

Fourth Edition

# Health Visiting

Preparation for Practice

Edited by  
Karen A. Luker, Gretl A. McHugh  
and Rosamund M. Bryar



WILEY Blackwell



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### Fourth Edition

#### Edited by

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This edition first published 2017 © 2017 by John Wiley & Sons, Ltd.

*Registered office:*

John Wiley & Sons, Ltd, The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

*Editorial offices:*

9600 Garsington Road, Oxford, OX4 2DQ, UK

The Atrium, Southern Gate, Chichester, West Sussex, PO19 8SQ, UK

111 River Street, Hoboken, NJ 07030-5774, USA

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*Library of Congress Cataloging-in-Publication Data*

Names: Luker, Karen A., editor. | McHugh, Gretl A., editor. | Bryar, Rosamund M., editor.

Title: Health visiting : preparation for practice / edited by Karen A Luker, Gretl A McHugh, Rosamund M Bryar.

Other titles: Health visiting (Luker)

Description: Fourth edition. | Chichester, West Sussex ; Hoboken, NJ : John Wiley & Sons, Ltd., 2017. | Includes bibliographical references and index.

Identifiers: LCCN 2016012189 | ISBN 9781119078586 (cloth) | ISBN 9781119084593 (pdf) | ISBN 9781119084556 (epub)

Subjects: | MESH: Community Health Nursing | Evidence-Based Nursing | Great Britain

Classification: LCC RT98 | NLM WY 106 | DDC 610.73/43--dc23 LC record available at <http://lccn.loc.gov/2016012189>

A catalogue record for this book is available from the British Library.

Wiley also publishes its books in a variety of electronic formats. Some content that appears in print may not be available in electronic books.

Cover image: Vicky Kasala Productions

Set in 9/12.5pt, NewsGothicStd by SPi Global, Chennai, India

# Contents

List of Contributors	ix
<b>Introduction</b>	<b>1</b>
<i>Karen A. Luker, Gretl A. McHugh and Rosamund M. Bryar</i>	
Prevention, public health, and health visiting	2
Health visiting: preparation for practice	4
References	6
<b>1 Managing Knowledge in Health Visiting</b>	<b>8</b>
<i>Kate Robinson</i>	
Introduction	8
Defining health visiting practice	10
What do health visitors do – and where do they do it?	13
Evidence-based practice	16
The current landscape of EBP	21
Managing knowledge and evidence in practice	26
Case study 1.1: Introducing new technology	26
Case study 1.2: Creating guidelines in primary care	27
Case study 1.3: Protocol-based decision making in nursing	29
Case study 1.4: Knowledge management in primary care	30
Communities of practice	35
Reflective practice	37
Clients: what do they know and how do they know it?	40
Social networking and the media	41
The debate	44
Summary	45
References	46
Activities	50
<b>2 Health Visiting: Context and Public Health Practice</b>	<b>53</b>
<i>Martin Smith</i>	
Introduction	53
Public health	56
Defining 'public'	56
Defining 'health'	57
Defining 'public health'	59

Human rights and public health	60
The principles of health visiting	63
The search for health needs	65
The stimulation of an awareness of health needs	65
The influence on policies affecting health	66
The facilitation of health enhancing activities	67
Summary	68
Health inequalities	69
Summary	76
References	77
Activities	82
<b>3 The Community Dimension</b>	<b>85</b>
<i>Rosamund M. Bryar</i>	
Introduction	85
Public health and communities	87
Defining 'community'	89
Impact of communities on health	91
The role of health visitors in working with communities	96
Gaining an understanding of the health of your local community	100
Windshield survey	101
Public health walk	101
Health needs assessment	102
Building community capacity	110
Using health promotion models to support community working	113
Summary	116
References	118
Activities	124
<b>4 Approaches to Supporting Families</b>	<b>127</b>
<i>Karen I. Chalmers and Karen A. Whittaker</i>	
Introduction	127
Models of intervention in family life	128
Three models relevant to health visiting practice in families with young children	129
Application of the models in practice	132
Policies	133
Evidence for interventions to support families	136
Characteristics of services and programmes to support families with young children	137
Early home visiting programmes	138
First Parent Health Visiting Programme	138
Community Mothers Programme (CMP)	139
Current home visiting programmes	140
Family Nurse Partnership (FNP) Programme	140
Flying Start – Wales	143



The Triple-P (Positive Parenting Programme)	144
Maternal Early Childhood Sustained Home Visiting (MECSH)	145
Sure Start programmes	146
Summary	148
Working with families	148
Empirical evidence on relationship development	152
Challenges	154
Public health agenda	154
Level of evidence	155
Adhering to the programme criteria	155
High-needs families	156
Practice specialisation	157
Concerns about child safety	157
Adequate resources	157
Summary	158
Note	158
References	158
Activities	167
 <b>5   Safeguarding Children: Debates and Dilemmas for Health Visitors</b>	 <b>170</b>
<i>Julianne Harlow and Martin Smith</i>	
Introduction	170
The key concepts	172
Defining 'child'	172
Defining 'childhood'	174
Defining 'safeguarding'	175
Defining 'child abuse'	180
Defining 'significant harm'	187
Incidence and prevalence of child abuse	193
Assessment of vulnerable children	197
Assessment of children in need and their families	198
Common Assessment Framework (CAF)	200
Graded Care Profile (GCP)	202
Working together	203
Confidentiality and information sharing	205
Supervision	206
Summary	210
References	211
Activities	217
 <b>6   Working with Diverse Communities</b>	 <b>220</b>
<i>Sharin Baldwin and Mark R.D. Johnson</i>	
Introduction	220
Culture and migration	221

Cultural sensitivity and competence	222
Some useful tips for developing cultural competence	225
Institutional discrimination and organisational cultural competence	225
Understanding different cultural practices	226
Pregnancy	226
Birth customs	228
Confinement following birth	231
Breastfeeding	231
Diet, weaning, and feeding practices	232
Maternal mental health	235
Safeguarding, domestic violence, and abuse	237
Communication	239
Other communities	240
Case studies	241
Case study 6.1: Breastfeeding support project for Somali mothers in Harrow	241
Case study 6.2: New ways of delivering health visiting services for Orthodox Jewish community in Hackney	242
Summary	244
References	244
Activities	250

## **7 Evaluating Practice 252**

*Karen A. Luker and Gretl A. McHugh*

Introduction	252
Sources of evidence for practice	253
Evaluation – the problem of definition	257
Conceptualising evaluation	259
Example: tackling childhood obesity	261
Evaluation and evaluative research	263
Evaluation of health care	263
Structure, process, and outcome evaluation	266
Structure evaluation	266
Process evaluation	268
Outcome evaluation	270
Summary	272
The care planning process	272
Actual and potential problems	274
Problem solving	275
Additional issues in evaluating the practice of health visiting	275
Summary	280
References	281
Activities	287

Index	291
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# Introduction

**Karen A. Luker, Gretl A. McHugh, and Rosamund M. Bryar**

Our fourth edition of *Health Visiting: Preparation for Practice* is a key resource for health visitors, health visitor students, students on nursing, public health, early years, and health sciences programmes, and other health professionals working in public health, primary care, and community services. The practice of health visiting is focused on the promotion of health and the prevention of ill health. The fourth edition of *Health Visiting: Preparation for Practice* aims to inform, educate, and challenge you to deliver the most effective health visiting and so enable the promotion of health and prevention of ill health in the children, families, and communities with whom you work.

Prevention and public health have been the focus of health visiting since the early days of the sanitary visitors – the forerunners of health visitors – appointed by the Manchester and Salford Ladies Sanitary Reform Association in 1862. Since 1862, the living conditions, life expectancy, and health of the population have evolved, and alongside this there have been changes in the health challenges faced by the population. Over these more than 150 years, health visiting has responded to these changes by contributing to addressing public health issues from prevention of infectious diseases to prevention of long-term conditions; from addressing poverty and under-nutrition to working to reduce obesity in children and their parents. The aim of this edition of *Health Visiting: Preparation for Practice* is to provide you with the most up-to-date evidence to support your work on the front line of public health.

The fourth edition of this book is the latest in the line of works entitled *Health Visiting* which have aimed to support the delivery of health visiting. The first of these, *Health Visiting: A Textbook for Health Visitor Students* by Margaret McEwan, was first published in 1951. This was followed by three further editions, and, in 1977, by *Health Visiting*, edited by Grace M. Owen and written by Grace M. Owen and health visiting colleagues drawn from the health visiting programme at the Polytechnic of the South Bank (now London South Bank University). These books remind us of the changes in the preparation of health visitors during the past 60-plus years, but the statement by McEwan (1961: 17) of the purpose of health visiting is still the centre

of today's practice: 'The health visitor is primarily a teacher and her aim is to teach the value of healthy living and to interpret the principles of health.' In addition, her observation that health visiting is: '... concerned with the little things of everyday life' (McEwan, 1961: 17) is also very pertinent. However, the evidence and knowledge base underpinning some of these 'little things of everyday life', such as weaning, play, and parenting, has grown enormously, as shown in the four editions of the present book. The first edition, by Karen Luker and Jean Orr, was published in 1985 and also entitled *Health Visiting*. The second edition followed in 1992 and was entitled *Health Visiting: Towards Community Health Nursing*, reflecting changes in the education of nurses and health visitors in the early 1990s. The third edition, edited by Karen Luker, Jean Orr, and Gretl McHugh, did not appear until 20 years later, in 2012, but the title, *Health Visiting: A Rediscovery*, shows the new confidence in health visiting and the role of health visitors in supporting families based on evidence concerning the importance of support for early child development and the need to reduce inequalities in health (Field, 2010; Marmot et al., 2010; Allen, 2011; Dartington Social Research Unit et al., 2015). The fourth edition, entitled *Health Visiting: Preparation for Practice*, builds on the third. It includes a new chapter on working with diverse communities, reflecting their multicultural make-up, and, critically, provides additional guidance on evaluation, enabling you to demonstrate the outcomes of your practice. What these books all illustrate are the ways that health visiting, over the past decades, has responded to and applied new and emerging evidence to support children, families, and communities to better promote their health.

### Prevention, public health, and health visiting

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Over the past 5 years, there has been investment into the education and employment of health visitors, with a subsequent increase in the number of health visitors, particularly in England and Scotland. Alongside this investment has been clarification of the health visiting service, with greater emphasis being placed on the public health role of health visitors working with children, their families, and communities. Health visitors have a long-standing role in helping communities to improve their health and well being; for example, in increasing immunisation uptake, preventing obesity, and tackling health inequalities. The Marmot Report, *Fair Society, Healthy Lives* (Marmot et al., 2010), sets out a framework for tackling the wider social determinants of health, stating that health inequalities will require action on:

- giving every child the best start in life;
- enabling all children, young people, and adults to maximise their capabilities and have control over their lives;
- creating fair employment and good work for all;
- ensuring a healthy standard of living for all;
- creating and developing healthy and sustainable places and communities;
- strengthening the role and impact of ill-health prevention.

Health visitors are the lead professionals for delivery of the *Healthy Child Programme* (DH, 2009; Public Health England, 2015), and therefore have a critical role

in helping to improve the life chances of current and future generations by reducing the impact of inequalities on the immediate and long-term health of the population. Recognition of the important role that prevention has to play in improving health, and also in reducing health care costs, was identified in reports undertaken by Sir Derek Wanless in England and in Wales (Wanless, 2002; Project Team and Wanless, 2003) and reiterated for England in the *NHS Five Year Forward View* (DH, 2014a). In *NHS Five Year Forward View: Time to Deliver* (DH, 2015: 7), three gaps were identified: ‘... the health and wellbeing gap, the care and quality gap, and the funding and efficiency gap.’ Health visitors have a key role in their work with children and their families in contributing to public health outcomes that address early on the health and well being gap. The six high-impact areas show where health visitors can have the greatest influence:

- Transition to Parenthood and the Early Weeks
- Maternal Mental Health (Perinatal Depression)
- Breastfeeding (Initiation and Duration)
- Healthy Weight, Healthy Nutrition (to include Physical Activity)
- Managing Minor Illness and Reducing Accidents (Reducing Hospital Attendance/Admissions)
- Healthy Two Year Olds and School Readiness

(DH, 2014b)

Over the coming years, these areas for prevention will be the focus of health visiting services. From October 2015, local authorities took over from NHS England in the commissioning of public health services for children under 5 years (DH, 2014c). Currently, health visitors continue to be employed initially by the same employer, but service commissioning processes in coming years may see a range of new models of employment. The continued contribution of health visitors to the 0–5 years will remain key, but the greater integration of health and social care services (e.g. the Greater Manchester Health and Social Care Devolution (previously referred to as Devo Manc) project developments (Ham, 2015)) may present new opportunities, including wider integration of 0–19 services and the involvement of health visitors in population-based initiatives. In Northern Ireland, an integrated service for all children up to the age of 19 years is provided by health visitors and school nurses. There is an emphasis on working together, with a focus on delivery of child health promotion programmes and increased intensive home visiting for the 0–19 years (DHSSPS, 2010). In Wales, the recent nursing and midwifery strategy by Public Health Wales places nurses and midwives at the forefront of its public health strategy (Public Health Wales, 2014). In Scotland, in 2014, the government pledged to increase the number of health visitors by 500 over the next 4 years (The Scottish Government, 2014). Greater collaboration between services and practitioners (e.g. midwives and health visitors working with women in the antenatal period, social workers and health visitors working with families experiencing domestic violence or child safeguarding issues, school nurses and health visitors working to address obesity in 0–19 services) will be central to health visiting over the coming years. These additional

resources and initiatives will assist with improving health visiting services. However, there remains a need to focus on measurable outcomes in order to evaluate these initiatives, which could lead to further changes and improvements in the methods of delivering health visiting services.

## Health visiting: preparation for practice

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The first and second editions of this book were pioneering in the quest for evidence to support practice and in emphasising the need for evaluation of practice. Evidence-based practice and evaluation of impact now seem to be a given, and this acknowledgement by the professional colleges, the governments of the four countries of the UK, and health visiting organisations means that our chapter on evaluating practice will be a must read and makes this an exciting time to launch the fourth edition of the book. The structure of the book is similar to that of the other editions: the content has been updated from the last edition and a new chapter has been included which focuses on the health visitor working with diverse communities. These changes have been necessary to keep pace with the developments in health policy, public health priorities, and health visiting practice. There are some new authors for this edition – some who are teaching public health and health visiting, and others who are practising as health visitors and public health specialists – ensuring that this fourth edition is relevant to meet the needs of those undergoing preparation to become health visitors and those who are practitioners working with and in the community.

**Chapter 1: 'Managing Knowledge in Health Visiting'** discusses the demands on the health visitor to understand the different forms and sources of knowledge in order ensure the delivery of evidence-based practice, with reference to case studies. It highlights the issues surrounding the use of guidelines and protocols in practice and looks at the concept of communities of practice (CoPs), with regard to how they can assist practitioners in working to improve their own practice. In addition, it discusses the generation and management of knowledge in practice using reflective practice and examines the perspective of the client in terms of what they know and how they know it, drawing attention to the use of social networking sites.

**Chapter 2: 'Health Visiting: Context and Public Health Practice'** explores the specialist and public health role of the health visitor in working with families. It examines the tensions between the public health role and the health visiting role with children and families. The public health role needs to become more clearly defined, with a focus on reducing health inequalities and giving every child in the community the best start in life (Marmot *et al.*, 2010); this is explored in a section specifically about 'Health Inequalities'. This chapter also examines the evidence for health inequities and the contribution health visitors can bring in addressing the wider determinants of health. In addition, it highlights the importance of good leadership in public health and the challenges for health visitors in engaging in a public health role.

**Chapter 3: 'The Community Dimension'** explores the importance of the communities within which people live to their health and considers the range of factors impacting on people's health. It looks at the role of health visitors working with



communities and the renewed focus on this area, for example as part of the health visiting service model in England. It discusses tools that health visitors can use to gain an understanding of communities through an exploration of their social history and identification and assessment of their current health needs. It looks at the development of the skills required to work with communities, making use of health promotion theory and building on the skills that health visitors have in working with individuals and collaborating with other services, with reference to national and international learning resources and tools. Working with communities to achieve better health is a long-term process, but health visitors, with their access to all families with children under 5 years of age, are in a unique position to support the building of healthier communities.

**Chapter 4: 'Approaches to Supporting Families'** explores different approaches to supporting families and evaluates several child health programmes that are currently in existence. It discusses the evidence for successful interventions to support families, including the findings from evaluations of these programmes, and considers the influence of policies on health visitors' work in supporting families. Finally, it examines the competing challenges faced by health visitors in trying to work with families, including the public health agenda, the level of evidence, and the availability of resources.

**Chapter 5: 'Safeguarding Children: Debates and Dilemmas for Health Visitors'** focuses on safeguarding and the enhanced child protection role of the health visitor. It defines the key concepts, such as 'child abuse' and 'significant harm', and highlights the incidence and prevalence of child abuse. It discusses the policy and legislation relevant to safeguarding practice, as well as the assessment of vulnerable children using the Common Assessment Framework (CAF) and the Graded Care Profile (GCP) for neglect. It looks at the issues and dilemmas around safeguarding children that students will encounter in their practice and discusses how the utilisation of supervision to support critical reflection and thinking can provide a supportive mechanism. It also highlights examples of published inquiries into child deaths and serious case reviews. Overall, this chapter will assist with the development of leadership in practitioners working in the safeguarding arena.

**Chapter 6: 'Working with Diverse Communities'** is a welcome addition to the fourth edition. It outlines the changes in the ethnic makeup of the UK population and discusses their implications for health care in general, with a specific consideration of religious issues. It introduces the concepts of 'cultural competence' and 'institutional discrimination', and considers what we mean by 'diverse'. It discusses cultural practices relevant to health visitor practice, including matters around pregnancy, diet, customs relating to birth and naming, and mental health, and provides some examples. Finally, it considers safeguarding in a multicultural setting, with a special focus on genital cutting or female genital mutilation (FGM). Throughout the chapter, communication is addressed, and the case is made that increasing cultural competency will help in developing communication skills to support work with diverse communities.

In the previous editions, **Chapter 7: 'Evaluating Practice'** was always ahead of its time, insofar as everyday health visitors seldom formally evaluated the impact of their work. This chapter has been updated and explores the importance of evaluation

in health visiting practice, which is a necessity in today's economy, to ensure that what health visitors are doing is effective and of value. It discusses key sources of evidence available to health visitors in the evaluation of their practice. It examines the different types of evaluation and suggests ways to approach them. It is important to ensure that health visitors and other practitioners have the skills and knowledge to identify and critique the available evidence and information in their role in supporting families and communities. Health visitors need knowledge about where to get the best information and the skills to be able to access up-to-date resources for the delivery of evidence-based practice; this chapter helps to provide this.

As in previous editions, the reader is encouraged to engage in learning activities at various points throughout the text; these can be found at the end of each chapter. It is anticipated that these activities will help students, health visitors, and others to reflect upon and develop their practice.

Health visitors will face many challenges over the coming years, but the vision for high-quality care and improved service provision makes it an exciting time for the profession. We hope that this new edition will assist with 'preparation for practice' and improve the contribution health visitors can make to the health and well being of children, their families, and communities, which will ultimately lead to better health outcomes for the whole population.

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# 1

# Managing Knowledge in Health Visiting

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## Introduction

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The mantra of evidence-based practice (EBP) is now heard everywhere in health-care. This chapter will explore what it might mean, both theoretically and in the context of everyday health visiting practice. Is it a way of enhancing the effectiveness of practice or yet another part of the new managerialism of guidelines, targets, and effectiveness? Why might EBP be an important ideal? When a practitioner intervenes in a client's life, the outcome should be that the client is significantly advantaged. In health visiting, that advantage can take many forms: the client can have more and better knowledge, they might feel more capable of managing their affairs, they might better understand and be able to cope with difficult thoughts, feelings, and actions – the list is extensive. Later chapters will detail the ways in which health visiting can lead to better outcomes for clients and communities. However, the proposition that there should be an advantage derived from the practitioner's intervention is particularly important in the context of a state-financed (i.e. taxpayer-funded) healthcare system. If an individual wishes to spend their money on treatments or therapies of dubious or unexplored value offered by unregulated practitioners, then that is entirely a matter for them, provided that they have not been misled or mis-sold! However, when the state decides to invest its resources in the provision of a particular service and associated interventions then arguably there has to be some level of evidence or collective informed agreement which gives confidence that the choice is justified. In addition, of course, every health visitor must be able to account for what she does and doesn't do to the Nursing and Midwifery Council (NMC), if required.

Chapter 7 explores how health visiting might be assessed, measured, and evaluated. The emphasis in this chapter is on how we choose, individually or collectively, to develop particular services and perform particular actions which we know with some degree of certainty should lead to better outcomes for the client. But how do

we know things with any certainty? What sort of knowledge do we need to make good choices? Although there are very many different ways of categorising or describing forms of knowledge, for our purpose here it will be sufficient to make some simple distinctions. We might categorise knowledge by type. For example, Carper's (1978) categorisation of knowledge as empirical (largely derived from science), aesthetic (or artistic), ethical, or personal is well known and is used in nursing. Or we might categorise it by source, and ask where it comes from (books, journals, other people, personal experience, etc.). Or we might use the simple but important distinction between knowing *that* and knowing *how* (McKenna *et al.*, 1999). For example, I can know that swimming pools are places people go to engage in swimming and other water sports without ever having been to a swimming pool, but I can only say I know *how* to swim if I can do so. In the former case, I can probably explain how I came by the knowledge, but in the latter, I may not be able to explain how I know how to swim or what I am doing when swimming; the knowledge statement *I know how to swim* is dispositional: its truth is determined by my ability to swim. Such 'knowing how' knowledge is sometimes called 'tacit knowledge', in contrast to 'explicit knowledge' or 'knowing that'. Our concern here is less about how theoretically we might define knowledge than about the question of what sort of knowledge health visitors *could* and *should* be using – and who says so – and what sort of knowledge they *are* using. There is substantial controversy here, as various factions argue that *their* type or source of knowledge is the most important. And the outcome of what might be argued to be a fight to define the 'proper' knowledge basis for practice is important as it has the potential to impinge directly on the health and safety of the client and on the degree to which health visiting can be said to 'add value' to clients.

In later sections of this chapter, we will look more closely at EBP, which is currently the dominant knowledge protocol in the National Health Service (NHS), and try to establish what forms of knowledge it valorises – and what forms it discounts – and why. The chapter will also look at reflective practice (an alternative protocol for generating and managing knowledge about practice that is supported by many institutions and individuals within nursing) and at the idea of knowledge being generated and managed within communities of practice (CoPs) (an idea that is popular in education and some other public sector areas); each of these can be viewed as a social movement, with enthusiastic advocates trying to 'capture' the support of key health organisations and institutions, as well as the hearts and minds of individual practitioners. We will also look at what is known about the types and sources of knowledge that healthcare practitioners actually use in practice – which prove to be somewhat different from any of the 'ideals' promoted by these social movements.

But before examining any of these 'ideal' types of knowledge management, it will be useful to remind ourselves about the practice of health visiting. For evidence-based health visiting or reflective health visiting or any other imported concept to be a reality, it must be integrated into the taken-for-granted, existing ways in which health visitors go about their business. But defining or describing health visiting is not simple. If we start by looking at what the government thinks it is, then we must recognise that, in the UK, health visiting is practised in four nations (involving two assemblies and two parliaments), each of which has a different idea of what health visitors should do, and to what ends. We then have the view of the

profession as a whole, which is expressed through various collective means. But when we try and look at the actual practice of health visiting, we find that there is a lack of shared knowledge about what goes on in the very many interactions which lie outside of the public domain of hospitals and clinics. Despite these difficulties, the next two sections will look briefly at the contexts in which health visitors manage knowledge.

## Defining health visiting practice

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The Department of Health commissioned a review of health visiting, *Facing the Future* (DH, 2007), aimed at highlighting key areas of health visiting practice and skills. This is not a wholly research-based document – and makes no claims to be – although there are some references to research. Rather, ‘this review is informed by evidence, government policy and the views of many stakeholders’ (DH, 2007: §1). Decisions about what health visiting should be about are therefore largely presented as decisions for the community of stakeholders in the context of stated government priorities. Key elements of the decision-making process can be seen as pragmatic and commonsensical – in the best sense. For example, the review argues that the health visiting service should be one which someone will commission (i.e. pay for), one that is supported by families and communities (i.e. acceptable to the users of the service), and one that is attractive enough to secure a succession of new entrants (i.e. it has a workforce of sufficient size and ability).

In terms of the future skills of health visitors, the review is clear that they will be expected to be able to translate evidence into practice – although it is less specific about what sort of evidence will count and how the process will be managed. However, at the national level, it recommends that the relevant research findings to support a 21st-century child and family health service be assembled. There is also some indication that future practice will be guided by clear protocols: ‘Inconsistent service provision with individual interpretation’ will be replaced by ‘Planned, systematic and/or licensed programmes’ (DH, 2007: recommendation 8). As we shall see, the reduction in variations in practice is one of the key aims of the EBP movement. In terms of evidence underpinning practice, the document also draws specific attention to the expanding knowledge base in mental health promotion, the neurological development of young children, and the effectiveness of early intervention, parenting programmes, and health visiting. Clearly, this is a very broad base of evidence, derived from a range of academic and practice disciplines.

So, while the review is not specifically about the evidence or knowledge base of health visiting and how it might be used, many of the relevant themes in debates about EBP begin to emerge. For example:

- What is the role of the practitioner in assembling and assessing evidence?
- How can evidence be translated into practice?
- What counts as evidence?
- How can other bodies support the practitioner by generating and assembling evidence?

- How can any practitioner be conversant with developing knowledge bases in a wide variety of other disciplines?
- What will be the role of protocols, guidelines, and 'recipes' for practice?

These questions all remain relevant, and health visiting commissioners, managers, and practitioners attempt to answer and reconcile them at all levels of practice. However, at the highest level of government, where the health visiting service is created and defined, significant changes in the knowledge base have been used to refocus the purpose and practice of health visiting. The new knowledge largely stems from the neurosciences and developmental psychology, and not from within health visiting itself, and is concerned with how and when brain development occurs. It underpins the premise that early intervention in every child's life – starting from conception – to optimise brain development is a key plank in strategies aimed at improving educational attainment, reducing crime and antisocial behaviour, reducing obesity, and improving health. Perhaps the most robust expression of what might be called the 'early intervention movement' is the first of two government reports by the Labour MP Graham Allen: *Early Intervention: The Next Steps* (Allen, 2011a). The context of Allen's report is the UK fiscal deficit and the Conservative/Liberal Democrat coalition government's agenda of addressing this deficit by making substantial reductions in public spending. Indeed, Allen's second report (Allen, 2011b) is entitled *Early Intervention: Smart Investment, Massive Savings*. In order to emphasise the need for early intervention, his first report starts with two images of a child's brain: one from a 'normal' child and one from a child who has suffered significant deprivation in early childhood. The differences in neurological development are obvious and striking, even to a lay reader, but the important conclusion from the evidence is that such damage is caused by poor parenting, is largely permanent, and is the cause of significant problems in the child's behaviour, which both impede the well being of the child and damage society. These are claims which stem from research that is not easily accessible to health practitioners or their clients. It is also research that is ongoing, with claims being contested and disputed: work by Noble *et al.* (2015) identifies family income and parental education as being the prime correlates to neurological development, for example.

While the claims about neurological development in Allen's first report remain deeply contested, they have been accepted at the highest levels of government, so the questions of what to do and who will do it become acute. In terms of what to do, policy makers look to evidence-based, precisely defined packages of action that have been robustly evaluated to provide the most secure way forward. Allen (2011a: ch. 6) identifies 19 programmes (e.g. the Family Nurse Partnership (FNP)) which he believes should form the basis of early intervention because of their targets and proven efficacy. Such intervention packages have been developed in many countries, often by private agencies, and need either to be incorporated into 'traditional' ways of working – or to replace them (see Chapter 5). So we now have complex bodies of evidence about both a perceived problem *and* a systematic solution used to prescribe practice. Such packages do not just say what must be done but also define *how* it must be done, and we will look at some of the issues raised by them in a later section. In practice, the responses to the early intervention imperative

have varied between the UK's nations, each having to answer such questions as: To what degree should intervention be targeted, and at whom? Who should carry out the intervention, and do they have the capacity and capability? and How should we ensure that the work is carried out consistently and effectively?

The Department of Health in England responded with the creation of a revitalised and expanded health visiting profession. The Health Visitor Implementation Plan 2011–15 (DH, 2011) proposed that health visitors provide a four-level service, with services allocated according to the needs of the child and family. There was also to be increased recruitment and training, including an emphasis on leadership development. While this was welcomed by the profession, there were dissenting voices. *The Lancet*, for example, posted a commentary by a public health doctor who supported the emphasis on early years intervention but argued that 'This policy takes a narrow approach, concentrating investment in expanding professional capacity in a service which can only provide part of the solution' (Buttivant, 2011). And the Department of Health itself commissioned a major literature review (Cowley *et al.*, 2013, 2015) to try and identify evidence to support the policy. In the other nations of the UK, different approaches were taken. In Scotland, for example, health visiting as such remained comparatively marginalised until in 2013 the Chief Nursing Officer required that 'the current Public Health Nursing (PHN) role ... should be re-focused and the titles of Health Visitor and School Nurse be reintroduced' (Moore, 2013: summary). The health visitor was to work with children aged 0–5 using 'targeted' interventions. Part of the rationale for the change was evidence that the public understood and preferred these 'traditional' titles. In Wales and Northern Ireland, too, there was increased focus on early years, although local policies reflected local traditions and ambitions. So, while no-one was disputing the knowledge base of an early intervention strategy, there have been considerable differences in the way this translates into policy for practice. High-level policy makers have their own ideological commitments and knowledge of local history, which mediate between knowledge and policy (for practice). Research rarely dictates policy, but it does inform it.

In England, the three key policies of early intervention, evidence-based pathways, and health visitor leadership remained throughout the defined years of the Health Visitor Implementation Plan 2011–15. The National Health Visiting Service Specification 2014/15 (NHS England, 2014) continued to make explicit reference to the evidence base of the Allen (2011a) report: 'Research studies in neuroscience and developmental psychology have shown that interactions and experiences with caregivers in the first months of a child's life determine whether the child's developing brain structure will provide a strong or a weak foundation for their future health, well-being, psychological and social development' (NHS England, 2014: 1.1.3 p. 5). The four levels of intervention remained in place and explicit reference was made to care pathways. Additional specifications for practice come in the form of required assessment protocols. This national specification is reflected in local practice handbooks. As an example, a practice handbook for health visiting team members published in 2012 by the Shropshire County Primary Care Trust (PCT) (Langford, 2012) ran to 43 pages of prescription concerning when visits were to be made and what should be done in each. The document is rich in references – 'Evidence/Rational' (*sic*) – but these are largely not to original research but to recipes for action; for example, it



specifies 10 assessment tools. So, by 2015, the idea that health visiting was an innovation technology rather than an individualistic practice was well established, at least in England and some other parts of the UK. Health visiting practice was conceived of as something which could be prescribed to solve defined national problems. Such policy prescriptions are not confined to health problems but can also be found elsewhere in social care, education, and the justice system – usually in areas where governments are particularly concerned to achieve particular outcomes. For example, a similar approach was taken in the case of another perceived threat to society – (Islamist) terrorism – where schools were encouraged to use packaged interventions designed to prevent the radicalisation of children.

From the point of view of the profession as a whole, the resurgence of health visiting was seen as an opportunity to raise its profile and consolidate its gains. A new body, the Institute of Health Visiting (iHV), was founded in 2012 with the avowed core purpose of raising ‘professional standards in health visiting practice ... By promoting and supporting a strong evidence base for health visiting and offering CPD [continuing professional development] and professional training’ (iHV, 2012). In other words, it sought to improve practice not by telling health visitors what to do but by improving their knowledge and skills. A central part of the work of the iHV is therefore the development of various ‘tools’ to help practitioners enhance their practice and guide them through an increasingly complex world of guidelines, pathways, programmes, and protocols and an expanding research base involving many disciplines. These tools are not ‘prescriptions’ of good practice but rather provisions of access to learning opportunities, case studies, publications, and Web-facilitated channels for practitioner–practitioner and practitioner–expert interaction. You could characterise this as a ‘bottom-up’ process of using evidence to improve practice, in contrast to the ‘top-down’ process of prescription based on policy, but as we shall see, both models remain part of the EBP ideology. Within EBP, there is also a substantial body of work exploring how knowledge management fits into the everyday realities of practice. So, what do we know of actual practice in health visiting – its opportunities and constraints?

## What do health visitors do – and where do they do it?

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Against the background of the government seeking to prescribe health visiting practice as a remedy for society’s ills, it is important to review what is known about the actual practice of health visiting; that is, what health visitors do on a day-to-day basis. Unfortunately, relatively little is known – other than tacitly by those who do it – about the realities of everyday health visiting. That it is rarely seen as a valid subject either for scientific research or for practice narratives is also true of a similar practice: social work. In the case of social work, however, we find an interesting research programme conducted by Harry Ferguson (2008, 2010), which aims to bring to light the essential nature of its practice. Ferguson argues that current research is focused on systems and interprofessional communication, which ‘leaves largely unaddressed practitioners’ experiences of the work they have to do that goes on beyond the

office, on the street and in doing the home visit' (Ferguson, 2010:1100). Ferguson is trying to refocus on actual practice; he further argues:

Reclaiming this lost experience of movement, adventure, atmosphere and emotion is an important step in developing better understandings of what social workers can do, the risks and limits to their achievements, and provides for deeper learning about the skilled performances and successes that routinely go on.

(Ferguson, 2010:1102)

Of course, this is just as true for health visiting, where a significant part of the practice is leaving the office, driving to the client, thinking about how the visit will work, knocking on the door, and so on. Ferguson's account of the excitement and fear of walking through disadvantaged neighbourhoods and of negotiating home visits with disobliging clients is focused on social workers working in child protection, but it must resonate with all practising health visitors. The way in which he conceptualises the home visit is of particular interest: 'All homes and the relationships within them have atmospheres and how professionals manage stepping into and negotiating them is at the core of performing social work and child protection and managing risk effectively' (Ferguson, 2010:1109).

So how would the ever-useful Martian sociologist describe health visiting practice? They would be bound to notice that it is largely about doing things with words. Note the emphasis on *doing*; talk isn't just something which surrounds the doing, it is the doing – praising, blaming, asking, advising, persuading: every utterance is an action produced for a purpose, although the speaker is rarely consciously aware of this. The skills involved in talking are so deep that, just like with walking, they are not normally subject to constant ongoing analysis. Most of us do not consciously think about how to walk – we just do it. But talk is the health visitor's key performative skill, and because doing things with talk is a primary skill, health visitors need a more profound understanding of how it works – just as a ballet dancer would need a more profound understanding of how her body works than would the person taking the dog for a walk. Of course, as well as talking, health visitors also make notes and write reports, but this is still doing things with language in order to interact with others.

In the 1980s, there was considerable interest within sociology in researching how interactions, largely based on talk, could constitute various forms of institutional practice. This idea was rather neatly defined in an edited volume of studies called *Talk at Work*. The editors argue:

that talk-in-interaction is the principal means through which lay persons pursue various practical goals and the central medium through which the daily working activities of many professionals and organisational representatives are conducted.

(Drew & Heritage, 1992: 3)

Health visiting is one such profession, and a number of studies have been conducted within that sociological tradition (see, for example, Dingwall & Robinson, 1990; Heritage & Sefi, 1992). The focus is on making available what happens in the

'private' world of the home visit. Cowley *et al.* (2013), in their extensive review of health visiting literature, reinforce the centrality of the home visit in health visiting, arguing that it is one of the three key components of practice (the other two being the health visitor–client relationship and health visitor needs assessment).

Health visitors also work in clinics, general practitioner (GP) surgeries, children's centres, church halls, social services departments, and so on. So a further defining characteristic of health visiting is that it does not have a fixed locality or place of work. There is an interesting literature on the issue of place in healthcare (see, for example, Angus *et al.*, 2005; Poland *et al.*, 2005), and of course it relates to the issue of mobility which is central to Ferguson's (2008, 2010) work. Poland *et al.* (2005) argue that, while practitioners are sensitive to issues of place, this has largely been ignored in debates about best practice and EBP. They further assert that:

Interventions wither or thrive based on complex interactions between key personalities, circumstances and coincidences ... A detailed analysis of the setting ... can help practitioners skilfully anticipate and navigate potentially murky waters filled with hidden obstacles.

(Poland *et al.*, 2005: 171)

By 'place', Poland *et al.* (2005) mean a great deal more than mere geography. The concept includes a range of issues, notably the way power relationships are constructed and the way in which technologies operate in and on various places. Alaszewski (2006) draws our attention to the risk involved in practising outside 'the institution'. While there are ways in which physical institutions mitigate the risks from their clientele:

The institutional structure of classification, surveillance and control is significantly changed in the community. Much of the activity takes place within spaces that are not designed or controlled by professionals, for example the service user's own home.

(Alaszewski, 2006: 4)

The discussion in this section draws on concepts and evidence from a number of sources, which can be used as vehicles for thinking about health visiting. But, as Peckover (2013) points out, we do not have a coherent body of research on the reality of health visiting practice. Cowley *et al.* (2015: 473), in their review of the literature, acknowledge that their work has revealed the concepts and theories underlying health visiting but not 'the forms of practice that exist in reality.' We know what health visitors *aim* to do but not what they *actually* do. Peckover argues that this lack of a 'meta-narrative' for health visiting is both a weakness and a strength: a weakness because it struggles to explain itself to policy makers and to establish a strong base in higher education, but a strength in that it seems to be able to adapt to changing demands. Given the complexity of health visiting, we need to look at the top-down prescriptions for practice and ask, first, how we can reconcile the practice prescriptions of the policy makers and managers with what we know about what Ferguson calls 'the fluid, squelchy nature of practices ...' (Ferguson, 2008: 576),

and, second, how we can source evidence to support the parts of practice which do not, or do not yet, fall within the realm of defined practice. Can the concepts and practices of EBP and knowledge management help?

## Evidence-based practice

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In order to understand the importance of the EBP movement, you need to take yourself back in time about 30 years. Back then, doctors and nurses did what they had been taught to do; experienced practitioners became teachers and passed on what they had learned in their years of practice. There was almost no reference to research findings, but lots of reference to both ‘facts’ and ‘proper ways of doing things’. That is not to say that there was no innovation: new drugs became available and there were surgeons trialling procedures we now take for granted, such as joint replacements. But the idea that the way to do things in healthcare was passed on from previous practitioners was prevalent. So the idea of EBP was really revolutionary – and there was considerable opposition to it.

What has come to be known as EBP had its foundations in the evidence-based medicine (EBM) movement, which started in the UK in the early 1990s. The NHS was interested in funding and promoting research, and there was a research infrastructure. However, there was increasing dissatisfaction among some key individuals in the medical profession – notably Dr (now Sir) Muir Gray, who was an NHS Regional Director of Research and Development – over the fact that, within medicine, treatments which had been proven to be effective were not being used, while treatments which had been shown to have no or little beneficial effect continued to be used. This was despite considerable efforts to change practice; for example, the Getting Research into Practice and Purchasing (GRIPP) project, developed in the Oxford NHS region, looked at four treatments:

- the use of corticosteroids in preterm delivery;
- the management of services for stroke patients;
- the use of dilation and curettage (D&C) for dysfunctional uterine bleeding;
- insertion of grommets for children with glue ear.

Good research evidence was available to underpin decisions in all these areas of practice, and health authorities within the Oxford region sought to ensure that practice adhered to the research-based recommendations. However, variations in practice proved difficult to eradicate, and it was felt that more needed to be done. Did the practitioners not understand the research? Did they need motivation to change from their traditional ways of practice? Perhaps a more widespread and coordinated effort to base practice on research needed to be developed.

The fundamental proposition of the subsequent EBM movement was that practice should take account of the latest and best research-generated evidence to underpin both individual clinical decision making and collective policy making. At the heart of EBM is the idea that it provides a vehicle by which the practitioner can continually examine and improve their individual practice by testing it against scientifically validated external evidence and importing proven treatments. Activity 1.1 will help you to explore the evidence around interventions delivered by health visitors.

Sackett *et al.* (1997) define EBM as consisting of five sequential steps:

1. Identifying the need for information and formulating a question.
2. Tracking down the best possible source of evidence to answer that question.
3. Evaluating the evidence for validity and clinical applicability.
4. Applying the evidence in practice.
5. Evaluating the outcomes.

So, for example, a doctor faced with a patient with a severe infection might ask, 'Which antibiotic will best cure this infection?' and look to the literature on drug trials for an answer. Thereafter, they would evaluate the validity of the trial and its relevance to their patient, administer the drug (or not), and see what happened. Or, to use one of the examples from the GRIPP project, a doctor treating a child with 'glue ear' might ask, 'Will surgery to insert grommets make a difference in the long term compared with conservative treatment?' A search of the literature would indicate that surgery to insert grommets is not necessarily cost-effective in the long run in terms of outcome. But this example illustrates a complexity that the rational model of EBM does not necessarily deal with. At the point that the doctor opts for conservative treatment, what message is conveyed to the parent with a child who has suddenly gone deaf and who is losing both speech and friends? The research evidence on cost-effectiveness may not fully acknowledge the social issues surrounding the clinical problem. EBM is essentially a linear model for change which assumes that clinicians should make rational choices based on the scientific evidence available to them. It does not necessarily take into account the choices that clients would make, which might be equally rational for them. Activity 1.2 will be helpful in gaining some experience in the practice of EBM.

EBM defines the best source of evidence as the randomised control trial (RCT), or better still a group of RCTs, which can be systematically reviewed and analysed. Early on in EBM, the idea was that clinicians would get involved in all stages of the process, including the search for and evaluation of the evidence, and there were – and are – various manuals and training programmes to help them do that. This can be defined as the simple linear model of practitioner-based EBP, which is still espoused by some. But, in practice, a cadre of specialist and largely university-based 'experts' has grown up to manage the search for and evaluation of the scientific evidence and to produce specifications for practice, which are then disseminated through various fora. These specifications are known by a number of names, including 'clinical guidelines' and 'care pathways', and their use will be explored later in the chapter. The degree to which any specification will constitute a suggestion or an instruction to practitioners largely depends on the importance of the topic and the costs of that area of practice. The contrast between two propositions found in EBM – that individual practitioners should evaluate the evidence and change their practice accordingly and that evaluating evidence is an expert skill requiring considerable resources – remains important. Research evaluation is a key component of many healthcare curricula, but the degree to which it might or should be a key component of practice remains contested.

So, the EBM movement has been, and continues to be, subject to considerable debate and criticism. However, there is a danger that it is criticised for ideas which it does not wholly espouse.

First, its initial proponents did not suppose that the use of research evidence would entirely override clinical judgment, but rather that it would work in conjunction with it:

External clinical evidence can inform, but can never replace, individual clinical expertise and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision.

(Sackett *et al.*, 1997: 4)

Second, while it is true that a hierarchy of evidence was proposed, which placed that derived from RCTs at the top as the 'gold standard', it did not assert that other forms of evidence were not of some value, and neither did it entirely ignore evidence derived from qualitative research (Glasziou *et al.*, 2004).

Early EBM was an enthusiasts' movement, but a whole industry has since grown up around it, and it is now central to government health policy and is spreading into other occupations. So, who is supporting the development of EBM and its promotion in new disciplines such as nursing, social work, and education – and why?

First, there is a lobby from researchers. After all, if no-one uses their work then why should government continue to fund it? Healthcare research is now a substantial industry, forming a significant part of many university budgets. New journals have sprung up to explore the issues, and, of course, publication is the lifeblood of academics. Gerrish (2003), citing Estabrooks (1998), argues that EBM has generated a shift in power and prestige in healthcare from experienced expert clinicians to researchers.

Second, there is the government, which is increasingly committed to the development of evidence-based policy making in many spheres, certainly including health. A range of organisations have been established to support EBM and fund research designed to feed directly into practice, including the Cochrane Collaboration (which exists to produce systematic reviews), the National Institute for Health and Care Excellence (NICE), and a number of university-based units, such as the University of York Centre for Reviews and Dissemination. Within government-funded research programmes, there has been an increased emphasis on 'impact', in addition to validity, reliability, and so on. Activity 1.3 will help you to explore elements of effective health visiting practice.

Third, there are the nurses, social workers, and teachers themselves. Although there was (and is) some concern within medicine that EBM would erode the importance of clinical judgment, in these professions the idea of developing a strong formal and recognised evidence base was seductive. A few decades ago, the theory that a profession needed to have certain characteristics became popular in occupations such as nursing, social work, and teaching. While the theory itself was deeply flawed, as it largely ignored issues of power and prestige based on class and gender, it did inspire a section of nursing to fight for an independent regulatory body – now the NMC – and for graduate entry to the occupation, which has

now been realised with the 2010 change in NMC regulations. This professionalising agenda has extended to a belief that a 'proper' profession will have – and use – an extensive evidence base gleaned from research; that is, it should aspire to be an 'evidence-based' profession. Consequently, some nursing constituencies have vigorously championed the development of nursing research and the inclusion of nursing in multidisciplinary research – and indeed there has been a very rapid expansion of nursing research, although much of it remains small-scale (Cowley *et al.*, 2013, 2015).

Fourth, there is the consumer, who increasingly wants the 'best' treatment available and is intolerant of variations in practice – or 'postcode lotteries'. This may in part be fuelled by media reports of research 'breakthroughs'. However, the consumer's attitudes are at best ambivalent – the extensive and growing use of 'alternative' therapies, many of which have a research evidence base which is slight at best, shows that the consumer also wants to decide for themselves what works. Activity 1.4 will help you to explore this further.

So, we can conclude that powerful forces have fuelled the development of the EBM movement and have vested interests in its success. More fundamentally, like any social movement, it had to be in the right place at the right time. A number of factors seem to have been crucial. Importantly, the oil crisis of the mid 1970s forced Western industrial societies into financial panic. Muir Gray acknowledges the importance of this economic crisis in the development of EBM (cited in Traynor, 2002). Never again would the price of something not matter, and state-funded healthcare represents a massive part of government expenditure. When doctors undertook operations for glue ear with no proven benefit, that was no longer just their decision. And partly as a result of the economic crisis, society was also changing. Traynor (2002) defines key products of this new emphasis on fiscal control to be the rise of managerialism, the increased use of audit, and an increased emphasis on research and development (R&D). In addition, society was increasingly conscious of risk but wary of the power and authority of both science and professions to provide solutions. How did EBM fit into this landscape? In theory, having sufficient research evidence to specify 'best practice' allowed managers greater control over individual practitioners, and audit systems ensured that this control was maintained. Although EBM is based on a science embedded in experimental work, it was not a scientific 'grand narrative'; rather, it provided 'recipes' for best practice, which would, in theory, reduce variations in practice and control risk. A further key element in the success of EBM – and in making it a worldwide phenomenon – is the exponential growth in information technology. Without the ability to search digital databases worldwide, EBM would be a much reduced enterprise.

The concepts behind EBM have spread to other healthcare occupations, and subsequently beyond healthcare into management, education, and social work; it is commonplace now to describe the movement as EBP. In 2008, NICE was given a remit for work in public health, including disease prevention and health promotion. Changes have thus had to be made to the way in which EBP operates even within the heartland of medicine. Kelly *et al.* (2010) offer an 'insider's' perspective on some of these challenges as they work within NICE on the public health agenda – which of course goes beyond healthcare into education, social welfare, and so on, and