policy (no regional trends emerged either from the survey or the interview study), but have been selected to illustrate dominant influencing factors. All names of participants have been changed.

It can be seen from Box 3 that local child health promotion policy is not necessarily fixed but can be modified according to changing circumstances. Initial influences on local policy formation were national policy, which could be adopted in full or in part according to local influences (Box 3, 3.1, 3.2). Organisational factors were a major influence on the form of local health policy, for instance when newly amalgamated Trusts revised their diverse child health promotion programmes (3.3). More than one interviewee described the number of mandatory universal contacts stipulated in local policy as being reduced as a cost-cutting measure (3.4). By contrast, one area was planning to reinstate a universal health visitor contact no longer contained in national policy because it was considered that a reduction in the programme had led to more hitherto unrecognised health problems being identified only on school entry (3.5). Thus, modification of policy could result from local opinion about the optimum service required to meet children's preventive health needs, as well as pragmatic issues of service organisation and costs.

Practitioners ultimately had the ability to decide what level of child health promotion programme to deliver. A minority of interviewees deliberately chose to contravene local policy by providing a more extensive universal programme than required. These health visitors were notable in having freedom to administer their own caseload without much managerial control, and in also having the capacity to voluntarily maintain an increased workload. One interviewee said:

> 'I like to offer a full universal surveillance and target extra the ones that are problems, because if you don't see them you don't know if they've got problems anyway, do you?'
> Siobhan, North East

In this way health visitors could ameliorate the effects of a programme which they did not consider adequate to meet the health promotion needs of the children they encountered. However, the majority of interviewees described themselves as unable to contemplate delivering more than the minimum required, as a result of staff shortages and pressure of work. A Sure Start health visitor reported that she was loaned back to the local Trust on a regular basis to assist over-worked mainstream health visitors in their universal work with children and families. She quoted her Sure Start manager as saying, 'How can you possibly start providing add-on services, when you can't even provide the universal service?' (Chris, South West).

Who gets a targeted service?

As stated in national policy (DH 2004) an assessment at birth forms the basis of deciding which families have significant health needs which merit targeting. Newly qualified health visitors were most likely to present assessment as a logical and relatively uncomplicated procedure. More experienced health visitors often emphasised the universality of family health needs, irrespective of socio-economic status. Taking this wider perspective of health need, some health visitors considered that families who would not merit targeting using a high-threshold assessment procedure, could have a short-term need for enhanced services, for instance due to feeding or behavioural problems (see Box 4, 4.1). Under a strict system of prioritising the delivery of services to the most socio-economically disadvantaged, many interviewees described such common and ubiquitous needs as frequently remaining unmet, despite being linked to national public health improvement targets.

Many health visitors referred to the difficulty of assessing need at an early stage of their involvement with a family. It was felt by many that health needs assessment questions were rarely answered honestly, especially at a first contact. Parents with severe problems were considered least likely to be explicit about their needs. Several health visitors described assessment questions as very stark (being concerned with such subjects as substance misuse, domestic violence and parents' own childhood experiences) and therefore potentially alienating:

> 'Often there's a very poor background to the mums, they've been in care themselves, they've had poor upbringings themselves, there's been domestic violence, all that kind of problem which actually is very difficult to bring yourself out of…So people are very angry sometimes…they don't want any interference in their lives.'
> Ruth, North West

Interviewees spoke of the paramount importance of attending first of all to the parents' own agenda. If health visitors tried to impose their own perceptions of health needs upon parents too early in the relationship, they risked being rejected by the family. A specialist health visitor commented that if a health visitor failed to engage with the family's agenda (for instance by completing assessment paperwork at a home visit) she would be unequivocally told that she was 'rubbish' and possibly denied future access to the home. A health visitor here describes the move from the parents' current concerns to the health needs of the child:

> ‘[It’s] getting alongside a family and talking about whatever that person wants to talk about, the issue of the day, whether it be the debt or whatever, and then… gradually you come to why little Joey is looking a bit unkempt…[and] there are cat fleas jumping around.’
> Chris, South West

Where health needs were universally high, it then became difficult for health visitors to assess which children to target amidst a multiplicity of need (see Box 4, 4.2). In some cases risk of harm to the child had become the criteria for targeting (4.3). Where Trusts had allocated greater numbers of health visitors to areas of multiple deprivation, this permitted targeting of all families with high health needs (4.4). Elsewhere, in circumstances of limited health visiting capacity, families who were judged to merit enhanced health visiting could not be targeted (4.5, 4.6). Two health visitors said that such families had to ‘fend for themselves’, which appeared to mean that instead of health visitors maintaining ongoing contact with the family over time in order to monitor the child’s health, the health visitor would wait for concerns to be raised by the parents or other agencies.

The implications of policy reform for children with high health needs

Many interviewees said that universal child health promotion is the key to gaining access to the family in a way which is generally acceptable to parents. One health visitor explained:

> ‘We are going into all families, there’s no stigma attached...there’s no association of, you’re a bad mother if your health visitor’s visiting, and I think that’s a huge thing. And just the ability to build up a relationship, that parents can feel they can approach you and ask for advice without being stigmatised.’
> Sam, North West

Where the core programme was minimal, it was considered that the onus was placed upon parents to bring health problems to the attention of relevant services. Interviewees raised concerns about the ability of all parents to do this. Firstly, some of the parents they encountered had difficulties in assessing the needs of their own children. This could be because they had low expectations of the child, or because they were not able to prioritise the needs of their children due to their own health and social problems. Secondly, where parents did identify problems they could lack knowledge of how to access services, particularly if they were new to the United Kingdom or spoke little English. Some health visitors considered that any parent could potentially fail to observe a health problem which might be readily apparent to a child health professional. The reliance upon parents to identify health problems could mean that children did not receive a service designed to meet their health needs.

A further issue raised by interviewees was that the distinction between a core and targeted well-child programme has the consequence of alerting parents to the level of service they are receiving (see Box 5). Many interviewees considered that it was right that parents should be aware that family health needs had been assessed as warranting targeting, and were comfortable in explaining this to parents (5.1, 5.4). However, a problem could arise when a health visitor had concerns about hidden problems within the family, such as domestic abuse, and wished to maintain an ongoing relationship with parents, in order to encourage disclosure and to monitor the wellbeing of the child (5.2). In some cases health visitors had previously used the routine contacts of the child health promotion programme in order to facilitate this kind of low-key support and surveillance, even adding in extra post-natal or developmental review visits where necessary (5.3).

The balance between universal and targeted child health promotion services impacted upon related aspects of the health visitor's role, such interprofessional liaison and safeguarding children. One health visitor explained that, as a consequence of a minimal core programme ('I'll do a new birth and I will probably never ever see that family again'), she did not know children on her caseload. When a request was made by secondary services to judge whether a child who had failed to attend a speech and language therapy appointment needed to be followed up, the health visitor had insufficient information upon which to base an opinion:

> 'Probably in the past you would have known them, you see, so you'd have gone, 'Oh, why isn't Aimee going? Let's see what's happening with her'. Whereas now it's, 'Oh well, I don't know who this Aimee is, nobody knows who she is'… you're kind of just dealing with little bits that you don't know enough about.'
> Karen, London

Other professionals were described as continuing to expect, and rely upon, health visitors having an ongoing relationship with children and families, including social workers, hospital staff, police and family doctors. Health visitors saw themselves as no longer able to fulfill this traditional health visiting role, which led to difficulties in interprofessional working and increased risk for children.

Discussion

A limitation of the study is that the self-selected sample included a preponderance of health visitors working in under-resourced areas who had unusually large caseloads. As a result these findings may present an overly negative picture of how increased targeting has been implemented in practice and the subsequent implications for children's health and wellbeing. Given the large difference between the numbers of health visitors who volunteered to participate and those who could potentially have participated, it can be inferred that respondents were not typical of the study population in being more ready to make their views known. In order to achieve internal validity a qualitative study should reflect reliably the views of study participants but does not aim to be representative of the views of the wider study population (Bowling 1997). A further limitation is that the findings must inevitably be interpreted in the light of the time and policy climate in which the study was carried out. Lewis and Ritchie (2003) consider that while qualitative social science research does not aim to achieve universal applicability, it can contribute to theory in the evaluation of social policy.

This interview study has given a valuable insight into the way in which national policy translates into practice, shedding light on the implementation and evaluation phases of the policy cycle (see Box 1). It supports the findings of the national child health promotion survey which showed that the move to a more targeted service has not uniformly resulted in changed practice at grass-roots level (Condon 2008). Following the health inequalities agenda (Graham and Kelly 2004, Wanless 2004) child health promotion policy has advocated targeting to those with the most complex health and social needs. This study suggests that thresholds for targeting can be set at a very high level, even in areas of socio-economic disadvantage. The gap between the intentions of policy and the reality of practice has meant that child health promotion policy reform has not consistently led to enhanced child health promotion services for those who potentially could have benefited most from a targeted service. This supports the view of Baggott (2004) that the 'core service' model of National Service Frameworks may serve to contribute to greater rationing as well as targeting of services.

Targeting of services is also related to the way national guidelines concerning child health promotion are implemented locally. While it is acknowledged that practitioners act as 'street-level bureaucrats' in deciding the extent of services (Lipsky 1980), the part played by local health organisations in interpreting health policy is less well recognised. This study makes clear that national policy modification can occur when PCTs make pragmatic decisions about what to deliver. In England the current system of implementation is reliant on local health organisations adopting national 'best practice' guidelines and allocating resources to deliver them. In the case of child health promotion, factors arising at PCT level have led to either a more comprehensive core programme being adopted, or, more commonly, children's preventive services being, in effect, rationed due to financial pressures or lack of health visitors. Without adequate investment in health visiting services, the health needs of many children and families remain unmet. As Wright *et al*. (2009) have pointed out, it is the interpretation of the national guidance, rather than the recommendations themselves, which most forcibly impact upon the service delivered.

The reform of preventive health services for children may have insufficiently taken into account the part played by the universal surveillance programme in providing an established and acceptable framework for monitoring children's health and wellbeing. A system of early assessment followed by a minimal core programme for the majority and targeting for those with greater need, does not fit well with the traditional nature of health visiting as a universal low-threshold service, which is well accepted by parents (Mayall 1986, Family and Parenting Institute 2007). An examination of service users' views carried out by Roche *et al.* (2005) has given early indications that mothers dislike being assessed at a first contact and resent being assigned a service according to their socio-economic standing. If health visiting is tied to a model of targeted intervention the acceptability of the service to parents is potentially jeopardised, as the delivery of child health promotion interventions requires the development of a therapeutic relationship with the family. It is particularly concerning when health visitors cannot act as a knowledge resource and point of contact for other agencies due to lack of familiarity with the children and families within their remit of care.

This study has served to reveal how child health promotion policy is implemented in practice, and to suggest the consequent impact upon the preventive health services offered by health visitors to children in areas of social deprivation. The findings from this study have implications for future policy direction in child health promotion both in England and abroad, in relation to the impact of increased targeting of health promotion services on child welfare. Although England has been one of the pioneers of a targeted programme of child health promotion, there has been re-examination in other countries of the extent of universal preventive health services provided by for children (Kuo *et al.* 2006). Some countries have chosen to continue to adopt a wider frame of reference in considering the worth of existing services than in the UK (de Winter *et al.* 1995, 1997, Bremberg 2000), while others lean towards an increasingly targeted programme (Oberklaid 2000). It is important that the way on which a targeted programme is implemented in practice is explored, as this has implications for the future development of child health promotion policy in England and in other countries.

Conclusion

New policy developments in England since this empirical study was carried out, have led to the partial restoration of a more comprehensive universal service within the renamed Healthy Child Programme (DH 2008). There is increased emphasis on the importance of the health visiting role in both leading and delivering the Healthy Child Programme (DH 2008, DH/DCSF 2009). Instead of just a minimum core programme, PCTs in England are asked to commission a universal core programme plus services to meet different levels of need; it is stated that variation of provision should be according to need and risks rather than according to local investment (DH 2008). These policy developments are welcomed in the light of the findings from this research, and have been welcomed by the health visiting profession (Adams & Newland 2008).

As Adams and Newland (2008) point out, national guidelines remain merely that, unless the means exist to put them into practice. In the case of the child health promotion programme there is a recognised gap between national policy and practice. This is linked to high levels of health needs among disadvantaged children and families, and the capacity of local community services to meet both universal and complex family health needs. This study has demonstrated the value of examining policy implementation from a social policy perspective, and the need to explore and monitor the outcomes and any unintended impacts of policy reform. To enable health visitors to provide a consistent national child health promotion service which meets the needs of children in England, it is vital that consideration is given to the realities of successful implementation at both the practitioner and local health organisation level.

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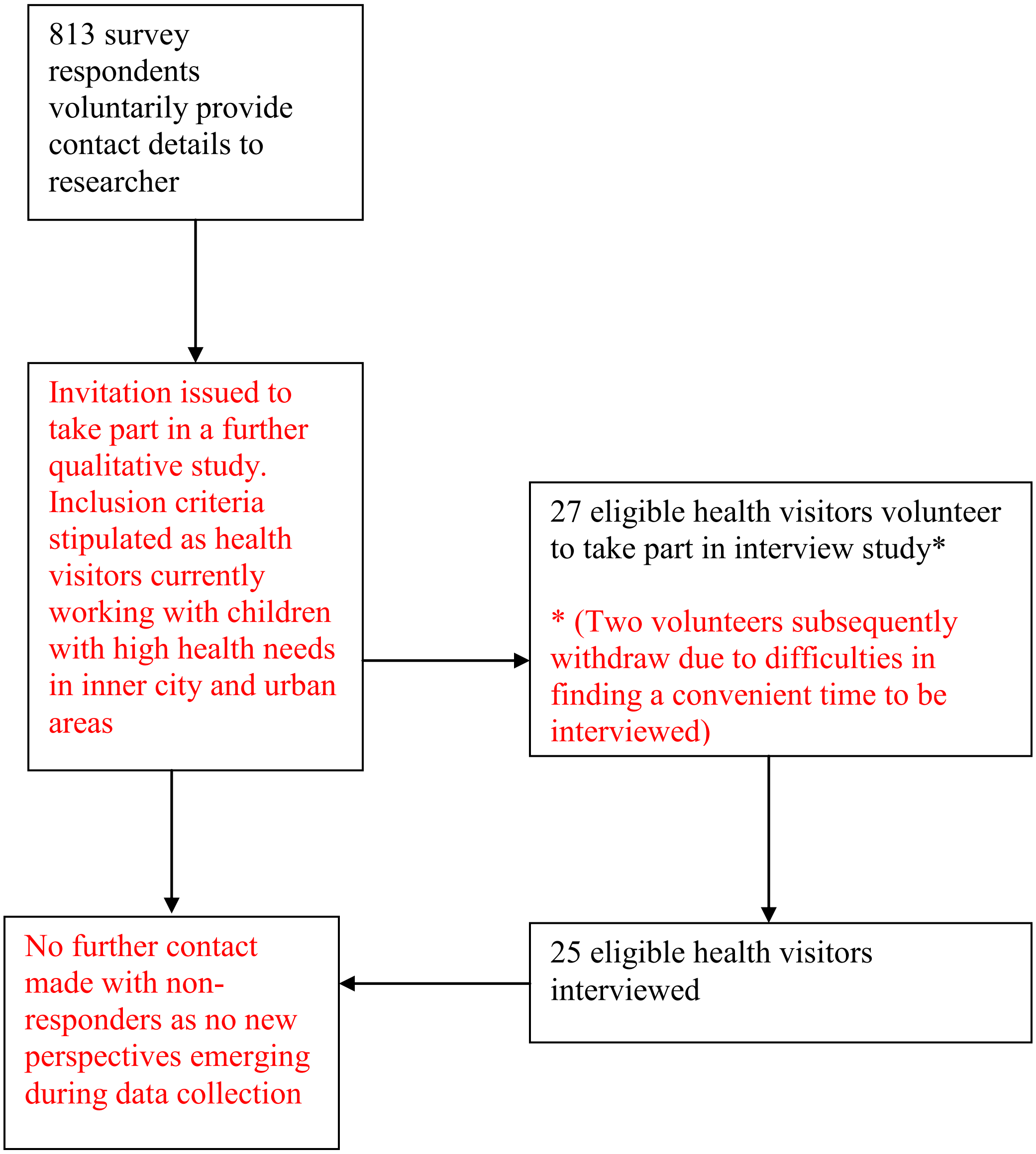
Box 1

Green and Thorogood’s (1998) policy process framework

1. Setting the agenda- how some social problems come to the fore of government and public attention and become the objects of policy making
2. Formation- how possible responses to these problems are identified and which groups in society have a legitimate role in forwarding solutions
3. Implementation- how policy initiatives are decided upon and responses by policy makers are put into practice at different levels
4. Evaluation- how the outcomes of policy are evaluated, whether it meets its implicit objectives and what unintended impacts it has had and upon whom

Figure 1: FLOW CHART OF RECRUITMENT TO INTERVIEW STUDY



813 survey respondents voluntarily provide contact details to researcher

Invitation issued to take part in a further qualitative study. Inclusion criteria stipulated as health visitors currently working with children with high health needs in inner city and urban areas

27 eligible health visitors volunteer to take part in interview study*

* (Two volunteers subsequently withdraw due to difficulties in finding a convenient time to be interviewed)

25 eligible health visitors interviewed

No further contact made with non-responders as no new perspectives emerging during data collection

Box 2

Topic guide for interviews

1. The health visitor's work

- clients and their health needs
- work done in the last week
- work done in partnership with other agencies
- the effects of organisational factors on work

2. The health visitor's child health promotion work

- content of child health promotion work
- universal services offered to pre-school children and their families
- targeted services offered to pre-school children and their families
- criteria for offering universal/targeted services

3. The revised child health promotion programme.

- revision of programme
- view of local programme delivered
- what preventive health services are offered to pre-school children
- influence of changes to the programme upon other aspects of health visiting work

4. Child health promotion policy

- reasons for policy change
- view of national policy
- relationship between local and national child health promotion policy
- relationship between policy and health visiting practice

5. The role of the health visitor

- role in providing a service for pre-school children and families
- the challenges for health visitors
- the opportunities for health visitors
- the health visitor's changing role

Table 1: Characteristics of interviewees

Age	average 48 years (range 33-59 years)
Sex	25 x women
Ethnicity	20 x white British 2 x white European 1 x black African 1 x Anglo-Indian 1 x refused to state ethnicity
Length of time qualified as a health visitor	average 18 years (range 1-33 years)
Geographical location in England	6 x South West 5 x South East 5 x Midlands 4 x London 3 x North West 2 x North East
Additional/specialised roles	3 x Sure Start health visitors[1] 3 x health visiting team leaders[2]

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[1] Sure Start is a government programme targeted to areas of high health inequalities.

[2] Team leaders manage the health visiting team and combine management with practice.

	2 x trades' union representatives 1 x specialist health visitor for gypsies and travellers

Box 3
Factors which influence local child health promotion policy

National policy
3.1: 'We've just gone through a complete modernisation process…which has been allied to the Children's NSF [National Service Framework], and we've completely changed the access times.'
Jeanette, Midlands

Local agreement
3.2: 'A little working group of people who were interested in the revision of it…got together and had a series of consultations, and that was brought back to the team [and they] said, 'Look this is what we're thinking of, what do you think? Is this helpful?'….there was a reasonable amount of liaison really.'
Beverley, North West

Service restructure
3.3: 'They've reconfigured into a big…PCT [Primary Care Trust], so there's six PCTs gone together…and trying to get some agreement because every PCT is doing something different as their core universal programme… We're doing less than some other areas…so there's a bit of trying to agree on that.'
Jane, Midlands

Financial savings
3.4: 'Our core programme originally was developed through Hall, 2004, and…the more and more the cutbacks came, the smaller and smaller and smaller our core programme's got.'
Barbara, South East

Re-evaluation in practice
3.5: 'The three year checks on the whole aren't being done, although we want to start to do them…the feedback we are having is that schools are identifying and having to deal with a lot more problems now that the health visitors are not doing the three and a half year checks, and also because children have not had two year checks.'
Theresa, London

Box 4
Providing a targeted child health promotion service

Thresholds for targeting

4.1: ‘Of course [due to a minimal core programme] we couldn’t offer the same sort of service that we had been offering …seeing mums with difficult children or feeding problems or sleep problems, and an awful lot of our bread and butter work that we would have been doing…we couldn’t achieve…[although] it’s…government policy…we don’t have time to do it.’
Naomi, South East

4.2: ‘In our area we target everybody because they’re all socially quite deprived [but] we realise that we cannot reach everybody you know, we have to actually focus our efforts, because some of the children that we work with are very, very needy so the others really have to fend for themselves a little bit.’
Diane, South West

4.3: ‘There are a lot of families that I think need more support, but because they’re a bit lower down on the needs list they don’t really get much support… So you know the sort nearer they are towards child protection, the more priority you have to give them.
Frances, South West

Capacity to provide a targeted service

4.4: ‘Our managers have been very, very responsive to the fact that…we work in a really challenging area…and what they have done is they've allocated more health visitors to areas where there's more need.’
Beverley, North West

4.5: If you looked at the guidelines for targeting , [in] the area we work in we would see them all…What we do now, we send…a letter…at two years and three and a half years, and it says, this is what your child should be doing, if you’ve got any concerns contact the health visitor.’
Vanessa, Midlands

4.6: ‘We aren’t really providing a service, the service that is needed by the clients, and therefore the clients then - I don’t know whether they fend for themselves or they just sink under. It depends really on them, I guess. But that’s not good.’
Maya, London

Box 5
Offering a targeted service to parents

Discussing targeting with parents
5.1: ‘If it’s routine health visiting I’ll say, I just want to do a health visiting plan with you, and that includes future visits…I say, I think you’re doing really well…so that puts you into my routine category, does that feel comfortable? If they’re in [a targeted category] I tell them and we’ll talk about it because it’s not up to me just to have that information, it’s to be shared and discussed, isn’t it, really?’
Jeanette, Midlands

5.2: ‘I don't think it's possible to target the most needy, they don't want to be targeted... they talk about transparency, being open with people and so forth, I've tried being transparent and open, people don't want to know, they never open the door again…so I find myself saying, ‘Well, it would be lovely to see you again next month’…and glossing over the vulnerability, in order to keep the relationship going...As soon as they know that you think that there might be something wrong, then they simply opt out.’
Theresa, London

Using the core service to facilitate targeted access to families
5.3: ‘I would use an excuse like, ‘Oh, you’re almost 18 months, I’ll come and see you’, so that they don’t feel picked on…word gets round the estate and they’re very tight in this estate, so if the mother can say, ‘Oh, she only came to do the 18 month check’, rather than, ‘She came to follow up a domestic violence referral’, you know, it sounds better!
Jenny, North East

5.4: ‘My feeling really is that if you're going to be very open with families you shouldn't be going behind their back and using something like the health surveillance programme to monitor families, I think you've got to be very up-front with families and say I'm concerned about this and can we talk about this and I want to come back in such and such a time.’
Ruth, North West