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Abstract

Internationally, there is a strong interest in engaging the public more widely in both the development and governance of public services. This study aimed to explore family perspectives on the introduction of a new policy initiative called the 'Health Visitor Implementation Plan' (DH 2011) and their experiences of the new health visitor service provision. The policy aimed to increase the health visitor workforce by 4200 additional practitioners between 2011 and 2015, in parallel with introducing a new service model to provide comprehensive and accessible support for parents with children 0-5 years. Questions focused around the extent to which the new service met parental expectation and need.

Using a qualitative approach, data were collected via semi-structured interviews and focus groups with 22 parents between March 2013 and March 2014. Participants were recruited through Children's Centres and interviewed during established group sessions. Analysis was conducted using thematic analysis and constant comparative methods.

The participants were asked to share their experiences of the health visiting service and their views on this national policy initiative. Although asked to comment on the macro and national level about the policy, their responses were predominantly around personal experience. Parents welcomed the increase in workforce capacity and positive experiences centred on health visitors who were caring, knowledgeable, skilled and facilitated positive outcomes. Many of the negative experiences were seen to be due to poor relationships between the parent and the health visitor. Parents were influenced by the communication skills and personal attributes of the individual health visitors, including time to listen. The strength of parental opinion indicated that parents are willing to contribute to service development, consequently policy makers and health visitors themselves need to have clarity around the purpose and mechanism of parental involvement if meaningful partnership is to become a reality.

296

Key words (up to 6)

Health visitor, User Involvement, Qualitative

What we already know about this topic

- There is a policy movement towards public and patient involvement in service development
- There is no explicit parental voice in the development of the Health Visitor Implementation Plan
- Previous studies exploring parental perspectives may have been subject to bias due to sampling methodology, potentially excluding parents from disadvantaged communities, or those with a critical perspective

What this paper adds

- Perspectives of parents previously marginalised or ignored on an important family policy and health visiting service delivery
- Evidence that workforce capacity has impacted on the health visitor-parent relationship, particularly around the perception of available time
- Extends the debate about health visitor service provision and how parent opinion can be acknowledged and incorporated

Introduction

The involvement of users and carers in service development and delivery plays an increasingly important role in creating health services that are fit for purpose. Internationally, there is strong interest in engaging the public more widely in both the development and governance of public services. Changes have been made to legal and regulatory frameworks across the European Union to acknowledge the importance of public and patient involvement (McEvoy *et al* 2008) and in the USA, Canada, Australia and New Zealand, there is growing emphasis on public or consumer participation and citizen engagement (Edgman-Levitan *et al* 2013). In developing countries, a long history of community projects has provided a foundation to inform more recent moves towards consultation and engagement of community members (Morrow *et al* 2012). Beresford (2010) argues that the context for participatory approaches has a strong influence on their nature and impact, referring to the mainly market-based approaches in the USA, compared to the mainly state-based systems of Scandinavian countries. Likewise, in the UK, Morrow *et al* (2012) suggest that drivers for participation include challenges to medical authority, the changing role of patients in policy, the democratisation of public services and public responses to professional scandals.

This has been particularly evident in UK family policy. Not only did the government emphasise their commitment to the role of service users in all aspects of family care in their policy *Healthy Lives, Healthy People* (Department of Health (DH) 2010), the Health and Social Care Act 2012 (HM Government 2012) also formalised the duty of service commissioners for NHS England to enable patients and carers to participate in planning and making decisions about their care in to statute.

Health visitors are nurses who undertake an additional qualification, which equips them to assess the health needs of families and work therapeutically with their clients or support them to access services to meet those needs. They visit all new parents, have expert knowledge of the health needs of the communities in which they work and the skills to build community capacity in line with the Government's concept of social capital (DH 2011). The publication of the Health Visitor Implementation Plan (HVIP) (DH 2011) launched the Government's commitment towards developing the health visiting service, with a pledge to increase the workforce by 4,200 extra health visitors by 2015 (DH 2011). This wide reaching policy also presents an aspirational service model based in proportionate universalism. It is well documented that the policy was developed in consultation with service managers, health visitors and policy makers but the voice of the parent is not explicit within the policy process (DH 2011). Subsequently, while there has been significant financial commitment to this area and recognition that starting from the parents' perspective is crucial to effective policy and service development, parental involvement is notable by its absence.

Over the last decade there have been a number of studies that have explored parental perceptions of the health visiting service (Plews *et al* 2004, Bloomfield *et al* 2005, Roche *et al* 2005, Russel and Drennan 2007, Marshall *et al* 2012). Parents report that good health visiting makes them feel

'known', respected and listened to (Donetto *et al* 2013). Emphasis is placed on the significance of trusting relationships, in helping to build parental confidence and promote parents' trust in their own decisions about child and family health. A view reiterated by Cowley *et al* (2015) who define the values, skills and attitudes key to delivering the health visiting service: salutogenesis, person centeredness, viewing the client in situation.

Allen's (2011) report, *Early intervention: the next steps*, emphasised the increasing need for partnership and reciprocity to lie at the heart of health visitor interventions. However, establishing family priorities or concerns about broader social problems and structural disadvantage continue to be assessed from a professional perspective rather than client led (Hogg *et al* 2012).

In addition, the views of a number of disadvantaged groups suggest that they can find access to the service challenging, and at times discriminatory (Donetto *et al* 2013). These criticisms were seen as having a negative impact on service use in the future (Donetto *et al* 2013) and was particularly pertinent where parents did not see themselves as active agents in service development, or where targeted provision was introduced insensitively. Marshall *et al* (2012) concluded that parents were well placed to decide whether they would access services and being involved in service development may be a crucial and beneficial next step.

This study was funded by Health Education South West to examine the impact of the HVIP on health visitor education and service delivery. A key aspect of the study was to explore family and community perspectives on the introduction of the HVIP and their experiences of the new health visitor service provision. These views and experiences contribute to the national debate surrounding the role of parents in shaping service development and policy implementation. There is a paucity of research around parent participation in health policy implementation or health visiting service development. In order to address this, the paper explores the opinions of a range of parents across the South West of England on the health visiting service that they receive and their responses to the implications of the HVIP.

Methods

The qualitative data on which this paper is based was collected to assess the extent to which the ambitions of the Government's Health Visitor Implementation Plan have been met from the perspectives of parents using the service. Using a qualitative approach, data were collected using one to one semi-structured interviews and focus groups with a range of service users in the South West of England, UK.

Sampling and data collection

Participants were recruited through Children's Centres, which in the UK provide a range of services, many of which are free, to support families. These are generally run by non-government organisations or public private partnerships. The managers of all the centres in the region were approached directly to encourage participation and all those who agreed to participate were included. Three focus groups with parents and ten face to face interviews were held in four Children's Centres in the South West of England on five separate occasions between March 2013 and March 2014, arranged to coincide with group sessions at the centres. The Children's Centres

were located in both rural and urban areas, with a range of deprivation indices. The health visitors that the participants would have encountered were employed by three separate health service providers across the region. Children's Centres were chosen as the venue as they were seen to be neutral territory and did not have direct involvement with the organisation or management of health visitors.

The participants were all attending organised groups and activities, including a multiple births group, new babies groups and a breastfeeding support group. Some of the participants were first-time parents and some had more than one child. All the attendees of the groups on the occasions that the researchers visited were invited to take part. Participation was voluntary and the participants were self-selecting; the parents were given information about the research the week before the interviews and written consent was obtained on the day of the interview. The researchers had no prior relationship to the participants, the Children's Centres or to the Health Visiting Service Providers.

Focus group and interview questions were developed drawing on key findings from previous research (Donetto et al 2013, Marshall 2012, Roche *et al* 2005). This was in addition to the influence of the policy context set out within the HVIP, which placed partnership working with parents central to its aims. Using the same semi-structured topic guides, participants were asked to reflect on their experiences to date of the health visiting service, personal expectations of service delivery and potential areas for improvement. Parents' understanding of the introduction of the recent Implementation Plan and their views on these developments were also sought. The interviews and focus groups lasted between 10 and 30 minutes, were audio recorded and transcribed by an independent research administrator. Individual data was anonymised by assigning a participant number to each participant during transcription. A total of 22 parents took part in the discussions, 21 mothers and one father.

Ethics

The research was informed by guidance cited in the British Educational Research Association's Ethical Guidelines for Educational Research (British Education Research Association 2011). Prior to commencement of the study ethical approval was obtained from the University Research Ethics Committee. In accordance with ethical principles all the data collected was anonymised and pseudonyms used to protect the identity of those who took part.

Data analysis

Thematic analysis of the qualitative data was undertaken independently by two members of the research team (JB, DS), with further scrutiny and corroboration of the themes by an experienced researcher from the advisory group (JO). Iterative reading of transcripts led to identification of codes and agreement of dominant themes. Analysis followed the six-phase guide outlined by Braun and Clarke (2006). This allowed access to the 'thick description' of the data set and uncovered insights in to the perspectives of the service users. Thematic analysis was chosen as a method in its own right to allow the researchers to derive useful and plausible phenomena, which will be influential to health visiting practice. The interpretations were data driven rather than theory driven and both social and psychological interpretation of the data were applied (Braun and Clarke 2006).

Four themes, present in both the focus group and interview data, were derived: organising and delivering the service, the role of knowledge and practitioner attributes in shaping experience, characterising the parent-health visitor relationship and talking about time and the impact on parent perception.

Findings

Organising and delivering the service

The majority of the parents stated a preference for health visitor contacts at home. Clinics were described as busy, hectic places with very little privacy so there was a reluctance to 'bother' the health visitor with minor issues. The fact that the clinic may be in a doctor's surgery where they would have to wait alongside ill patients was also a deterrent:

It (clinic) just feels like you have got a short time period and you are kind of aware of all the mums outside waiting to come in..... I just feel like you have got a couple of minutes to get it out and get the answer (Parent 2).

Conversely co-locating health visitors within a Children's Centre brought added value, not least because it meant that parents had a reason to leave the house and meet other families.

R: I mean she was happy to come to me if needed because I don't drive so and it was quite a walk sometimes it was all uphill so she was like do you want me to come out to you and I was like no I prefer to come out because to get out of the house as well which was nice (Parent 15).

The parents particularly valued the personal contact of the health visitor, and the majority would have welcomed more home visits during the first year of their child's life, particularly those who felt that their transition in to parenthood had not been easy. In this situation the home visit was seen to be more valuable if the health visitor initiated the contact. This was particularly salient if the health visitor had referred the parent to another agency, and then decreased their contacts given that another professional was now involved:

Kind of they haven't really checked to see if I am ok for a long time now which is fine but at the time I was in a bad place and they kind of said oh you know have you seen the specialist and I said yeah and that's it I have not heard from them again and that was in January....I see her around and she knows who I am she says hello and everything but that's it (Parent 6).

There was an underlying assertion in many of the comments that the service received was not as good as it might have been in other geographical areas where they may have received more home visits. The majority of parents identified that to see the same health visitor was important. This enabled the parents to feel comfortable talking to the health visitor and avoided repeating their history to new practitioners, particularly important if they had been experiencing difficulties. Conversely, the opportunity to see a range of practitioners was also important if the parent had not found their initial contacts useful.

Only four of the parents knew about the government drive to increase the number of health visitors. The majority felt this would be positive given how pared down the service seemed to be. They were also asked to comment on the new service vision, in particular the concept of proportionate universalism, ie a level of service allocated according to assessed need.

I think it would be very easy for everyone to say well you're a universal second child um you know or no complications first time mum so we will just keep a kind of little eye on you because someone

else is telling us they need more when actually the person over here is just not telling you how bad they are finding it (Parent 8).

None of the parents were aware of the service model. Their concerns were around the ability of health visitors to assess whether a family required more support than a universal service would offer.

The role of practitioner knowledge and attributes in shaping parental experience

Parents felt strongly that health visitors should give advice linked to the current evidence base and should be consistent between health visitors. Maintaining up to date knowledge was seen to be the responsibility of the individual practitioner and they should avoid slipping in to complacent practice. This was linked to their credibility as a practitioner; parents did not respect health visitors who used personal experience with their own family as a basis on which to advise:

I think it could be that she is not up-to-date because she was talking about what she did when she was a mum and her boys are now at university so she was giving me advice from that long ago and I much rather she respected the up-to-date views (Parent 3).

However, there was also some recognition that individual situations may require an individual approach. Three parents indicated that health visitors were restrained by the parameters of the evidence base and this hindered them in situations that didn't fit with the mainstream. Consequently, parents were likely to turn to other sources of advice such as crisis lines or friends and family, which were more likely to draw on personal experience. This in turn made them feel anxious about making alternative choices to those recommended by the health visitor:

At the end of the day obviously it's our decision whether to do it or not you know and I would never put that on a health visitor but it just seems at times that they don't want to advise because they are too worried of any like repercussions or anything you know what it's like ...or like I feel myself like oh no I can't do that because otherwise the health visitor might go oh no you can't do this, you can't do that... (Parent 6).

The parents identified that it was essential for a health visitor to be enthusiastic, supportive, approachable, proactive and friendly. They valued the listening skills of their health visitor and their ability to identify the cause of the problem but also their ability to empathise and to be able to advise without making them feel uncomfortable or embarrassed. Parents valued open mindedness, particularly a non-judgemental attitude, and highlighted a strong link between credibility and integrity.

I: Ok so when you say she was lovely what was it that made you think she was lovely?

R: Um just her disposition I suppose and the way she never judged me particularly with my circumstances and everything she sort of listened to what I had to say and any sort of concerns I had or anything like that and if I got a bit upset she would obviously was comforting and things like that (Parent 16).

These attributes are also fundamental to the relationship between the parent and the practitioner that was described by parents as central to effective engagement.

Characterising the parent/health visitor relationship

A relationship based on trust and effective communication was integral to an effective contact. If the trust between the parent and the health visitor was lost then the parents were reluctant to engage

with the service. If the communication skills were inappropriate this also prevented a relationship being formed. The fact that the health visitors made few home visits impacted on their ability to build a relationship, as did the lack of consistency around who they saw at home or clinic. There was a strong feeling that unless a relationship was established, parents would not discuss their concerns and admit that they were struggling:

I say it time and time again you can get people that clinically are very good but actually you know you have got to be very good at communication and interpersonal skills to get that across and you have also got to relate to different personality types different age groups (Parent 12).

Yeah definitely some people don't feel they want to talk to a health visitor if they don't really feel comfortable with them they think that the information is going to get misled or next minute you feel a bad parent or something yeah... (Parent 4).

Central to developing a relationship was credibility, honesty and the health visitor respecting the views of the parent. Critically, parents did not want to feel intimidated or that they were a bad parent. However, when a good relationship was formed between practitioner and parent, it was very beneficial:

..because like sometimes they can come across like they know more than what you know even though obviously you go for your mother's instinct don't you ...where my first health visitor would be like well he will do it in his own time don't force him and she was like quite laid back with you know the advice and I took it on a lot more as where when you are told you should be doing this to me it's quite intimidating and you feel like you are failing if you know what I mean as well like you are not doing as well as you should be doing but yeah so... (Parent 15).

The relationship was strongly influenced by both the practitioner and parent perceptions of whether there was enough time to invest in its development.

'Talking about time' and the impact on parental perception

The participants repeatedly brought up the issue of lack of time and resources in the earlier interviews and this too was seen to be a major influence on whether a contact was positive or negative. This was characterised by practitioners saying they didn't have time to visit or to spend long with the parents because they were too busy. In some of the later interviews, time was an issue raised from a different perspective; health visitors were praised for giving the impression that they had as much time as the parents needed, which was highly valued by the participants.

Lack of resource was seen to be due to both local issues such as increased birth rate, and national issues such as government cuts. The majority of the participants were of the view that this impacted on the ability of practitioners to provide a satisfactory service. Nevertheless, lack of time and resources as an explanation for delivery of limited services was met with both understanding and frustration. Health visitors repeated reference to 'not having time' impacted negatively on the development of parent/health visitor relationship and motivated the parents to turn to other agencies, such as Children's Centres or private sources for help:

R: I am not sure I think their workload is... I think they are really overstretched and I think if you seem to be doing ok then you are sort of left alone to your own devices unless you need anything. But I do think it's just the fact that they are overstretched

I. So how do you know they are overstretched?

R: They are always telling us, they are always telling us (Parent 10).

...yes and from a not so great point of view especially for first time mums that's not a helpful message to give anybody because actually all you care about is you and your baby and your situation and not the fact that they are understaffed, overstretched and everything else... (Parent 8).

Lack of time was cited as a reason why health visitors did not always call back, did not visit at home and why the clinics were so busy. However, when parents felt that they were given enough time this made them feel valued, listened to (and crucially, felt 'heard') and they reflected positively on the service:

So my health visitor did a few more checks with us just to make sure that we were all right and she was lovely really nice, really understanding it never felt like I was rushed so if I needed to speak to her she wouldn't act like oh I have got to leave to go to another appointment you know she would stay there quite a while as well (Parent 16).

Whilst there was some resignation that the current national climate would not support aspirations of a better resourced service, other parents felt that individuals in the profession could change the way they worked to protect themselves against the high workload:

She said actually I won't give you a next date but I will contact you and she didn't and I found out that actually what had happened was she is off sick with stress now so I think her approach might be backfiring on her as well because if you always do the tell them, tell them, tell them that's a lot of effort on your part so I think part of the stress is self-generated (Parent 3).

The issue of time was a recurrent theme throughout the research, perhaps reflecting the impact that workforce capacity has on practitioner behaviour and parent perception of the service.

Discussion

The findings reiterate, to a large extent, those of previous authors in that relationship development, advanced communication and current knowledge are all important to parents (Donetto *et al* 2013, Marshall 2012, Russel and Drennan 2007, Roche *et al* 2005, Bloomfield *et al* 2005, Plews *et al* 2004). What is different about these results is the willingness of participants to discuss the negative as well as positive aspects of their experience. Parents felt that health visitors were too busy to provide the service that they expected or wanted and on the whole, practitioners did not allocate time to develop a partnership with parents and explain the service model. It would seem that, despite the efforts of the Department of Health to raise the profile of health visiting, at the family level there is still much work to be done to maintain the credibility of the service. These candid responses may be a result of the choice of methodological approach; the parents were recruited through the Children's Centres rather than in previous studies (Donetto *et al* 2013) where the Health Visiting teams were employed as a link to participants. Parents may have felt that there was some distance between the researchers and the health visitors, so reducing bias and encouraging more open disclosure.

The interviews conducted later in the course of the Implementation Plan elicited more positive comments about workforce capacity, which is an indication that the increased numbers of health visitors were starting to have an effect at service delivery level. Ultimately the parents' perspectives on the health visiting service were a spread of positive and more challenging experiences. The perceptions of the parents may well have been influenced by their individual backgrounds, not least any previous experience of stigmatisation and their feelings of self-worth (Porr 2015). When a parent feels that they need the service most, the perception may be that health visitors are least likely to be able to support them at the level parents expect. Taking either position, it is clear that the availability of health visitors has had a major impact on the service that parents receive.

The service vision falls short of being open and transparent to the families to which it applies. This may in part be explained by the incomplete implementation of the new service model in practice, however, Hogg *et al* (2012) encountered a similar pattern when evaluating a new assessment process in Scotland. Health visitors had difficulty explaining the process to parents and the families that they worked with were unclear about the health visiting role and its limitations, which suggest lack of partnership working with families around their care.

Peplau's theory of interpersonal relationships describes the four phases of the therapeutic nurse-patient relationship (Forchuck 1994). Applying Peplau's model to the parent-health visitor context, it appears the relationship is not always moving beyond the orientation phase, deemed significant for the development of a therapeutic relationship. If a productive alliance does not form early then it is unlikely to develop at all (Frank and Gunderson 1990). Not until the identification phase does the client feel confident enough to express feelings and work interdependently with the practitioner and only in the third phase, exploitation, do they make full use of the services offered. If workload pressures and lack of practitioner skill are preventing the health visitor from developing partnerships with parents, the transition for the parent through to the resolution phase where they no longer need professional services is unlikely, compounding the workload pressures already endemic within the provision.

Parents were asked to discuss their views on the health visiting service at the macro, national level and at an individual level, however responses were predominantly around personal experience. Possibly parents see national policy enacted at the level of the parent-health visitor relationship; their dialogue suggest that some saw practitioners who were unable to respond to the needs of parents, or to translate the national policy in to local delivery. These personal responses are a strength of the research and reiterate the meaningful nature of involvement at local level but also indicate that as a profession, health visitors should work towards resolving the issues raised. It is crucial that education for the new generation of health visitors promotes the philosophy of client centeredness. This means equipping practitioners with the advanced communication skills to proactively support and build on parental strength.

These study findings indicate that participation is often understood by parents to be at the level of the relationship between practitioner and parent. Although the parents described their aspirations for a partnership, this was infrequently reached and instead a situation where the parents felt disempowered to make their own choices was prevalent. On a wider level it could be argued that NHS structures, heavily influenced by the need to meet commissioner targets, are perpetuating a system that favours tokenistic participation rather than true devolution of power (Schehrer and Sexton 2010).

Limitations

Limitations of the study include the self-selecting nature of the sample; it is not possible to determine the degree to which their views were representative of families in general and in particular those who decided not to take part. In addition, the data was collected over a 12 month period. Given the pace of the HVIP, parental experiences may have been influenced by the stage of policy implementation. As the HVIP has now been fully adopted, further research with parents would allow a contemporary analysis of their views now that the policy implementation is complete.

Conclusion

The findings of this study were consistent with previous research in that parents focused on the relationship that they feel they had with their health visitor. Whilst this highlighted positive aspects, criticisms included lack of practitioner time, lack of client centeredness, judgemental attitudes and inflexibility. Persistent references by health visitors to workload pressures and an emphasis on deficits within the service had a significant impact on parental perceptions of the service. Health visitors need to consider how they can be positive ambassadors for the virtues of the service, focusing on communicating new policy developments in a meaningful way to parents, building on partnership working rather than sustaining a power imbalance. A further solution lies in the appropriate education of the health visitors of the future, developing communication skills and attributes that can build on the strengths of families and respond to their identified needs.

Fundamentally, the HVIP as a policy has been implemented from the top down, with little involvement from the parents at either national or local level. It is important to distinguish whether the process of involving parents in the health visiting service is an ambition in itself, or a means to achieving better outcomes for children and families (Schehrer and Sexton 2010). The UK health visiting service may benefit from lessons learned internationally as public engagement in service development becomes more sophisticated. Given the strength of parental opinion uncovered by this study, it is clear that at least some parents are willing to contribute to the development of health visiting services and many have clear opinions on how the service could be rejuvenated. Whilst it would be naïve to assume that all participation is positive, resulting in better services, better outcomes and better service users (Stewart 2013), the ethos and rhetoric of the health visiting profession where partnership and empowerment are seen as fundamental indicate that this should at least be an aspiration.

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5999

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