From reassurance to parental self-efficacy: Lay and professional perceptions of the purpose and value of health visitor-led child health clinics

A Grounded Theory Study

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A Thesis submitted in partial fulfilment
of the requirements of the University of the West of England, Bristol for the degree of

Professional Doctorate in Health Psychology

Faculty of Health and Social Sciences

April 2018

Word count: 31,173
Abstract

Despite the widespread presence of Health Visitor led baby clinics across the UK for over a century, there is little published research about this model of support, its purpose or effectiveness. No national guidance exists about how or indeed, if, baby clinics should be conducted; local services are therefore left to consult their own professional instincts and experience for guidance on the delivery of this long-standing service offer.

This research follows a systematic review of the effectiveness of universal Health Visitor led Child Health Clinics, which suggested that professional reflection and research into the focus, structure and function of clinic models and the theoretical process of community-based family support within the health visiting service is now needed in order to progress this element of universal service provision to an evidence base.

The aim of this research was to take a preliminary look at both lay and professional perspectives of the purpose and value of baby clinics, in order to illuminate the experiences of mothers and professionals attending clinics and the process of support that they may be engaged in.

Informal semi structured interviews were conducted with 24 participants; 9 Health Visitors, 3 Community Nursery Nurses, 8 Mothers, 2 Infant Feeding Specialists, A senior lecturer delivering a Public Health Nursing Course and an NCT Postnatal leader and Tutor. A constructivist Grounded theory methodology was used to analyse the data. A substantive theory was constructed from the analysis which suggests that the experience of support at baby clinics can be conceptualised in two constructed social psychological processes, which represent two disparate models of clinic provision: A surveillance model, focussing on weighing and monitoring which appears to engender a cycle of ‘serial reassurance’ and a primary prevention model focussing on reflection and compassion, facilitating the promotion of parental self-efficacy.
The two iterative, cyclical support processes, each have four conceptual categories which were developed from the narratives:

The first reflecting a didactic approach, where weighing, monitoring and advising form the basis of the interaction between health visitor and mother. The second reflecting an heuristic approach where the exchange of support between mothers and between health visitors and mothers is relational, experiential and socially orientated.

The grounded theory outlined in this study provides conceptual insight into the social process of providing support for mothers and infants at health visitor led baby clinics. Implications for practice are considered and it is suggested that organisations providing health visiting services who seek to align their model of clinic provision with a primary prevention agenda should consider restructuring clinics to deliver a psychologically informed heuristic model which encourages social interaction between parents. Such a model should focus on facilitating self-compassion, resilience and self-efficacy within parents as they make the psycho-social adjustment into their new or renewed parenting role and should encourage a sensitive and responsive approach to parenting.
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I would like to thank my family, friends, colleagues and tutors for their invaluable support during this research process.
Preface

The choice of grounded theory as a research method for this study and the subsequent chosen structure of this thesis reflects the absence of theory and limited research which exists around the delivery of health visitor led baby clinics.

The process of grounded theory necessitates both an early review of the literature in the substantive area of study and an integration of extant theories into the narrative of the study, once the model of the constructed social process under investigation has been established. Charmaz suggests that extant concepts ‘earn their way into your narrative’ (2006, p. 126) and it is recognised that for researchers employing grounded theory as a research methodology the issue of how to represent their engagement with existing literature in an area can therefore be problematic (Dunne 2011).

Stern (2007) suggests that a review of literature which arises from the grounded theory constructed process is important for both academic honesty and also to illustrate how the study contributes to the field of inquiry.

The introduction to this thesis therefore aims to provide a comprehensive synthesis of current literature that exists around this topic and a reflexive account of the professional background of the researcher in order to contextualise the motivation and justification for the research.

In depth engagement with extant theories, constructs, concepts, models and approaches are then included in the discussion section, after data analysis has been presented because of the absence of theoretical constructs currently informing approaches to clinic provision. They are discussed as exploratory explanations and approaches to baby clinic provision grounded in the data generated through this research and representing new areas of potential focus.
Introduction

Why this study?

National rationale

In 2010, informed by the Marmot Review ‘Fair Society, Healthy Lives’ (2010), the UK Government set out a national vision to improve health, reduce health inequalities and build community resilience to health threats. The vision was outlined in a White Paper; ‘Healthy Lives, Healthy People: Our Strategy for Public Health in England. The paper asserts that to ensure the effective use of resources, public health interventions should be focused on evidence, linked to clear health outcomes and be both efficient and effective (Department of Health 2010, [2.15]).

Baby clinics are an area of health visiting practice where the service focus and outcomes are unspecified, where little evaluative research exists and where no evidence of effectiveness has been found (Webb 2016) and yet they continue to be offered by health visiting services across the UK, consuming a significant amount of health visiting hours. There is an urgent need therefore to progress this enduring element of service delivery to an evidence base to ensure that public health resources are utilised efficiently and effectively.

The process of creating effective public health interventions underpinned by robust theory is complex and in order to begin to work towards this goal, the process of support sought and offered at baby clinics first needs to be explored and understood through the perceived experiences of mothers and staff attending. This study takes a preliminary look at this social process in an effort to illuminate this area of practice and provide service providers with clear process models of delivery, underpinned by theoretical constructs, which may be discussed and explored in practice.
When service providers can deliver baby clinics with a clearly defined rationale and model and fidelity to the model and effective implementation can be established, research evaluating the effectiveness of such models should then be conducted to continue to progress this service element to an evidence base.

**Personal rationale**

As a Lactation Consultant and trainee Health Psychologist working as an Infant Feeding Lead within a Health Visiting Service in the South West of England, I became very interested in maximising the effectiveness of our local baby clinics in terms of supporting infant feeding and early parenting. The Baby Friendly Initiative (UK) community standards, which had been updated and re-orientated towards a more psycho-social approach to supporting early relationships (Entwistle 2013) highlight the importance of providing community-based support groups for infant feeding and at a time where significant cuts to Children’s Centre Services were being made, there were increasingly fewer opportunities for parents to meet socially with their babies and access crucial peer support. The potential of baby clinics to meet this valuable need for parents and provide a service more aligned with the current focus and orientation of the Health Visiting Service (Cowley et al 2013) was apparent.

My search for national or professional guidance on the delivery of baby clinics proved unsuccessful, I therefore began to explore if there was any research which could inform an evidence-based model of service delivery. What became clear was the lack of professional guidance in this area was due to a lack of research; baby clinics it appeared, were being delivered based on tradition and ritual, with their purpose and effectiveness unclear.

The systematic review which informed this research (Webb 2016) was conducted to review the evidence around the effectiveness of universal health visitor led child health clinics, in a hope to provide some insight into the delivery of this prevalent element of service provision within health visiting. The review
however, found a lack of evaluative research about the structure, process and outcomes of baby clinics, making it impossible to draw a conclusion about their effectiveness, further research was therefore suggested to illuminate this underexplored area. A search for further significant literature on this topic has been conducted since the systematic review in 2016, however no further relevant studies have been found.

Health visiting and health psychology

The disciplines of health visiting and health psychology are natural bedfellows, one having evolved as a public health intervention with little theoretical underpinning (Cowley et al 2013) and the other as a theory-based discipline with a potentially wide range of applications in the public health and clinical field (Division of Health Psychology 2017). Health visiting has sat at an intersection between the agenda of epidemiologically informed bio-medical public health work and supporting the psycho social needs of families for many decades (Malone 2000), but improved understanding of how these agendas interface and the broader meaning and impact of health and wellbeing, informed by a bio-psycho-social perspective is gradually defining the professional focus and role of health visitors (Cowley et al 2013). Health visiting has arrived at a point where it now needs theoretical focus (Cowley et al 2013) and health psychologists can support services to understand and explore health promotion processes within the unique and immensely valuable sphere of health visiting work, building theory and models to inform practice.

Baby clinics are one area of practice which appear to have received little attention in terms of research and development of practice and the systematic review that informed this research highlights the importance of considering the psychological, emotional and social needs of mothers and infants at clinics as well as their infant’s physical needs (Webb 2016). Psychologically informed practice at baby clinics has potential to improve public health outcomes on both
a population and individual basis through the appropriate consideration of relevant psychosocial factors.

The commitment to the provision of baby clinics appears to be robust, having been delivered for over a century in the UK (Webb 2016). In the absence of current professional guidance on service delivery however, health visiting service providers need to reflect on the aims of this service provision and adopt a psychologically informed approach which appears best able to meet those goals.

The development of the research question

The systematic review informing this research suggests that community-based family support is under-theorised in health visiting literature, with little research into the psycho-social processes around which effective universal parenting interventions should be focussed. This is in line with the conclusions of a narrative review of literature examining the potential public health benefits from health visiting practice (Cowley et al 2014) which suggests that in general there is a lack of evaluative research about the mechanisms by which the service promotes health and reduces health inequalities.

The direction of focus for the research question was therefore guided by the need to understand both why and how baby clinics are being delivered in order to begin to gain an understanding of this area of practice and its contribution to child health. The absence of national or professional guidance on why or how baby clinics are being delivered suggested that a starting point which focussed on eliciting the experiences of both parents and professionals attending the clinics may be appropriate. A poster presentation of the systematic review was presented at the UNICEF Baby Friendly Initiative Conference in December 2015 (Webb 2015, Appendix A) which gave me an opportunity to speak to delegates
(health professionals, academics and parents) about their thoughts around further potential research and the method of data collection.

A peer reviewed version of the systematic review was published in the Journal of Health Visiting in September 2016 (Webb, 2016) and as a result of the publication I was asked to speak at a Public Health England South West event for commissioners in 2016. This also provided another opportunity to explore ideas about the potential focus and approach of research following the review.

It became clear that, similarly to the review of research, there was indeed little consensus from practitioners, parents and commissioners about the purpose or value of baby clinics. To explore both lay and professional perceptions appeared therefore to be an appropriate starting point in the development of a research question. The initial proposed question was:

_Lay and professional perceptions of the purpose and value of health visitor led health clinics: How do baby clinics promote positive outcomes for pre-school children?_

Feedback from academics following my progression exam during the research process suggested a subtle but significant change to the second part of the research question, to reflect the current lack of evidence of effectiveness for baby clinics, in line with my systematic review. The research question was therefore changed to:

_Lay and professional perceptions of the purpose and value of health visitor led health clinics: How do baby clinics influence outcomes for pre-school children?_

The research was to focus on exploring the experiences and perceptions of both parents and professionals attending baby clinics in the hope that it may begin to illuminate a social process or processes which may be influencing outcomes for the children attending. The decision to remove the last section of the research question from the title of the research was made following reflective supervision with academic supervisors, where it was suggested that whilst there was a focus
on exploring the social process of clinics in terms of how outcomes are being mediated, the title may mislead readers to believe that it is an outcomes-based study. The title has therefore been modified to reflect the focus and findings of the qualitative study and avoid any confusion.

**Literature Review**

The landscape of public health has significantly evolved in the twenty first century, moving from medical approaches to health promotion which focused the responsibility for health and wellbeing at an individual level (Hall and Elliman 2003), through to a wider and more holistic life course framework with the aim of tackling the wider social determinants of health, starting in childhood (Marmot 2010).

The UK Government’s strategy for public health in England set out in 2010, informed by the Marmot review states: ‘The new approach will aim to build people’s self-esteem, confidence and resilience right from infancy – with stronger support for early years’. (DOH 2010 p.4).

A Government led call to action to expand and strengthen health visiting services in 2011 set out a commitment to grow the health visiting workforce, invest in training and development and engender a transformation of the service (DOH 2011).

The new Healthy Child Programme in 2009 (DOH), re-orientated the approach to child health in the UK away from extensive health surveillance towards primary prevention and early intervention and reflected what had been a growing recognition; that the relationship between parents and health professionals needed to move towards one of partnership rather than supervision (Hall and Elliman 2003 p.3).

Protecting and promoting the health of children, whilst primarily a parental responsibility is now globally recognised as both a moral imperative of wider
society and an economic and social investment (Rees, Chai and Anthony 2012). Ecological models of health promotion (Brofenbrenner 1977; Sallis, Owen, & Fisher, 2008; Stokols, 1992) which focus on the interplay between individual and social environmental factors, now inform the training of public health nurses and the delivery of their specialist community focussed services in the UK.

Such models are also reflected in approaches to the orientation of national programmes such as the UNICEF Baby Friendly Initiative (UK) who led a ‘Call to Action’ in 2016 which aims to refocus the conversation around breastfeeding, locating it in a wider social narrative: ‘We need to change the conversation around breastfeeding by stopping laying the responsibility for this major public health issue in the laps of individual women and acknowledging the role that politics and society has to play at every level’ (UNICEF 2016).

The UNICEF Baby Friendly Initiative’s evidence and rationale document for their current community standards recognise that positive interpersonal and community relationships are key to promoting a nurturing environment for children. The promotion of interdependent, compassionate and respectful connections with parents and between parents and also their community are therefore prioritised: Promoting a sensitive and responsive approach to parenting and lobbying for improved understanding from wider society about the community support needs of parents and infants (Entwistle 2013).

The Marmot Review (2010) set out a comprehensive survey of the key causes of poor health, locating them in socio-economic inequalities, social disadvantage and unhealthy behaviours. The UK Faculty of Public Health (FPH) response to the Marmot Review (FPH 2009) did however highlight that there was an evidence gap in the report around the significant impact of ‘Adverse Childhood Experiences’ (Felitti 1998) on health outcomes.

A retrospective public health study conducted in the UK and published in 2014 (Bellis et al) that explored the dose response relationship between adverse childhood experiences (ACEs) and poor adult health and social outcomes, found
that in line with research in US populations, ‘ACEs contributed to poor life-course health and social outcomes in a UK population’ (p.81). The original longitudinal, seminal study (Felitti 1998) and the multiple subsequent papers in this area of research have provided a rich source of evidence around the impact of early trauma and are informing shifts in both public health practice and education, particularly in Scotland (Couper and Mackie 2016). Trauma informed approaches to behaviour management in early years settings and schools and a refocussing of the narrative around public health work towards individual and community resilience has been gathering pace (Oehlberg 2008, WHO 2009, Ford et al 2016). A recognition of the value of supporting parents to understand the cumulative impact on children of exposure to acutely stressful situations in childhood and the protective power of connection to a caring and protective adult is emerging. Also, the importance of offering parents support with practicing compassionate self-care, who may have experienced adverse childhood experiences themselves, which affect their own levels of resilience.

In 2014 six high impact areas were developed at a national level (to articulate the key areas where health visitors contribute to the 0-5 agenda (PHE 2016). Whilst the areas do not describe the entire scope of health visiting services working to deliver the Healthy Child Programme (DOH 2009) they provide important key areas of focus for health visitors to support the health and wellbeing of children. The contribution of the five nationally mandated Health Visiting contacts (antenatal, new birth, 6-8 weeks, 9-12 months and 2-2.5 years) can be mapped to the six high impact areas and although baby clinics may also have much to offer families in terms of support around these areas, their contribution has yet to been established or specified (PHE 2016).

It is useful therefore to reflect on the essence of support that health visiting services currently offer in each high impact domain:

1. **Transition to parenthood and the early weeks**
Becoming a parent is a transitional period characterised by biological, psychological and social change for both mothers and fathers (Mayes et al 2012). Whilst it is a normative developmental phase in an adult’s life, it can be experienced as a period of intense adjustment; getting to grips with new roles and responsibilities, navigating a renewed identity and negotiating the changing relational dynamics within family systems (Bornstein 2016). As with any transitional period in the life course however, becoming a parent can provide a catalyst for positive change; ‘a teachable moment’ when parents are highly receptive to developmental change (Lawson and Flocke 2009). The refocussing of the Healthy Child Programme (2009) towards parenting support beginning in the antenatal period reflects both the evidence around behaviour change potential in the perinatal period (Lawson and Flocke 2009) and also the wide-ranging evidence about the impact of early relationships on the neurological development of children (Gerhardt 2004, Sunderland 2016). Health Visitors therefore have an important role in supporting parents to explore their feelings around becoming parents, to reflect on the way they were parented and to connect with their baby in a sensitive and responsive way that promotes a strong child-parent attachment in the first years of life (HCP 2009). They are encouraged to take a guiding approach to the sharing of evidence-based information and support parents to recognise reliable sources of information and build support networks in order to build their reflective capacity, resilience and confidence as parents (Entwistle 2012).

2. Maternal mental health
The emotional wellbeing of mothers is now recognised as an important public health priority within child health because of the adverse impact on children of maternal mental health problems (PHE 2016). Whilst there is currently no population screening programme for postnatal depression, NICE guidelines recommend that Health Visitors use screening questions within
part of a general discussion about mental health and wellbeing in order to identify those women who may need specialised support (NICE 2016).

Estimates of the incidents of perinatal mental illness vary from 10% to 20% in research publications, with many using the term ‘at least 10%’. It is thought however that about 50% of cases are undetected (NHSIQ 2015).

There is often a reluctance for women to discuss mental health (PHE 2016) as whilst ‘mental health’ incorporates both mental ill health and mental or psychological well-being, the term is often perceived to denote mental illness rather than wellbeing, which holds an associated social stigma for many women. Approaches which focus on maternal wellbeing rather than maternal mental illness are therefore encouraged (Brook 2015).

The role of health visiting in addressing maternal mental health remains within the domain of preventative public health; identifying mothers at risk because of past history, psychosocial adversity or social isolation and encouraging them to access further support for their own wellbeing and the wellbeing of their child or children (Brook 2015).

A systematic review of systematic reviews to improve maternal mental health and wellbeing found that parenting programmes can positively contribute to the psycho social wellbeing of mothers in the short term however more research is needed to explore longer term effects in order to draw any conclusions about the role of parenting programmes in the primary prevention of mental health problems (Alderdice et al 2013). Health visitors may therefore have an important role in delivering group-based support which promotes mental wellbeing through for example; promoting social contact between parents (Brook 2015).

3. **Breastfeeding (initiation and duration)**

Breastfeeding is a high impact area which can have a positive influence on all of the other high impact areas; supporting a healthy hormonal transition into parenting for mothers, being a protective factor for maternal mental health,
supporting healthy weight and nutrition for infants, reducing child hospital admissions through offering immunological protection and promoting bonding and attachment through both hormonal activity and sensitive and responsive approaches endemic in the relational process (Victora et al 2016). The risks of not breastfeeding are well established through a rigorous research base, spanning numerous disciplines and its importance on both a mother-infant dyadic level and population level are widely reported and accepted (Brown 2016).

Although breastfeeding is the physiological norm however, it is not the cultural norm in the UK and many mothers have difficult experiences, through poor support from health professionals, lack of support for feeding from the community and ingrained beliefs that formula is of equal nutritional value (Brown 2016).

Health Visitors have an extremely important role in both supporting individual mothers to understand and reflect on the normality of breastfeeding, the risks of formula feeding and in promoting the social conditions to enable those that choose to breastfeed to do so successfully and enjoyably (Entwistle 2013). Historically baby clinics have provided poor support for breastfeeding, with an emphasis on weighing and monitoring rather than supporting mothers to have a comfortable, effective, sustainable and enjoyable feeding experience and whilst their potential contribution to supporting this crucial public health priority may be significant, it has yet to be explored and defined (Sachs 2005, Webb 2016).

4. Healthy weight, healthy nutrition (to include physical activity)

Childhood obesity is a priority public health area for government because of the well evidenced health and social care costs of associated co-morbidities (Pulgaron 2013). Overweight children are at increased risk of poor health outcomes and rates are greater for children living in economically
disadvantaged families, it is therefore a significant health inequality that needs to be addressed (Mayor 2017).

Health Visitors are in a unique position to influence early nutrition and make an important contribution to the government’s strategy on obesity which encourages local authorities to take a ‘whole systems’ approach to promote healthy weight, healthy nutrition and a physically active lifestyle in local communities (DOH 2018).

To address the historically complex and culturally sensitive issues of what and how we feed our children, it is recognised that a holistic approach is required from health visiting services, with healthy weight and appropriate infant feeding messages embedded in and layered throughout all contacts with families in a way which is non stigmatising and encourages self empowerment using evidence based approaches such as promotional guidance and motivational interviewing (PHE 2016).

Starting antenatally, mothers are encouraged to reflect on their diet in pregnancy and parents are encouraged to reflect on how their family eats (CPHVA 2015). Infant feeding is discussed which promotes and normalises breastfeeding and encourages parents to understand and reflect on the immunological, nutritional and relational needs of their baby in relation to feeding (Entwistle 2013).

Whether breastfeeding of formula feeding, parents are encouraged to feed responsively, acknowledging their infant’s hunger and satiety cues in order to support the maintenance of appetite regulation into toddlerhood. The appropriate introduction of solid foods at six months in a way which allows infants to explore different tastes, textures and preferences is also an area of focus with appropriate signposting to accessible, evidence-based sources of information to support parents to engage in self-directed learning opportunities around healthy eating (Entwistle 2013).
5. **Managing minor illnesses and reducing hospital attendance/admissions**

Every year approximately 50% of children under 5 will visit an Accident & Emergency department (Baker 2017). The leading cause of attendances and hospitalisation for this group are accidents in the home and illness such as gastrointestinal and respiratory infections (PHE 2016). Health visitors have a primary prevention role in promoting immunisations to protect against childhood illnesses and to promote, protect and enable women to breastfeed to prevent them from being at increased risk of infection and illness through the use of formula (Stuebe 2009).

They also have a role in promoting child safety through offering anticipatory guidance; such as understanding how children develop and how we can ensure their environments are safe to explore as they development and grow increasingly mobile and curious (DOH 2009).

In addition, supporting parents to understand the importance of oral health, both in terms of what children eat and drink, but also how they clean their teeth is an increasing public health priority for health visitors (DOH 2009) with tooth decay leading to tooth removal the main cause of hospital admissions and subsequent anaesthesia for the under 5’s (PHE 2016).

6. **Health, wellbeing and development of the child aged 2: Two year old review (integrated review) and support to be ‘ready for school’**

The focus of this high impact area on the assessment of children at two - two and a half recognises the importance of offering early support and help to families with children who may be demonstrating developmental delay, difficulties with emotional regulation or perhaps physiological problems, in order to give the child the best chance to be ‘ready for school’ with their peers (PHE 2016).

The review is conducted in partnership with the child’s parents or carers and looks holistically at each individual child in the context of their familial and
social environment; identifying the child’s strengths and needs in order to promote school readiness. For example; an assessment may identify difficulties or delay with speech, language or communication, behavioural problems or perhaps tooth decay and appropriate support pathways would be discussed with parents (DOH 2009).

As Health Visitors work within an ecological model of preventative child health which looks for future risks, many families may already have been encouraged to engage with support after assessment at one of the earlier mandated contacts, in order to minimise any potential inequities in child development that may have a social or economic aetiology. Support to be ‘ready for school’ from health visiting services begins antenatally and continues throughout the first two years with mothers being encouraged to connect with their baby in utero from birth, to engage in a sensitive and responsive style of parenting to promote a healthy attachment style which in turn supports appropriate emotional regulation and resilience in children, supporting their transition into school (DOH 2009).

Whilst the six public health ‘high impact areas’ are clearly defined for health visiting services, the process through which such support around these areas may be effectively offered and received at clinics has not been explored. It is clear that didactically telling people to adopt or change behaviours doesn’t work (Miller and Rollnick 2013) and health visiting services are therefore increasing using psychologically informed techniques in their work with parents (Cowley et al 2013).

Solution focussed, self-empowerment models of support which promote self-esteem and autonomy and aim to explore how this can be supported and facilitated at an individual, familial and community level are being embraced (Hall and Elliman 2003, DOH 2009, 2015). For example models and programmes such as ‘Promotional Guidance’ (Day et al 2014), ‘Signs of Safety’ (Bunn 2013) and the UNICEF BFI standards (Entwistle 2013) recognise the importance of
adopting a relational approach, where goals are negotiated with parents, individualised and transparency is key.

Much of health visiting work is conducted on a one to one basis in family homes (DOH 2009), but there is recognition that community work is an important element of the universal health visiting offer that has much to contribute to the psycho social well-being of mothers and children (Donetto et al 2013 p.12).

Despite the progression within public health practice and the clear focus now identified within health visiting, the rationale, objectives and outcomes of health visitor led baby clinics are unspecified at a national level and have not been explicitly linked to any of the health visiting six high impact areas. Staff and parents are therefore left to intu¬it their purpose, leaving meaningful evaluation difficult to obtain (Webb 2016).

In order to embrace a solution focussed, partnership approach and communicate openly with parents about the purpose of baby clinics, clear evidence-based objectives are necessary; linked to explicit health outcomes and with a psycho-socially informed rationale and approach that acknowledges the complex interplay of bio-psycho-social processes in child health outcomes (Webb 2016). However, in order to contextualise the current delivery of clinics explored in this research, it is important to understand the evolution of clinics and the health visiting service and how embedded ritual and a narrative around health surveillance and monitoring are still informing practice.

**Historical context**

The first child health clinics were set up in the UK in the late 1800’s, primarily to supply uncontaminated modified cow’s milk and support mothers with infant feeding and nutrition. With the advent of the NHS in the mid-20th century, clinics became part of mandatory local authority provision and developed an
educational outlook aimed at providing advice around childcare, development and health (Plews 2001).

Whilst the value of Health Visitors in providing this service was acknowledged in the Sheldon Committee report into the function of the child health clinic in 1967, their contribution was subsumed by the emerging wider medical remit of the clinics which focussed on immunisations, screening and growth monitoring. Research primarily focussed on the uptake of secondary preventative programmes leaving the advisory role of the health visitor within clinics largely unexplored (Plews 2001).

The move from a national programme of child health surveillance to an approach based on primary prevention through health promotion engendered significant professional reflection and development of the health visiting service, which in turn led to a reduction in the level of screening and physical growth monitoring by health visitors (Healthy Child Programme 2009, updated 2015).

A continued focus on weighing at clinics (Barlow & Coe 2011, Burgess-Allen 2010, Russell 2008, Sparrow 2005, Sachs 2005, Plews and Bryar 2002), against a backdrop of professional progress towards more holistic approaches to health promotion raises the question however, of whether a focus on weight monitoring at clinics has prevented this service element from evolving in line with the rest of the Health Visiting Service offer.

A national survey of health visiting activities and service organisation published in 2007 (Cowley et al) reveals that, at that time, baby clinics were a core service being delivered by 98% of the 968 caseload holders included. The only other service having such a high prevalence of delivery being the ‘new birth’ home visit by health visitors.

It is clear therefore that historically, a significant number of health visiting hours have been used in the delivery of baby clinics. However, Cowley et al (2013), in the literature review ‘Why Health Visiting?’ found insufficient research on this topic to demonstrate whether clinic work should be deemed as a ‘core practice’.
Given the lack of a theoretical basis, it is unsurprising therefore that they were not mentioned in the review of health-led parenting interventions in pregnancy and early years (Barlow et al 2008) conducted to inform the structure of the Healthy Child Programme (2009).

In fact, when Health Visiting was commissioned nationally during the Health Visiting Implementation Plan phase (2011-2015), there did not appear to be an explicit expectation that clinics were delivered as part of the Health Visiting Core service offer (National Health Visitor Service specification 2014 /15). Despite this, baby clinics continue to be routinely offered by many service providers, with their purpose, value and effectiveness unclear.

Clinic models


Weighing is frequently given as the reason for clinic attendance and is conceptualised by parents as an indication of an infant’s progress (Sefi and Macfarlane 1985, Turya and Webster 1986, Cubbon 1987, Sharpe and Lowenthal 1992, McIntosh 1992). A study by Sachs in 2005 however, suggested that weighing had become privileged in our understanding of how to evaluate the health and wellbeing of babies and may prevent other important means of assessment from being discussed with parents. A shift in emphasis away from weighing towards mother-infant interaction is suggested by Barlow and Coe in 2011 and a focus on parenting support at clinics is identified as a need across more recent papers (Donetto and Maben 2014, Barlow and Coe 2011, Burgess-Allen et al 2010, Sparrow et al 2005, Plews and Bryar 2002).
In fact, in 2005 a paper looking at service provision in clinics concludes that ‘traditional child health clinics addressing the physical needs of pre-school children are at odds with the expressed psycho-social needs of parents and carers’ (Sparrow et al 2005, p.299). Suggesting perhaps that providers should reflect on how community-based family support at clinics might provide support to promote a positive psychosocial adjustment into parenting.


‘I’ve noticed when you take her to the clinic you need to strip her…. they look under their arms and in between their legs and things like that. They’re looking for marks’ (MacIntosh 1992, p. 139)

This sense of social control is also evident in research focussing on support for breastfeeding at clinics. Sachs (2005) suggests that the structure of clinic encounters are predicated on the conception of breast milk as a disembodied ‘product’ rather than infant feeding being a relational process. She describes the focus on weighing and monitoring as analogous to a production line with health visitors acting as quality controllers, drawing on the historical impact of the industrial revolution and the associated economic and cultural constructs of production, output, measurement and control. The sense of social control is also implied through formal clinic environments, with chairs organised in a regimented way, precluding parents and children from socialising (Gillespie et al 1992, Betts and Betts 1990, Kilpatrick and Mooney 1987).
An understanding of the importance of the social function of clinics is evident throughout much research with a number of papers describing successful attempts to revitalise clinic attendance by making changes which encourage a more social environment (Gillespie and Hanny 1992, Betts and Betts 1990, Kilpatrick and Mooney 1987).

Despite the recognition that clinics may have a social function, weighing is however described in two research papers as being almost an ‘admission ticket’ to the clinic, which may mask other reasons for attendance when talking to parents; such as the need for reassurance and contact with other mothers (Sefi and Macfarlane 1985, Sharpe and Loewenthal 1992):

‘The biggest benefit is talking over little worries with other mothers’  
(Sefi and Macfarlane 1985, p.129)

The need for contact with other mothers is echoed in a quote from a 2008 paper (Russell) demonstrating how a mother attempts to balance her undisclosed need for contact with other mothers within the framework of a clinic structured on weighing:

‘I started going to get my baby weighed weekly (just to get out of the house and to meet other mums) I was told that I didn't need to keep going, so I started going fortnightly and then she told me in no uncertain terms that I really, really didn't need to keep coming just to get my baby weighed.’ (Russell 2008 p.68).

The importance of prioritising opportunities for parents to share experiences and offer mutual support is a prevalent theme which emerges in more recent research (Donetto & Maben 2014, Donetto et al 2013, Barlow and Coe 2011, Burgess Allen 2010, Russell 2008, Sparrow et al 2005). Clinics structured around surveillance and perceived social control are thought to place parents in a passive position (Burgess-Allen et al 2010) and recommendations of later research acknowledge the importance of creating a less formal environment in order to promote parental autonomy (Donetto and Maben 2014). It is suggested
that the manner in which babies are weighed is also a potentially
disempowering activity for mothers.

‘They weighed him but that’s all they really did. Anyone can weigh a baby’
(Knott, 1999 p.584).

Sachs (2005) suggests that when health professionals weigh babies, if it is not
accompanied with an appropriate, knowledgeable conversation which supports
parents to understand and contextualise the information, it can undermine the
confidence of parents. A number of studies recognise that parents should also
be given the opportunity to weigh their own babies (Sparrow et al 2005, Plew &

An ‘expert’ led approach where health visitors bestow ‘advice’ to parents is
criticised in a number of the papers with the patronising or authoritarian
approach of staff undermining parents’ confidence (McIntosh 1992, Knott 1999).
It is also suggested that a lack of clarity about the purpose and function of clinics
places parents in a passive position, making them more reliant on professionals
(Burgess-Allen et al 2010).

Research by Donetto and Maben in 2014 begins to ‘unpick’ the process of
promoting parental autonomy at clinics, suggesting that relational readings of
the concept of autonomy may provide a more appropriate conceptualisation of
this construct for families and urge more research into the theoretical processes
underlying community-based family support. The importance of building
relationships with parents and providing safe and supportive community spaces
where parents can ‘rehearse agency and judgement’ is thought to support

‘Hearing other people asking questions….it builds confidence in me as well
because I can see how they (health visitors) respond to other people’s questions
and it makes me feel confident in asking my own silly questions’ (Bidmead 2013
p. 21).
Whilst continuity of staff at clinics was found to build relationships (Bidmead 2013), other studies also highlight the important role that clinics with multiple staff play in enabling parents to choose their own support networks and distance themselves from styles of support they find unhelpful (Donetto et al 2013, Donetto and Maben 2014).

‘If you find you don’t "click" with your health visitor, so long as you have the option to speak to someone else it’s fine.’ (Russell 2008 p.35)

A common theme throughout much early clinic research is that staff, believing their role to be ‘advice giving’ (Sefi and Macfarlane 1987), had a tendency to be patronising and authoritarian in their approach (McIntosh 1991). A paper by Plews and Bryer (2002) which evaluated the advisory role of Health Visitors within clinics, suggest a partnership approach where health visitors elicit and respond to the mother’s agenda rather than giving opportunistic advice, which is often unsolicited and unwelcome.

Barlow and Coe (2011) reframe the concept of advice giving at clinics with offering opportunities for families to access a wide range of information and data generated from parents’ discussions at focus groups in 2005 suggest that health visitor facilitated drop ins, where parents could be guided to the evidence base when topics were raised, would be preferable to groups which were led by health visitors (Sparrow 2005).

In addition to seeking professional advice at clinics Donetto and Maben (2014) suggest that mothers often seek reassurance at this transitional stage in their life and need safe social spaces where they can build positive perceptions of their ‘new or renewed parent identities’ (p.2563). A number of research papers focus on the objective of creating the conditions at health visitor drop ins which increase parental confidence and foster self-trust. Supporting parents to seek and evaluate both information and sources of information and to understand and consider their options, through building informal support networks with

Published literature around child health clinics show a clear progression from descriptive papers focussed on measuring outcomes such as clinic attendance, screening or immunisation uptakes, to more recent research which begins to explore parents’ experiences of support at clinics.

A number of studies are critical of the primacy of weight monitoring at clinics (Barlow & Coe 2011, Burgess-Allen 2010, Sachs 2005, Knott & Latter 1999) and a shift in focus towards exploring the relational processes through which parents’ access community based support is evident (Donetto and Maben 2014, Donetto et al 2013, Bidmead 2013).

Guidance on support however is not entirely clear, for example Bidmead (2013) suggests that continuity of staff can enhance relationships between parents and health visitors, whilst busy clinics with no staff continuity are a barrier to relationship building. Donetto et al (2013) also highlight that repeated one to one contact with the same professional is an important element of satisfaction, however the paper simultaneously highlights the value in parents being able to meet different health visiting team members in a clinic or group setting to ‘identify and access the professional with whom they felt most comfortable and in tune’ (p.42), in order to support autonomy.

The emphasis on weighing at clinics is a theme that pervades the limited research that exists around baby clinics. Weighing appears to be ritualistically prioritised and regarded as a progress check by staff and parents.

In 2005, Sachs laments:

‘The measure of success is weight gain which conforms to expectations, not the quality of the breastfeeding relationship or the emotional relationship between baby and mother, or wider family.’ (Sachs 2005 P.169)
The thematic movement that is evident across the literature reviewed suggests that an alternative to the ritual of weighing at clinics is needed and the purpose and potential value of clinic attendance needs to be made explicitly clear to parents.

A number of suggestions are made in more recent research, including: re-focussing clinics on mother-infant interaction (Barlow and Coe 2011); prioritising relationally based support to encourage parental autonomy, esteem and self-trust (Donetto and Maben 2014, Donetto et al 2013, Bidmead 2013); and building social capital through facilitating parent to parent support (Donetto and Maben 2014, Donetto et al 2013, Bidmead 2013, Barlow and Coe 2011, Burgess-Allen et al 2010, Sparrow 2005).

A number of papers suggest that social spaces are needed to support all forms of infant feeding without dividing parents (Burgess-Allen et al 2010, Russell, 2008 Sparrow et al 2005). In fact over ten years ago Sachs (2005) advocates rearranging clinics to include, but not impose weighing and replacing following the weight chart with focussing encounters at clinics on ‘relational aspects and holistic infant development’ Sachs 2005 p. 208.

Whilst a clear progression away from surveillance, monitoring and weighing towards relationally based support which supports autonomy is suggested in more recent research and may have informed localised practice in some areas, research has not informed any national professional guidance and an exploration of the process of baby clinics, through the construction of clinic process models has not previously been undertaken. Literature suggests that service delivery is deeply embedded in tradition and ritual and internalised concepts around surveillance monitoring and the primacy of weighing babies appear to be continuing to influence practice (Webb 2016).
Surveillance, control and the health visiting service

The history of the health visiting service is entwined with discourses around social surveillance, power and feminism within a public health narrative that spans 150 years. Despite services across the UK now operating within clearly defined models of service delivery (DOH 2009) and with clear theoretical guidance on service orientation (Cowley et al 2013), baby clinics remain an area of practice where lingering traditions and practices continue to influence service delivery (Webb 2016).

The literature reviewed has revealed accounts of didactic advising and monitoring practices at baby clinics, couched in expressions of benevolence, reflecting a complex relationship between health visitors and mothers, cultivated through a social history where mothers have been asked ‘to make their child care practices visible and to submit to monitoring and modification of their practices’ (Mayall 1990 p.326).

Originally a role for working class peers in the late 19th century, who lived in the districts in which they worked, health visitors were described as a ‘mother’s friend’, carrying out important public health work in their community ‘educating and influencing women in their own homes’ and reporting back to Lady Superintendents, who were middle class philanthropic volunteers with oversight of their role (Davies 1988, p.45). By the beginning of the 20th century the role of the health visitor had however evolved, and it was considered to be a position which required a good education and a ‘patient and refined’ manner (Hill 1907, cited by Davies 1988 p.46). Lady Superintendents who had previously supervised the health visitors were now assuming the role themselves and an inequity in education and class was acknowledged. A health visitor was then expected to achieve her goals ‘partly through knowledge and skills’, but also and most importantly through ‘her charm, her persuasiveness and her personality’ (Davies 1988 p.47).
The interpersonal skills required for the role and the importance of relationship building with mothers has been acknowledged in published narratives around health visiting across the last century. Similarly, the primary focus of improving the health and wellbeing of children and mothers through ‘loosely structured’ approaches to support behaviour change at social, familial and personal levels (Cowley et al 2004 p.504) has also been documented. It is recognised however that services have operated with an implicit surveillance and child protection focus throughout the 20th century and as such, health visitors are described as having to have operated within a ‘purposefully ambiguous and shifting conversational context’ around the operational focus of the service (Cowley et al 2004).

Such ambiguity about the operational focus of baby clinics is reflected in the narratives of much of the research reviewed, suggesting an explicit focus on offering reassurance through weighing and advising and an implicit agenda of surveillance. Scales are described as a useful tool to assess parental competence in terms of feeding and handling their baby, and weighing is described as presenting an opportunity to scan for bruises or marks (Webb, 2016).

The Foucauldian concept of ‘pastoral power’ (Foucault, 1979) has been critically applied to health visiting by a number of authors (Abbott & Sapsford 1990, Bloor & McIntosh 1990, Dingwall & Robinson 1990, Peckover 2002, Cowley et al 2004). This provides an explanatory concept for the process in which professionals engaged in health and welfare work cultivate supportive relationships with clients for the purposes of surveillance. In fact, Peckover (2002) suggests that the tension between support and surveillance that is inherent in relationships between health visitors and mothers is an important area of research that has implications for developing policy and practice and may help us to understand the difficulties that some women encounter in seeking help from health visitors.

The literature reviewed suggests that parents are conscious of a surveillance component in their interactions with health visitors at clinics and largely
accepting of the process when it related to their child’s physical wellbeing however, resistance is offered, for example through concealment or disengagement, when they felt an implied criticism of their parenting styles or practices (Mayall and Foster 1989). Sachs (2005) offers an ethnographic analysis of this behaviour, suggesting that clinics, through a ritual encounter of weighing, provide mothers with the opportunity to demonstrate that ‘they accept responsibility for their baby's well-being and that they are accountable to the wider family and society’ (Sachs 2005 p.175).

The notion of weighing as a means of social communication is an interesting one, evident in many narratives of participants across the literature reviewed (Webb, 2016), suggesting mothers attend clinic to display their commitment to the wellbeing of their baby, with the weight a record and symbol of their effort and commitment.

Whilst the weighing of infants at clinics is an important aspect of individualised support that can, if used appropriately, contribute to informing a wider holistic picture of the health and wellbeing of a baby (Sachs 2005), participants accounts in much of the literature reviewed suggest that health visiting staff appeared to be diligently and mechanistically weighing and recording the weight of babies to fulfil an unspecified surveillance agenda around unspecified risk reduction (Webb 2016). Sachs (2005) suggests that this serves as a social display; their professional commitment to monitoring the wellbeing of babies in the communities in which they work, which may be reassuring to the public and other professions, such as GP’s or local safeguarding teams, regardless of the effectiveness of the practice.

The explicit surveillance component of the health visiting role has now of course diminished with the national reduction in screening tests administered by health visitors (DOH, 2009), however health visitors continue to contribute to secondary prevention through universal health reviews, opportunistic contacts
at clinics and follow up contacts for higher risk infants, supporting the early
detection of developmental delay and the provision of early help.

The current ecological model of health visiting focusses on primary prevention,
contextualises a child’s developmental progress within their familial and social
environment and seeks to provide an ethnographically informed preventative
service, tailored to the needs of the local community and starting in the
antenatal period. It recognises that the majority of developmental and
behavioural issues stem from a variety of ‘potentially modifiable environment
factors’ that are a mixture of the impact of the child’s genes and environment
rather than genetic factors alone (Blair and Hall, 2006 p.732) and seeks to
provide effective anticipatory guidance and support to parents to maximise their
child’s potential.

It is incumbent on service providers to therefore reflect on why they are
providing baby clinics; is it a surveillance and monitoring service for the
purposes of monitoring infant weight and maternal competence, either on an
individual or population level - and if so, are they effective in fulfilling their
function and should this purpose not be made explicit? Or is their aim primary
prevention; to provide all parents with anticipatory health and wellbeing
guidance and effective support and information to maximise their relationship
with their child and the familial environment to which they are exposed.

**Primary prevention and the health visiting service**

Health Visiting services now focus on preventative work within a model of
progressive universalism (DOH, 2009). Progressive Universalism is defined as ‘a
continuum of support according to need, at neighbourhood and individual level,
to achieve greater equity of outcomes for all children’ (Lowe 2007 p28). Health
Visitors therefore offer support to all families, with additional support being
offered to families where current child health needs or the risk of poor
outcomes in the future are identified (DOH 2009).
Working from a strengths based, solution focussed approach with a salutogenic and relational orientation to practice, it is suggested that health visiting services are structured and organised to facilitate and support relationship based interventions (Cowley et al, 2013). The community level of service provision within the four progressive levels of service offered (IHV 2015) also encourages health visitors to engage in practice which builds community capacity and utilises that capacity to improve health outcomes (Cowley et al 2013).

The movement towards more relationally and socially orientated approaches to clinic provision discussed in this literature review would therefore align with the current health visiting orientation to practice and may provide an appropriately aligned model through which to explore the contribution of community based support to building both individual and community resilience with parents.

It has however, been recognised by the Institute of Health Visiting (IHV) in their framework for CPD for Health Visitors that ‘there is a risk that experienced health visitors make assumptions about their skillset in community development work and continue to consider development of the community level of the service from a “top down” perspective’ (IHV 2015 p.54) and the literature reviewed suggests that an ingrained didactic approach to the delivery of community-based baby clinics still persists. It would be valuable therefore if guidance and training for health visiting staff to provide effective community based engagement work at clinics encompassing a primary prevention agenda were explored at a national professional development level.

For although the Cowley et al 2013 found too little research on the topic of baby clinics to suggest that they are deemed as a core health visiting practice, a paper published in 2013 exploring the voice of health visiting service users to inform the development of UK health visiting practice and services suggested that ‘support outside of the home’ (Donetto et al 2013 p.12) should represent a fourth core practice of health visiting to complement and support the existing
A triad: 1) health visitor-client relationship; 2) health visitor home visiting; and 3) health visitor needs assessment (Cowley, et al., 2013).

Increasing budgetary cuts to public health and early years services in recent years has engendered a collective drive both within the health visiting profession and from local authority commissioners to identify and adopt integrated evidence-based approaches that have the potential to be collaborative, sustainable and effective (IHV, 2016). The delivery of health visiting clinics, which consume a substantial amount of health visiting hours (Cowley et al, 2007) is therefore an area of practice which requires an evidence based, innovative approach in order to explore their potential contribution to preventative work as universal, public health interventions.

Aims and objectives

The lack of evaluative evidence around the effectiveness of health visitor led baby clinics explored in a recent systematic review (Webb 2016) and briefly summarised in this literature review informs the focus of this research (Appendix C). The review suggests preliminary research is needed to understand the current function and value of baby clinics in order to begin to explore potential models of delivery.

The movement within public health nursing towards primary prevention, early intervention and a partnership approach with parents, coupled with the need for an evidence-based approach linked to clear health outcomes means that the history of covert surveillance, supervision and monitoring at clinics addressing unspecified risks, described in this literature review are no longer appropriate. The inherent power dynamic in such exchanges are not in line with current solution focussed, empowerment models of support and do not address the expressed psycho-social needs of parents and infants (Webb 2016).
The lack of evaluative evidence around health visitor led baby clinics and the suggestion that ‘support outside of the home’ should represent a fourth core practice of health visiting (Donetto et al 2013 p.12) necessitates a focus on how parents engage with community-based family support in order to understand its potential in influencing child outcomes.

The health visiting service now deliver five universal mandated contacts starting in the antenatal period, each with a clear focus and rationale and based on epidemiologically driven high impact areas (PHE 2016). The contacts are proactively offered to all parents which enables parents and health visitors to engage in collaborative assessment and support at known points. Clinics however are not mandated, have no national guidance underpinning their delivery and are generally offered as an adhoc point of contact initiated by parents (Webb 2016). Their purpose and value therefore needs to be explored with parents and staff attending, in order understand how they are used. The exploration of lay and professional perceptions of the purpose and value of baby clinics was therefore perceived to be an important area of research which may contribute to our understanding of how and why baby clinics are currently being utilised (Webb 2016).

The aim of this research was to elicit both lay and professional perspectives on baby clinics through an exploration of the experiences of mothers and health visiting staff attending and delivering clinics. Through this process it was hoped that explanatory models could be constructed representing the process of support that Health Visitors and mothers engage in at clinics.

Grounded Theory methods (Charmaz 2006) provide a framework to explore the social constructions of baby clinics through the experiences of staff and mothers attending and offer explanatory processes of how support at baby clinics is delivered and received rather than a descriptive study, which has historically been the focus of many qualitative papers around baby clinics (Webb 2016).
Health Psychology has much to offer this area of research and practice which is situated in the bio-psycho-social domain of public health and parenting and may help to address the challenging goals associated with improving the health of children: that of balancing epidemiologically driven public health imperatives with the need of mothers to receive individualised and person-centred support which enhances the quality of their relationship with their baby.

Methodology

Design

This was a qualitative study using semi structured interviews and a social constructionist grounded theory methodology.

Health Psychology, as a relatively new discipline established in the last fifty years has principally followed the methods of mainstream psychology in its focus on the objective identification and measurement of psychological constructs. However, debates about epistemology that began in branches of psychology such as social and feminist psychology (for example Gilligan 1982, Gergen 1985, Harding 1991) began to be applied to the realm of health psychology and an increasing criticism of the epistemology and methodology associated with quantitative methods, which are often critiqued as ignoring both process and context, has been voiced within the discipline (Murray 1999).

Qualitative psychological research utilises a variety of methods and designs but unifying the approach is an emphasis on human experience and meaning, offering a holistic alternative to the positivist tradition of scientific reductionist enquiry and quantification. An increasingly influential epistemological approach within qualitative research is social constructionism (Willig 2008), which assumes that knowledge and human experience are social constructions. Research from a social constructionist perspective is therefore concerned with exploring how a studied experience is constructed through explicit, implicit or
hidden ideologies, cultural norms, communication and relationships (Charmaz 2006).

**Grounded Theory Methodology**

Grounded theory offers a ‘systematic, inductive and comparative’ approach to research with the aim of generating new theory, rather than testing existing theory (Charmaz 2006 p.2). In their seminal work The Discovery of Grounded Theory (1967), Glaser and Strauss offer practical guidelines to progress qualitative inquiry beyond descriptive studies of human experience, to the generation of theoretical explanations of social processes, which according to Charmaz (2006) ‘legitimised qualitative research as a credible methodological approach in its own right’ (p 6). It is suggested that Grounded Theory Methods are particularly valid in under researched areas in order to generate an original theory (Strauss and Corbin 1998). This evolving approach is currently the most widely used qualitative research method across a range of disciplines (Bryant 2007) providing flexible analytic guidelines through which a conceptual and original theory, grounded in the data collected can be constructed.

**Social Constructionism and constructivist grounded theory**

This research adopts a social constructionist approach which assumes that knowledge is constructed rather than discovered and that social reality is created through individual and collective actions. Social constructionists ask how people construct their views and actions and when conflicting constructions arise, why and how a particular construction is taken as definitive (Charmaz 2006). Charmaz advocates a constructivist approach to grounded theory which adopts a relativist and interpretive position where reality is acknowledged to be a constantly changing construction influenced by the interaction and interpretation of individuals and their social reference groups. It is assumed
therefore that both the data and analyses are social constructions reflecting how the researcher and participants interpret meanings and actions and as such a reflexive approach to the research process has been methodologically important.

Why did I choose this research method?

Where little research or applied theory exists in a subject area, grounded theory methods can be used to potentially construct new contextualised theory, ‘grounded’ in the data generated by the research method. The clear methodological process of grounded theory as a method of research can enable researchers to move from data to theory construction and provide an explanatory framework with which to better understand the subject matter being explored.

My choice of a social constructionist version of grounded theory as a research method over other qualitative research approaches reflects the minimal research that exists around baby clinics and the lack of theory underpinning the process of Health Visiting. It also acknowledges that baby clinics are an activity that take place in the social domain, at health centres, GP surgeries or children centres and have a long social history, steeped in ritual and social meaning.

Social constructionism is an approach which acknowledges that human experience including perception, is mediated ‘historically, culturally and linguistically’ (Willig 2008 p.7), the historical context of clinics and the health visiting service is therefore recognised to be important in influencing the experiences and perceptions of the participants and the construction of the theoretical process models offered in this research.

Grounded theory methods, with their focus on social processes were felt to be a more appropriate choice than phenomenological methods, which have the potential to evoke richly illuminating accounts and analysis but are potentially
orientated towards how individuals represent their unique perspectives rather than why such differences exist.

The choice of research method is also a reflection of the researcher’s philosophical preferences and assumptions about the nature of knowledge acquisition; what is it possible to know and how is it possible to know it? A contextual constructionist position (Willig 2008 p.153) is assumed by the researcher which embraces an ontological orientation based on ‘subtle realism’ (Hammersley 1992), recognising the existence of an objective reality but maintaining that reality is socially constructed.

Knowledge is felt to be both contextual and viewpoint dependent. It is acknowledged that the different perspectives of participants would therefore generate different insights into the same phenomenon and the researchers own preferences, biases and experiences will influence the interpretation of the data and construction of the conceptual theory and process models.

From this philosophical position and with the focus and subject matter of the research topic in mind, a social constructionist version of grounded theory was felt to be intuitively an appropriate choice. A section entitled ‘Epistemological Reflexivity’ is included at the end of this paper sharing my reflections on my choice of research method and the process of researching this topic.

Reflexivity and Qualitative Rigour

In order to ensure qualitative rigour within the research process, transparency of the researcher’s epistemological and theoretical stance should be explicit within any study (Meyrick 2006). To achieve a reflexive narrative, enabling the reader to gain insight into the researcher’s perspective, a reflective diary was kept throughout this research process together with field ‘memos’ following each interview, which has proved useful in reflecting how my own assumptions have informed my interpretations and analysis.
Regular supervision was undertaken with two appointed supervisors with relevant experience in order to reflect on my developing ideas and interpretations and also my biases and preferences and how they were potentially influencing the course of the research process. Opportunity for scrutiny of the project by colleagues, peers and academics was also sought in order to challenge assumptions made, widening the vision of the researcher and contributing to the rigour of the research process: The constructed theoretical processes were therefore presented in a poster presentation at the 2017 UNICEF Baby Friendly Initiative UK Conference (Appendix B) which enabled the researcher to discuss the research with peers and academics prior to completion.

Background of the researcher

As an International Board-Certified Lactation Consultant and trainee Health Psychologist working within the Health Visiting Service as an Infant Feeding Lead, I approached this research with a desire to explore, understand and improve the provision of support for parents at baby clinics, in particular in relation to their infant feeding experience and relationship with their baby.

My intuitive belief at the outset, based on personal experience as a mother and professional experience working within a Health Visiting service, was that baby clinics were perhaps failing to provide effective psycho-social support for parents and were almost certainly missing an opportunity to provide more effective support for infant feeding. The emphasis on weighing seemed to me to be an historical tradition which was deeply embedded and influenced how support for feeding was being provided by health visitors. This felt like an important area of work to explore in view of the number of health visiting hours that are consumed by clinic delivery, I have also witnessed over many years, the impact on breastfeeding relationships when a continued narrative around weight as a primary measure of health and wellbeing is perpetuated.
Engaging in regular supervision and reflective practice has supported me in exploring and recognising my intuitive biases, preferences and assumptions around the delivery of clinics, which I acknowledge have informed and influenced the construction of this research. It is acknowledged therefore that the core processes identified through this research are a reflection of both the participants’ interpretations and constructions and the professional experience and philosophical preferences of the researcher in relation to the provision of support at baby clinics.

Data Collection

To enable a rich and open narrative to be shared by the participants it was felt that individual interviews would be the most appropriate method of data collection, with the interviewer utilising a person-centred approach; communicating warmth, empathy and non-judgemental positive regard to elicit rich, reflective accounts. Data was collected using informal, semi structured interviews, using broad open-ended questions in order to encourage ‘unanticipated statements and stories to emerge’ (Charmaz 2006, p.26). This approach aimed to elicit the participant’s own definitions, conceptions and reflections rather than obtain a chronology of events and behaviours.

The research interview

Charmaz (2006, p.29) suggests that questions should be ‘sufficiently general to cover a wide range of experiences and narrow enough to elicit and elaborate the participant’s specific experience’

The opening interview question was:

‘Can you tell me about your experience of baby clinics?’

Further questions or prompts were formulated based on the individual responses of the participants, to encourage reflection and elaboration of
emerging topics. The process was iterative whereby issues emerging from ongoing analysis were raised in subsequent interviews.

An interview topic guide with additional prompts was used to focus the interview to specifically address the research question focussing on the perceived purpose and value of baby clinics and the clinic process (Appendix D). The prompts aimed to elicit rich descriptions of the clinic environment, the dynamic of interactions and relationships and also the participants’ self-reflections around autonomy, all of which were prevalent themes identified in the systematic review (Appendix C).

Inclusion and exclusion criteria

Health Visiting Services deliver the Healthy Child Programme for children up to the age of 5 years. Parents could therefore conceivably attend child health clinics or baby clinics with children up to age 5. This research however focussed on participants with children aged 4 and under (i.e. pre ‘school reception’ age).

The researcher did not have the funds to utilise Sirona’s translation service for the purposes of this research project. Participants who were therefore unable to adequately understand verbal explanations or written information in English were therefore not recruited to the study as participants.

Vulnerable individuals who were unable to represent their own interests or understand the purpose and nature of the research in order to make an informed decision about participation were also not recruited to the study.

Parents, volunteers and practitioners under the age of 18 were not recruited to the study as many parents under the age of 18 years in the localities in which the research took place are supported by the ‘Family Nurse partnership’ service, (which provides intensive home visiting), rather than the Health Visiting service.
Procedure

Ethics

Full ethical approval to conduct the research project was granted by the University of the West of England’s Research Committee (Appendix E) and the Greater Manchester (South) Research Ethics Committee (Appendix F).

Participants

Twenty four participants were recruited through services being delivered by Sirona Care & Health. Sirona Care & Health is a not for profit, community interest company which had been awarded contracts to deliver statutory Health Visiting services in Bath & North East Somerset and South Gloucestershire. These services are commissioned by the respective local councils who now hold the public health budgets in these areas. The researcher works as the Infant Feeding Lead for Sirona’s Health Visiting Service in South Gloucestershire (and previously in Bath & North East Somerset) and as such had the support of this provider organisation in facilitating the practical and safe conduct of this research with participants.

The recruitment of participants was initially through a process of purposive and snowball sampling from staff and parents attending clinics across the two areas. Posters and flyers advertising for participants were circulated across the clinics and participants interested in taking part contacted the researcher by phone or email. The researcher also utilised the Health Visiting services social media sites (Facebook and Twitter) to recruit participants.

Health Visitors and other professionals were recruited by emailing professional teams, outlining the research and asking for those professionals interested in being interviewed to contact the researcher.
Potential participants were then sent an information sheet (Appendices G and H) by the researcher with further information about the study. If the participant wished to proceed with the interview a convenient time was arranged.

Participants were encouraged to consider the information provided and ask any questions. If after consideration, they were happy to continue, they were given a consent form to sign.

The focus of the research did not necessitate collating demographical information about the participants, however the 24 participants recruited have been allocated a number coding (Appendix I) to show the spread of quotations across the participants, used in the results section.

The participants included 9 Health Visitors, 3 Community Nursery Nurses, 8 Mothers, 2 Infant Feeding Specialists, A senior lecturer delivering a Public Health Nursing Course and an NCT Postnatal leader and Tutor.

**Theoretical sampling**

As the analysis developed and categories and tentative processes were being constructed, theoretical sampling was used to elaborate and refine the categories. Further participants were therefore specifically sought with pertinent professional backgrounds, who may have been able to contribute further insight to the developing process models. The aim of theoretical sampling is to explore the relationship between the categories and the intuitive logic of the proposed processes and to develop the properties of the categories, until no new properties emerge. An experienced Public Health Nursing Lecturer and an NCT Postnatal Leader and Tutor were approached through Sirona’s working partnership arrangements that are in place.
Saturation

Saturation is a methodological principle in qualitative research which is often used as a marker to determine when the process of data collection can stop. Saunders et al (2017) suggest that a lack of clarity about the way saturation is conceptualised and operationalised in research can lead to methodological issues in terms of quality and rigour and suggest greater transparency about the approach adopted and its relevance to the theoretical position and analytic framework being used.

The Grounded Theory approach to this research means that the process of data analysis and data collection continually informed each other. When interviews no longer appeared to be yielding new data and a point was reached in the coding process when no new codes were emerging the recruitment process paused (Urquhart 2013 p.194). The decision to pause was however, made at a data analysis level, rather than data collection level and was related to the identification of new codes, rather than the development of those already identified. Saunders et al (2017) describe this model of saturation as ‘inductive thematic saturation’ which focusses on new codes or themes at an analysis level rather than at a data collection or sampling level. The decision to pause data collection was then discussed with the academic supervisors of the research and the rationale described, together with the associated time constraints of a single researcher conducting time limited research within a doctoral programme informed the decision to stop recruitment of any further participants for the purposes of addressing the initial research question.

Two further participants were however recruited specifically to explore the emerging construction of the theoretical categories and processes in an effort to explore their intuitive logic and the relationship (including gaps and ambiguities) between the concepts in the proposed processes.
Right to withdraw

Participants were informed that they had the right to withdraw from the project at any time up to 3 months after being interviewed without giving a reason and without any penalty. This was made clear in the Information Sheet (Appendices G and H), Consent Form (Appendix J) and ‘Debrief’ letter (Appendices K and L) which was given to all participants following interview. It was also reiterated by the researcher before the interview began.

The removal of data was achievable by allocating each participant a unique ID number. This facilitated the anonymity of their data whilst ensuring that it was possible to withdraw an individual’s data from the project at any point up to 3 months after their interview date. The key linking ID numbers to actual identities was stored separately and securely from the anonymised data.

Confidentiality and safeguarding

Participants were reassured that the interviews would be anonymised and confidential subject to the safeguarding limitations outlined by the British Psychological Society (2009).

They were given a clearly written ‘Information sheet’ (Appendices G and H) about the research process which explained how they would be safeguarded and how their personal interview data would be anonymized and stored. Participants were also given an opportunity to ask any further questions about this process or clarify anything that was not clear, or they did not understand.

A ‘Procedure in case of disclosure’ (Appendix M) was drafted in case information was shared which was felt to be a cause for concern in terms of the safety or wellbeing of mother, infant or another child.
It was felt to be unlikely that there would be any risks to the participants in terms of physical, psychological and emotional wellbeing. A ‘Debrief Letter’ (Appendices K and L) was however given to all participants with the contact details of the researcher, enabling them to comment on the experience of being interviewed, should they wish to. The letter also provided details of their local Health Visiting Service, should they wish to discuss any issues which may have arisen as a result of sharing their experience of health visitor led baby clinics in their area. If anxiety or low mood had been indicated, the participant would have been encouraged to speak with their health visitor to access support and would have been given the appropriate contact details.

Interviews were audio recorded and transcribed verbatim. They were anonymized and stored electronically on the personal computer of the researcher which was password protected. The original recordings were then deleted. Only anonymised data was used in writing up the research.

**Interview process and transcription**

All interviews were conducted in a private room at local Health Clinics or Children’s Centre with the consent of the centre manager. Interviews lasted up to one hour and were audio recorded. Each interview was transcribed verbatim, password protected and stored electronically. The original recordings were then deleted. Paper copies of the transcripts and field notes were kept locked and secure.

**Data protection**

Identifying information was removed during transcription to ensure that data was anonymised. Each participant was given a unique ID number to facilitate the anonymity of their data whilst ensuring that it was possible to withdraw an individual’s data from the project at any point. Identifying data was held in a
locked filing cabinet and password protected on a computer. Only anonymised
data was used in writing up the research. The key linking ID numbers to actual
identities was kept separately.

To ensure data confidentiality the UWE ‘Research, data protection and data
security: guidelines for staff and students’ (2014) were followed which
encompasses the principles of the Data Protection Act (1988) and its
implications for research data.

Data analysis

Constructionist Grounded Theory Methods were used to arrive at a
representation of the participants’ experience of baby clinics and the data
analysis was based on methodology suggested by Bryant and Charmaz (2010).

The interviews were conducted alongside the data analysis. Following
transcription, initial line by line coding was performed using ‘gerunds’ (Glaser
1978) to construct codes in order to focus on actions and processes (Bryant and
Charmaz 2010). During this process the researcher engaged sensitively and
reflectively with the data to inform potential questions in subsequent
interviews.

Focussed coding was then undertaken in an attempt to ‘synthesize and explain’
(Charmaz 2006, p.57) the data, leading to the construction of conceptual
categories. The researcher frequently returned to earlier interviews during this
process to review the data in light of emerging concepts and meanings, thus
‘grounding’ the emerging theoretical process (Charmaz, 2006). An example of
the coding process is included in Appendix N.

Comparative methods were used throughout the research process whereby data
was initially compared with data and then with categories. Informal memos
were used to construct analytic notes about the differences and similarities
within the data and the relationship between categories (Charmaz 2006).
Memo writing is considered an important part of the methodological process in constructing a grounded theory, continually capturing the thoughts, reflections and ideas of the researcher (Charmaz 2006). Memos were used to construct and compare conceptual categories, initially recording intuitive thoughts and later becoming more analytic and abstract as the social process began to be constructed. Memos were particularly useful in highlighting areas of interest from the accounts of the participants to develop and track questions in subsequent interviews.

Tentative hypotheses were constructed regarding the nature of the support process that mothers and staff experience at baby clinics and two further participants were recruited through theoretical sampling at this point. Selective coding was adopted for these interview transcriptions to code for data relevant to the developing theory.

Analysis and data collection continually informed each other, and the process continued until data and analysis were no longer yielding new variations, concepts or categories. Two core categories central to the study were then constructed. Glaser (1998, p.117) describes a core category as ‘a pattern of behaviour which is most related to all the other categories and their properties in the theory which explains how the participants resolve their main concern’.

Selective coding was then adopted to limit coding to the data that only related to the conceptual categories and core. The use of diagrams is an important tool in grounded theory (Charmaz 2006); diagrams were developed and refined to provide a visual representation of the categories, their relationships and an ‘interpretative portrayal’ (Charmaz 2006, p.10) of the constructed processes.

Literature in relation to the constructed theoretical framework of the study was reviewed and served as a valuable source of comparison and analysis, illuminating the theoretical categories and contextualising the process constructed in this study.
A reflexive journal was kept throughout the process in order to enhance the theoretical sensitivity and rigour of the study. The journal contained field notes, memos, emerging codes and categories and the researcher’s thoughts, feelings, ideas and reactions to the emerging data and their implications in shaping the research.

**Results / Analysis**

The coding, comparison and analysis of the data collected from the participants attending baby clinics across two local authority areas in the South West of England produced two distinct core process categories offering explanatory social processes summarising the exchange of support experienced:

1. A process of staff and mothers engaging in a ‘cycle of serial reassurance’ through baby clinic attendance (Table 1)
2. A process of staff and mothers engaging in the ‘promotion of parental self-efficacy’ through baby clinic attendance (Table 2)

Each core category was informed by four conceptual ‘sub’ categories identified through the coding process and summarising the relationship between the concepts:

Table 1. Table of process categories constructed from the narratives of participants attending traditional baby clinics offering weighing and one to one ‘consultations’ with health visiting staff as part of a formal clinic process

<table>
<thead>
<tr>
<th>Category</th>
<th>Process</th>
<th>Key points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptual category</td>
<td>Seeking reassurance</td>
<td>Mothers attend clinics to seek reassurance about the health, wellbeing or development of their baby, their parenting decisions or their own psycho-social needs as new parents</td>
</tr>
</tbody>
</table>
The participants’ narratives suggest that the experience of support at traditional baby clinics focussed on seeking reassurance, weighing, monitoring and advising engenders a process whereby both mother and health visitor become locked into a cycle of serial reassurance.

Table 2. Table of process categories constructed from the narratives of participants attending informal, socially orientated clinics, where scales were available, but did not form part of a formal clinic process

<table>
<thead>
<tr>
<th>Category</th>
<th>Process</th>
<th>Key Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptual category</td>
<td>Sharing</td>
<td><strong>Mothers</strong> share their experiences with Health Visitors and other mothers</td>
</tr>
<tr>
<td>Conceptual category</td>
<td>Caring</td>
<td><strong>Health Visiting</strong> staff actively listen &amp; communicate empathy, compassion &amp; positive regard without judgement</td>
</tr>
<tr>
<td>Conceptual category</td>
<td>Layering</td>
<td><strong>Health Visiting</strong> staff share appropriate levels of information, at the appropriate time, in a variety of ways which guide and support mothers with self-reflection and self-compassion</td>
</tr>
<tr>
<td>Conceptual category</td>
<td>Repairing</td>
<td><strong>Mothers</strong> feel supported to reflect on their experiences, understand their infant’s behaviour &amp; treat themselves &amp; their children with compassion</td>
</tr>
</tbody>
</table>
An analysis of how the narratives of the participants informed each of the conceptual categories will now be conveyed through an exploration of verbatim quotes from the participants. The construction of the core categories, which summarise the relationship between the conceptual categories and describe key processes will also be explored.

Seeking reassurance

This cyclical process begins with mothers attending clinics to seek reassurance about the health, wellbeing or development of their baby, their parenting decisions or their own psycho-social needs as new parents.

‘she had a stage of having some funny coloured poo, so I thought, well I don’t really want to go to the doctors for that because she’s not ill in any way at all, so I just wanted to ask the health visitor about that and then other things like am I doing this right and is it ok for me to do this with her....you know I just wanted to check it was ok and the HV would say, ‘oh that’s absolutely fine’, it just stopped me worrying......it was reassurance around her health and my sanity’ (Mum, 4)

Health Visitors are felt to provide an important support service for new parents:
'it’s having somewhere that is not having to go to the doctors and not having to endlessly google’ (Mum, 6)

‘without the HV there isn’t really anyone else you can go and talk to once you’ve had your baby, I mean you have your GP but that’s not for casual conversations and it takes so long to get an appointment...anything medical I would see the GP about, but I don’t know who I would talk to about why my baby isn’t sleeping if we didn’t have Health Visitors’ (Mum, 2)

The narrative of the participants suggest however, that whilst the search for reassurance is multi-layered, with parents wanting to explore many aspects of their new role, the model of the clinic they encounter and the focus of staff at the clinic, influences their perception of what is a valuable measure of wellbeing and therefore reassuring. For example, in clinics where weighing is prioritised and is the centre point of an interaction with a professional, this becomes internalised (by parents and staff) as a reassuring metric of health that requires persistent monitoring.

‘I think mums want to be reassured that they are doing a good job and if you can see your baby’s weight going up, it’s reassuring’ (Nursery Nurse, 2)

The process of weighing is conceptualised as almost ceremonial in many of the participant’s accounts:

‘(Weighing) is done by the health visitor – it’s really relaxed and then you get called up and do your bit....there’s always a little bit of anxiety about it, you know; ‘will everything be ok?’ they weigh them and put the dot on the chart and then everything is ok and you can relax again’ (Mum, 6)

‘I think the scales are always just placed so prominently and publicly.....they’re like an altar and your offering up your baby for judgement.....it would be much nicer if they were just in a corner somewhere and the emphasis was on something else’ (Mum, 7)
Despite an expressed wish by a number of parent participants that weighing is performed in a less publicly visible and ritualistic way, weighing is acknowledged to be the gateway to a discussion with a health visitor.

**Weighing**

The participants accounts suggest that in order to access a conversation with a health visitor or community nursery nurse, the weighing ritual needs to be given ‘due process’ first:

‘you get your baby weighed and then have a quick chat about what’s going on – that’s the order…..’ (Mum, 1)

‘My clinic is just turn up and weigh; I always feel I have to be really quick because sometimes there’s a queue of ten or twenty people….if you have a question that you’re embarrassed to ask as it might be silly or something it’s really difficult to do it with a queue of people waiting behind you. I basically get her weighed so that I can then quickly ask a question…..you know like ‘oh while I’m in here can I quickly ask about…(something) ’. If I didn’t have to go through the weighing bit every week we might actually be able to have a proper conversation!’ (Mum, 1)

In fact, several participants suggest that the process of weighing is a useful ‘lead’ into conversations about other things that are on the parent’s mind:

‘The clinics are always really busy….parents come over and have their baby weighed first -the conversation always starts off about weight and then moves nicely onto other things....’ (Nursery Nurse, 3)

‘The scales are a transitional object really – parents use weighing as a reason to access support.........we start off by discussing weight and that conversation then helps parents open up about other, perhaps more sensitive things, you know...... things that might be difficult for them to just open a conversation with’  (Health Visitor, 3)
The weighing process is conceptualised as a catalyst for discussion:

‘it’s at the scales that mothers feel that they can discuss things which are a bit more personal, that perhaps didn’t lead with......it was always to do with weight first and then she would say oh and by the way.....’ (Health Visitor, 4)

Several practitioners felt however that some health professionals have become overly dependent on the use of scales as a ‘prop’ around which conversations take place:

‘I don’t think you need to have scales to get people to open up...if you’re less confident as a professional the scales might make you feel more confident as a way of opening up a conversation....but I think when you have a skilled practitioner you shouldn’t need them, scales are an extra thing to be used or not used depending on the parents preference but shouldn’t be a gateway to a Health Visitor or a Nursery Nurse’ (Nursery Nurse, 1)

‘I think for some health visitors who find informal group conversations messy and difficult, scales can become a bit of a safety blanket, weighing is an activity which needs to be done one at a time so it creates some order- it necessitates talking to parents individually and they provide a structure to the way the conversation is opened....we need to make sure we’re using scales for the right reason and in the right way, if we’re using them as props we probably need to re-think’ (Health Visitor, 7)

The narratives of a number of the professionals interviewed suggest that the historical model of clinics focussing on weight monitoring have influenced parental expectations, which in turn now drive current service models, regardless of effectiveness:

‘I think parents come with an expectation that they will weigh their baby at the clinic and then just ask a few questions and I think because often HV’s are so busy we don’t have the time to do much more than that before we are onto the next parent....it just feels like we could be doing so much more’ (Health Visitor, 2)
The account of this health visitor alludes to the culturally constructed nature of support needs with the participant questioning who is perpetuating the current narrative around weighing at clinics; parents or professionals?

‘I think parents see it (clinics) as a weighing thing and need weighing as an excuse to go….we then respond to their needs or maybe we’re responding to what they think their needs are, which is based on how we offer support.........it’s like we’re all locked into this thing that’s driven by something - but we’re not really sure what or why’  (Health Visitor. 7)

In fact, the accounts of both parents and health visitors attending traditional models of clinics included constructions of experiences which highlight a parental need to provide answers to the perennial question ‘how much does she weigh?’, suggesting that the narrative around infants and weighing is a much wider culturally normative expression of wellness:

‘I didn’t want to weigh him too much, it was more out of interest really, especially with him being small – but it’s the only question anybody ever asks you ‘how much does he weigh?’ so it’s having an answer to that!’ (Mum, 2)

There was a sense that participants needed to provide an answer to the weight question to display their commitment to their baby’s wellbeing:

‘I went there because I wanted to get her weighed out of curiosity because people keep asking me’ (Mum, 6)

‘I think some just purely want to weight their baby....and they want to be able to tell their relatives what the baby weighs....just so they can answer the constant question ’what does the baby weigh’.....(Health Visitor, 9)

A professional who had experience moving towards a more social model of clinic with less emphasis on weighing suggests that the shift in parental expectations around weighing needs to be acknowledged and addressed by health professionals and will take time to happen:
‘I think problems arise at some of the hubs because it takes a while for a shift in parental expectations and the way HV’s work to happen around clinics....at some of the hubs you have really large volumes of parents attending who simply want to weigh their babies and then it becomes very difficult for the HV’s to do much more than ‘process’ the parents through the weighing scales. We’ve managed to gradually make that shift and the parents now know that they can come and talk to us without having the excuse of having to weigh but I think that shift does take a while......’ (Health Visitor, 2)

Monitoring

Social conventions normalising the weighing of babies and monitoring of families construct the clinic experience. This in turn influences how health visitors and mothers interface at clinics, with many mothers accepting a ‘being monitored’ role and many health visitors adopting a ‘monitoring’ agenda as part of a safeguarding narrative. This in turn can lead to the early prevention, public health role of the health visitor at clinics becoming lost.

The expectation of being monitored is, it appears, from the accounts of the participants, an accepted feature of an interaction with a health visitor:

‘everyone goes to get their baby weighed and then have a quick chat about what’s going on but I think it feels much more like they really exist for health visitors to keep an eye on your baby’s weight and make sure you’re looking after her’ (Mum, 3)

With some confusion as to the extent of the monitoring process they are engaged in:

‘I never know if they have a computer system that starts flagging people up if they haven’t taken their baby to get weighed enough...I have no idea, if they are monitoring you or largely relying on you to make decisions about when you need to attend’ (Mum, 2)
Clinic staff were also explicit about the monitoring agenda:

‘Clinics are a bit more time efficient than home visits and they’re useful for keeping an eye on people….’ (Nursery Nurse, 2)

‘the weighing process is a way of looking at attachment; how warmly the mother interacts with the baby and how they take their clothes off and also seeing the baby’s health – you are always scanning babies for bruises and things like that’ (Health Visitor, 5)

However limits to the monitoring process were also expressed:

‘They’re checking that you’re being an ok parent basically – that your baby is healthy and well and that you’re ok and not depressed……I don’t mind being monitored for those reasons……but I do mind when that monitoring starts crossing over to criticisms of your parenting preferences or style’ (Mum, 7)

A number of parents shared examples where the focus on weight ‘monitoring’ had led to missed opportunities to support breastfeeding:

‘I’ve never had a feed observed at a clinic, it’s much more – let’s look at the line in the book…..which can be very difficult because it’s likely that the person weighing your baby will have no knowledge of your back story around feeding your baby and it’s very possible that they could look at a very tiny weight gain and just not realise how much effort has gone into actually getting them to that line on the chart, let alone anywhere else….there isn’t an opportunity to have an in depth conversation because there isn’t much time……they just don’t have the time to sensitively ‘unpick’ a breastfeeding issue in a clinic which is run like a factory line’ (Mum, 1)

With acknowledgment that the way clinics are set up is not conducive to providing effective breastfeeding support:

‘I was encouraged to start topping up with formula because he dropped through a centile line…..no support for breastfeeding, this was all based on one weigh, I mean I didn’t do it – I went and found better support, but it does make me think
how many other mothers might have been told to do this unnecessarily? The whole set up is wrong....I think it was just easier to tell me to top up than to sit and help me with the breastfeeding – it would have messed up their queue system’ (Mum, 7)

There were also examples where parents had perceived their health visitor to be monitoring their maternal competence in ways which they felt were judgemental or ill-informed:

‘I always feel nervous having sleep conversations with my health visitor – I don’t think she likes it that I bed share with my baby, I’m doing it safely but that’s not enough for her, she feels the need to constantly bring it up....there’s lots of judgement there, which I’m choosing to politely ignore’ (Mum, 5)

With differences in parenting values and approaches being misunderstood by staff:

‘I follow attachment parenting principles and disciplining doesn’t always look like disciplining, you know time in’s rather than time outs and sometimes that has been misunderstood by some Health Visitors – they watched how I interacted with my older child when I took her (points to her baby) to the clinic and made comments which were completely ill informed – I just felt like eeeuuugghhhhh’ (Mum, 4)

Advising

The narratives of the participants also suggested that having access to professional ‘advice’ is perceived to be an important feature of the clinic process;

‘my main purpose of going to clinic has been to see a health Visitor for the advice’ (Mum, 8)

With weighing and advise going hand in hand;
'you go because you want professional advice or because you want your baby weighed I suppose....’ (Mum, 6)

'I go just to get her weighed.....and to ask the Health Visitor’s advice on whatever it is that’s worrying me at the time....’ (Mum, 3)

'It is quick fire support and advice’ (Mum, 7)

There is a recognition amongst some of the participants however, that the concept of ‘advising’ has an inherent power dynamic that can be disempowering for parents:

‘I think with a clinic it feels like the parent hands over their power to the professional and the professional is very much in charge and they say ‘yes he’s gained weight’ and they give advice and then the parent goes away....’ (Health Visitor, 4)

And which engendered professional reflection and progression:

‘Our previous clinics were quite medicalised as they were in GP surgeries and it felt more like we were giving advice rather than helping mothers find their own solutions and it was more dictatorial I think and quite sterile environments’ (Health Visitor)

One mother reflected on her differing needs at different points and those of her husband, in relation to seeking ‘advice’ at her clinic:

‘We used to go to the clinic for advice because my husband wanted solid directives from our health visitor....(laughs) he’s an engineer and I have to keep reminding him that we haven’t got a mechanical baby!.......you know I think it depends on how you work and what your relationship is with information and authority – do you want someone to just tell you? When you’re tired and out of your depth, sometimes you do just want someone to tell you....but then if their advice doesn’t work for you, it’s more frustrating to have just gone along with what someone else ‘told’ you to do....... (Mum, 6)
The manner in which advice is shared is also explored, with one mother acknowledging that whilst evidence based advice is what she is looking for at a clinic, the opinions of health professionals can also be useful and interesting, but the distinction should be very clear to parents:

‘I mean obviously evidence based advice is what I’m looking for….but it’s ok for their advice to sometimes be their ‘opinion’, based on their experience, but it needs to be presented as their ‘opinion’ ……because sometimes you get told things and think ‘well I know that that isn’t fact, but your telling me as if it was fact’, that can be quite annoying and patronising (Mum, 1)

The challenges of health visitors communicating research evidence in practice in a way which is effective is reflected on in an account given by a clinical lead:

‘Health visitors are exceptionally busy and I think they don’t have chance to frequently pause and link what they are doing to the evidence base of what improves child outcomes. Many just react – they see someone come to them at clinic with a problem, they give advice and then job done….they don’t necessarily think about how effective their advice was….’ (Health Visiting Clinical Lead, 8)

Cycle of serial reassurance

Once advice has been bestowed and the parent leaves the clinic, the cyclical process of seeking reassurance through weighing and receiving professional advice then appears to be re-activated when the next concern or worry emerges for the parent:

‘Even when you get some reassurance from the health visitor that everything is ok there’s still a sense that you need to keep going to the clinic to keep checking that everything’s ok -everyone I know goes at least every other week to get their baby weighed……if you’re supposed to do it, it makes you feel like a good parent to do it’ (Mum, 2)

The reassurance is suggested to be extrinsically mediated:
‘some mums like to see numbers going up on the chart and that gives them reassurance.....some people just want regular reassurance from a trained professional’ (Health Visitor, 1)

‘I think mums want to be reassured that they are doing a good job and if you can see your baby’s weight going up, it’s reassuring.....’ (Nursery Nurse, 3)

With health visitors having the same conversations, multiple times with individual parents:

‘I feel as if I’m repeating the same information over and over, one at a time, to a queue of anxious mothers....of course it’s individualised, but essentially mums come with the same concerns and worries....it doesn’t feel very efficient or effective to be honest, we’re definitely not ‘building community capacity’” (Health Visitor, 7)

The sustainability of a clinic model focussed on weighing, monitoring and advising through brief one to one consultations is questioned by a clinical lead, suggesting that it is in effect a model that can never meet the needs of parents:

‘Over dependence on one to one support and weighing reassurance, these are perpetual cycles whereby Health Visitor’s can never meet need - the model needs to be fundamentally focussed on something else......’ (Health Visiting Clinical Lead, 8)

Sharing

The process begins with mothers sharing their experiences; with other parents and / or with the health visitors or nursery nurses at the clinics (or hubs). The participants that had experienced this approach describe the process of sharing in positive terms:

‘It’s useful to hear other people’s experiences and other people’s tips.....’ (Mum, 5)
‘There’s definitely a positive in having access to different view points and styles….’ (Mum, 8)

‘Lateral thinking completely goes out of the window when you have a new baby……you need to talk things through with other parents to work through some of the crazy problem solving cycles you get into…..you know the kind of things you do when you’re just so desperately tired and you stop trusting your own instincts’ (Mum, 6)

The narratives of both mothers and health visitors suggest however that the process of ‘sharing’ requires facilitation from the health visitors which can lead to friendships forming which continue outside of the clinic or hub:

‘It’s quite nice when health visitors introduce you to other parents ‘oh you two both have babies the same age….what do you both think about….’ It helps you meet other mums. I’ve kept in touch with a couple of mums I met and we meet up regularly…..’ (Mum, 2)

‘It’s about helping mothers build up those friendships and relationships so they can meet up outside the group….so it’s about building community capacity because resources are so stretched, a lot of the groups that were on offer here are not here anymore’ (Health Visitor, 4)

And in some cases can become long lasting support networks:

‘When I reflect back over all the clinics I’ve delivered, all my years as a health visitor, the ones that always felt better were the ones which had more of a community feel to them and promoted social contact for parents….it’s interesting when you talk to parents with teenagers and you ask how they know each other you often find that they met at an antenatal course or a postnatal group and those friendships can last years and years and years…so it’s really important to promote contact between parents….’ (Health Visitor, 1)

The forming of friendships and networks is also recognised as having the potential to support maternal mood:
'I think it helps maternal mood….we’re setting up those social networks, mums meeting each other and supporting each other - that’s going to help mood and confidence....’ (Health Visitor, 7)

Health visitors describe opportunities to ‘normalise’ the experiences of parenting through group discussion with opportunities to ‘guide’ parents to information which they may find helpful:

‘...being in a room with other people who are going through the same stuff as you – it helps to know it’s all normal, we can get them talking....and help them with where to go for information....we’re kind of exploring together rather than telling...’ (Health Visitor, 2)

One Health Visitor reflected on the usefulness of drawing on multiple perspectives around topics and mothers being able to take the most relevant or useful bits:

‘When it’s one to one it’s just the Health Visitor’s advice and perspective, but the hubs mean they (mums) can get 6 or 8 people’s take on something and they can take or leave what they feel is relevant to them or useful.....’ (Health Visitor, 5)

It was also suggested by one professional that sharing experiences with other peers around topics which are culturally constructed, (such as how infants sleep) can be very valuable to both parents and professionals:

‘I think it’s much harder to discuss topics which are culturally defined and very subjective such as sleep when there isn’t anyone else to draw on, you’re kind of set up as an expert and the mother is hanging on your every word......it’s much easier to normalise and guide when parents can see and hear that there are different ways of approaching things’ (Health Visitor, 2)

The sharing of experiences between parents is however recognised as process which needs nurturing at groups and may not always happen spontaneously.

One professional describes how it requires the commitment of staff and belief in the value of a more social approach, to avoid vacillating back to one to one
conversations, which perhaps engender a feeling of greater efficacy in the short term:

‘We do try and encourage group discussions and I think it just hasn’t worked, but if we persevered and embedded it in the culture of the hub it might….but when you try and change something and you don’t get that immediate feeling of efficiency….you kind of think ‘ok that didn’t work’ lets go back to what we were doing before because at least you knew you were seeing that number of people…. (Health Visitor, 3)

Caring

Whilst all health visiting staff work within a framework which requires a person centred approach to practice; actively listening to parents, valuing parents experiences and communicating warmth and positive regard (Donetto et al 2013). The narratives of the participants suggest that a clinic model which encourages parents to openly share their experiences with other mothers and health visitors, requires an explicitly ‘caring’ environment to be engendered where mothers feel safe to explore the ups and downs of life with a young baby and with their new or renewed identity as a parent.

‘There’s just a really lovely atmosphere at our hub, when you walk in you think, ok this feels ok in here – the health visitors always clock you when you walk in and even if they don’t come over to say hi straight away, there’s a wave and a smile’ (Mum, 5)

‘we don’t need to over-complicate it……it’s simple really, we just want mums to know that we are really interested in what’s going on for them at the moment with their baby and that as professionals, we genuinely care…..when you start from that point, you know, ummm ‘kindness’ I guess, it can be a powerful thing…..’ (Health Visitor, 7)

Several participants commented on the value of laughter at the hubs:
‘...it just feels safe....the staff are lovely and funny, we always have a bit of a laugh about stuff....everyone has funny stories about life with a baby and there’s no judgment....they don’t make you feel panicked about anything’ (Mum, 3)

With staff recognising the therapeutic value of modelling playful interaction, between mother and baby:

‘not everything about our work needs to be serious public health messages.....if we want parents to interact joyfully with their babies then we need to try to create an environment where that feels possible’ (Health Visitor, 2)

And between mothers:

‘tired mums with their boobs out who can barely hold a conversation.....we just end up laughing about it together......it makes it feel normal and ok – a sort of a rite of passage rather than a problem’ (Mum, 4)

The process of creating a caring, nurturing environment is reflected on by one of the health professionals:

‘more than anything else, when a mum turns up to hub for the first time, you just need to make her feel really welcomed and provide a bit of nurturing.....you know make sure she knows where the toilets are, ummm has somewhere to sit..... introduce her to other mums....those kind of things ‘ (Health Visitor, 5)

This was also echoed by one of the mothers that participated, who touched on the need for health visitors to be really welcoming and for mothers not needing to have a reason for attendance:

‘if you turn up and have a bad experience, likelihood is that you won’t go back....but if you feel like the health visitors are glad you came...not because you have a problem, but just because....you know, it’s good to get out of the house.......then it’s gonna be a nice place to go back to’ (Mum, 4)

One health professional who participated, also reflected on the concept of caring:
'of course you care – if you didn’t you wouldn’t be a health visitor……but we have to think about how we communicate that to parents……you’re a caring professional but it’s not caring in a paternalistic sense……it’s about building relationships….with parents and between parents, recognising that we can’t be the only source of support, so we need to provide a service which helps parents find their own support network……empowering I guess’ (Health Visitor, 7)

Layering

An orientation to the delivery of clinics (or hubs) based on a fundamental ‘caring’ approach is a starting point from which health visitors can then begin to support parents to build their knowledge and skills around parenting topics through the layering of information. This appears to be achieved by health professionals listening to the experiences of parents and then providing pertinent pieces of information at appropriate times, in a variety of ways.

For example, this may be through normalising with story telling:

‘I’ve been a health visitor for a long time now and so I have a lot of parenting ‘stories’ that I will share in a very vague way with people about how some people have managed different challenges….so it’s evidenced based information, but you’re trying to share it in a way which normalise what parenting is about and change expectation….and that can be done in all sorts of ways, but sometimes you want to wrap in up in a very conversational manner and sometimes that’s how I use story telling….I say things like ‘I can remember a mum saying to me once….’ It just might help somebody think about something in a different way….’ (Health Visitor, 1)

Or through contextualising information:

‘you have your core visits but that leaves huge gaps, so having a ‘drop in’ allows an opportunity to give advice and information when they need it….it’s preventative; you’re thinking about what little bit of info might be useful to them at that point and if you can contextualise it that’s even better…….’ oh look
they’re doing this or that’…. ‘notice how he’s looking at you’…….that’s much easier in a more relaxed environment where parents and babies stay and play’

(Health Visitor, 2)

Or through guiding parents to self-directed learning opportunities:

‘it’s great to have books and good quality resources at the hubs to share with parents…….like the First Steps Nutrition Trust info and the Infant Sleep Information Source – parents can have a quick look in the group and then know where to go for info on sleep or introducing solids when they get home…..’

(Health Visitor, 4)

It could also be through the use of humour and group reflection on shared experiences:

‘…if you can get parents laughing together it’s great – get them chatting about weaning or something and there’s loads of opportunity to chip in lots of little bits of info…. you know…like why it’s important to let babies play with their food and things like that…’ (Health Visitor, 7)

Or by supporting parents to understand their baby’s behaviour:

‘sleep is such a big issue for parents….and if we can just help them to understand their baby’s behaviour rather than try and change it…..I mean that really is the story of parenthood – that things never really stay the same for very long and that I suppose it’s encouraging people to allow their parenting to follow their child’s development rather than try to train their children to do things’ (Infant Feeding Specialist, 1)

Or navigate perceived social or familial norms:

‘….to support parents to build confidence in their own judgement, we also have to help them to question and sometimes side step some of the ‘advice’ they get from friends and family members – a lot of which can be out of date….’ (Nursery Nurse, 1)
The participants accounts reflected some interesting perspectives on the process of layering information at hubs:

‘When people have a new piece of knowledge that they’re experimenting with they oscillate around it.....so sometimes you need a few cycles around it exploring it and I think that’s the moment of opportunity for health visitors - to give that mum the little bit of knowledge that she needs at that particular moment, just being able to drip feed info that helps make sense of it all at any particular given time’ (Infant Feeding Specialist, 2)

The participant then expanded a little more about the process of acquiring new information and the value of having well informed professionals with a depth of knowledge facilitating discussions without overwhelming parents with information:

‘people should have the opportunity to experiment with a new piece of information, challenge it, ask questions – not just have to be given it didactically and accept it.....that then requires health professionals to have the ‘ice berg’ of knowledge so the bit that you may be giving at any one moment is just that very small little peak, but then when they come back and ask more questions you need that really strong foundation so that you can help them look at it from different perspectives’

One Health Visitor reflected on the process of layering being guided by the conversations and therefore agendas of the parents sharing their experiences:

‘It’s not prescriptive or medical it’s normalising being a parent and there is an opportunity for us to guide.....so if someone says ‘oh yeah wean them at 8 weeks’ we can come in with current guidance so there is still professional advice.....we can have that discussion about different perspectives and how advice has changed and why......it can really help parents understand the issue more.....so you’re also able to educate the whole group.....’ (Health Visitor, 5)

The guiding process is also recognised by a parent:
'You are probably going to leave a hub having been given advice, but it’s the way, I mean it’s informal and chatty and ultimately they are listening to the parent and kind of guiding them then, it’s still advice but it’s not ‘ok, I would do this, this, this and this’…..’bye’…..’ (Mum, 4)

A beautiful summary of the process of guiding and layering through group facilitation was shared by a professional:

‘it’s about acknowledging and holding a spectrum of views for the group and gently guiding them to the evidence base in a way which doesn’t undermine or devalue the range of experiences that the group hold’ (Infant Feeding Specialist, 2)

The concept of facilitating conversations, sharing guidance and then parents being able to pick out bits that are meaningful to them is recognised by one health visitor:

‘It’s very relaxed, they (parents) can see that they can be supported by different people and they’re talking to each other and learning from each other and sharing experiences, like not getting any sleep, problems with feeding…..sharing and normalising. They can share their experiences and we can facilitate that conversation and share guidance and they can pick out the bits that they feel work for them as a family’ (Health Visitor, 2)

The concept of experiential learning is also covered in conversations with both professionals and parents:

‘Postnatally, you are trying to help mothers make sense of their experiences in the moment and that’s a delicate balance of information giving and confidence building. People are right there in the thick of the experiential learning bit…..they are having the experience, that’s why it’s so valuable to have a model which allows you to sit and be with parents as they feed their baby or play’ (Infant Feeding Specialist, 2)
‘Sometimes there are things that you do which might be wrong but you don’t even know that they are…..so I suppose if you stay at a hub and play then the HV can see you playing with your baby and help you…..’ (Mum, 2)

**Repairing**

The process of sharing and exploring their experiences within a caring and supportive environment with other parents, where relevant information and guidance is then sensitively and appropriately shared by health visiting staff, then appears to engender a ‘repairing’ process:

‘I feel as if I’m making it up as I go along, like everyone else….so being with other mums makes you feel that we’re all muddling along in a similar way, making mistakes, trying different approaches and then working things out.....it makes you feel like it’s ok not to be perfect and not even your health visitor knows all the answers, it’s just good to talk things through’ (Mum, 3)

Mothers report feeling a little more renewed or positive about their parenting skills or a particular health or wellbeing issue through this exploring and guiding process.

‘I found it really helpful that every time I went to see them I would come away with 2 or 3 suggestions of things to try, they would say ok maybe try this and I would go away with a list of ideas and I’ve borrowed books from them and things like that – I mean I was so tired I just couldn’t think for myself, I was just ‘stuck’ so it was really good to have somebody who recognises that and gives you some ideas to try, not too many at a time, but sort of summarises some options for you. I mean they were always really positive that there were other things to try and that’s what I needed.....ideas....’ (Mum, 4)

A number of parents also shared how they reached an acceptance about the normality of their own feelings or their infant’s behaviour through discussions with health visitors and other parents:
'… its funny it’s really taboo to have your baby in your bed with you but then when you speak to other mums the number of people that whisper to you ‘yeah I do that!’.....my mum would have a fit if I told her......but me and my friends are all doing it....we don’t smoke or drink....I’ve even taken my teddy out of the bed – we follow the safe sleep advice that the health visitor gave us and it works for us.....’ (Mum, 2)

‘once you realise that it’s normal for babies not to sleep through the night and that everyone is tired and just about coping, you can stop fighting it and just accept it.....the nursery nurse got us all talking about sleep one week at the hub and it just made me feel better about the whole thing....I’m not rubbish, she’s not naughty, it’s just normal....’ (Mum, 3)

Promotion of parental self-efficacy

The narratives of the participants who had attended hubs with a social orientation which focussed on promoting self-compassion, flexibility of thinking and emotional resilience suggest that a heuristic learning process is taking place which promotes parental self-efficacy.

One parent reflected on the need to build confidence in your own parenting style:

‘When you’re tired and out of your depth sometimes you do just want someone to tell you what to do – but it doesn’t ultimately help you because when you have a baby, it’s hour to hour first of all and then day to day, you’re just trying to get through that next thing that crops up, whatever that might, you can keep asking for advice, but at some point you need to have confidence in yourself as a parent’ (Mum, 4)

Another parent commented on the value of gathering information to make your own decisions:
'I don’t have a clue on loads of things, but I like the approach of listening to what they said and then letting me interpret it how I want to.....so listening to what they say and thinking well I’ll take that piece of info and that piece of info and put them together and make my own decision’ (Mum, 6)

A number of mothers suggested that support to trust your own instincts was valued by parents:

‘I think sometimes the ‘public health’ advice from Health Visitor is really important and useful but mainly you kind of just need someone to listen and help you to trust your instincts....’ (Mum, 1)

The process of then having your intuitions affirmed, helps parents to feel more confident:

‘most of the time I came away thinking well they’ve just affirmed what I already thought, what I thought I would try to do, so it was good to have my intuitions affirmed, you feel more confident’ (Mum, 4)

Health professionals also described how the search for external reassurance that parents may embark on can be utilised as an opportunity to support self-efficacy if parents are empowered by the support process:

‘For me a hub that works best is when we recognise a parent’s needs.... so a couple that came - their need at that time was to receive reassurance that their baby was doing well and thriving, so I did that by talking through baby’s behaviour while they were interacting with him, talking about the signs of a well baby rather than just weighing for re-assurance as it wouldn’t give them skills to feel reassured when they leave the group and are at home with their baby. It’s much better to support them to recognise positive signs without relying on weight all of the time (although obviously sometimes that is appropriate)’

(Nursery Nurse, 1)
One health visitor felt that a social model gradually decreased parental anxieties when health visitors were able to support new parents to integrate into the group:

‘so they’ll initially come around weight and feeding and if you put in the groundwork, they will gradually integrate into the group and so they then won’t need you as much….as long as you put in the building blocks initially……anxiety decreases’  (Health Visitor, 2)

Process Models

An intrinsic part of grounded theory methods is the creation of diagrams or models to provide a visual representation of categories and their relationships (Charmaz 2006). The constructed conceptual categories identified from the coding process are represented in two process models, with each model illustrating a cyclical support process.

The first reflecting a didactic approach, where weighing, monitoring and advising form the basis of the interaction between health visitor and mother (Fig 1.)

The second reflecting an heuristic approach where the exchange of support between mothers and between health visitors and mothers is relational, experiential and socially orientated (Fig 2.)

The process models reflect two disparate models of clinic provision; a surveillance model, focussing on weighing and monitoring which appears to engender a cycle of ‘serial reassurance’ and a primary prevention model focussing on reflection and compassion, facilitating the promotion of parental self-efficacy.

This section will offer an overview of each model and explore the narratives of the participants that informed the conceptual categories and the core category for each.
Surveillance model

Fig 1.

Surveillance model – a didactic approach engendering a cycle of serial reassurance

Mothers attend clinics to seek reassurance about the health, wellbeing or development of their baby, their parenting decisions or their own psychosocial needs as new parents.

Health Visiting staff weigh their baby.

Health Visiting staff advise parents.

Health Visiting staff monitor the baby's weight.

Health Visiting staff plot the weight on the chart in the ‘red book’.

The participants’ narratives suggest that the experience of support at traditional baby clinics focussed on weighing engenders a process whereby both mother and health visitor become locked into a cycle of serial reassurance.

Mothers attend seeking reassurance through the socially constructed weighing ritual that is offered to them, along with individual consultations which enable them to obtain professional ‘advice’.
Health visitors become task focussed, ‘processing’ individual mothers through a ritualistic weighing procedure and then offer their expertise to allay presenting anxieties. This supports the reassurance needs of both the mother and health visitor within the confines of a service focussed on monitoring, recording and secondary surveillance.

‘I think for many health visitors, because of the monitoring culture we’ve created within the service, the fear of missing something and not recording it is greater than the motivation to try to provide a service that prevents it...’ (Health Visiting Clinical Lead, 8)

‘There’s a real emphasis on surveillance at our clinics and I think it’s kind of reflected in our role as a whole at the moment, with the lack of staffing and the work that we’ve had to do, it feels like we are less ‘preventing’ and more ‘reacting’ (Health Visitor, 2)
The participants who had experienced a social model of clinic where scales were available, but not the primary focus of any interaction and parents were encouraged to stay and talk to each other, provided narratives which suggest that a heuristic learning process is taking place.

In this qualitatively different model, parenting is conceptualised as an ‘imperfect’ process requiring self-compassion, flexibility and resilience to navigate cultural and familial norms and cultivate a loving relationship with your infant. The primary purpose of the clinic (or ‘hub’) is therefore not to monitor
families and provide reassurance through the metric of weight, but to facilitate self-reflection, self-compassion and self-efficacy to support loving, sensitive and responsive parenting styles.

**Reflections on the process models**

When presented with the process constructed through this research, the Specialist Community Public Health Nurse programme lead interviewed suggested that the models resonated with her experience:

‘My sense is, from teaching, that both models exist, but we are still trying to shift some of the students and practice teachers and those they work with to this primary prevention model, because there is still quite a didactic approach to working with families and children’

There were also parallels drawn with the education of student health visitors and the orientation of the SCPHN course:

‘…..I think they (students) often come in as nurses wanting to fix things, same as clinics isn’t it – you come to clinic with a problem, I sort it for you and you go away…..but actually they promote an over reliance and there are definite parallels in education with students….rather than always being here for students, always providing an answer or reassurance - you’re trying to get students to build and recognise their own resilience and resourcefulness and support each other as peers…..and that’s an approach they can use with families……’

The NCT Postnatal Practitioner and Tutor interviewed also recognised the surveillance model of clinic through her conversations with parents:

‘All of the mothers attending my drop-in postnatal group attend traditional clinics…..their experience is that baby weighing is at the centre of the clinic with this either providing reassurance or frequently leading to concern and anxiety’
The primary prevention model did however, resonate with her experience of existing approaches adopted by Postnatal Practitioners:

‘This is a model that sits comfortably alongside the NCT’s model of postnatal support. The postnatal practitioner is not an ‘expert’...rather she uses her knowledge of the transition to parenthood to support the new mother in building confidence...self-efficacy...networks...and to enjoy their experience. We use a range of activities to promote discussion and mothers’ self-discovery as well as, hopefully, providing them with a toolbox to deal with issues that concern them, such as feeding concerns, sleepless nights, relationship difficulties...our model is one that has the mother at its heart because we feel that by improving her experience of new parenthood, outcomes for children and families will be more positive’.

Discussion

This study aimed to illuminate the experiences of mothers and professionals attending clinics and the grounded theory outlined provides conceptual insight into the process of support sought and offered at baby clinics. The accounts of the participants reveal a synthesis of beliefs, conceptions and assumptions about the purpose and value of clinics which reflect both their personal experiences and the social history of health visiting explored in the literature review.

The narratives suggest that traditional baby clinics delivered within a surveillance model are an area of practice where consensus exists about their purpose; to weigh babies and give reassurance, however their value is less clear, beyond providing an externally mediated reassurance. In primary prevention models of clinics, the purpose of the clinic is less clearly defined by mothers and health visitors, but the question of their value engendered richer descriptions of
positive interactions, adjustments in thinking, self-reflection and warmth and engagement in the support process.

The clinic process models constructed in this study reflect two different service provision orientations;

1. an inclination towards reinforcing existing service structures and an underpinning surveillance paradigm
2. an inclination towards service development through reflective practice, informed by a focus on primary prevention

An exploration of social constructs, concepts, models and approaches that are relevant to the models constructed are explored together with implications for practice.

**Conceptual categories**

**Seeking Reassurance**

The narratives of all the mothers interviewed provide rich descriptions of their drive to attend baby clinics to explore varying psycho-social needs as new parents; such as increasing knowledge and skills, supporting their emotional adjustment and building social networks. The accounts of mothers attending traditional ‘surveillance’ models of baby clinic, were however particularly focussed on the process of ‘seeking reassurance’ from health professionals about the health or wellbeing of their baby or their own parenting decisions.

The need for reassurance during the transition into motherhood is a natural process for mothers as they learn to understand and care for their baby and explore their new or renewed identity. Stadlen (2004) suggests however, that we lack the language to describe the normal process of learning to be a mother. New mothers therefore often use psychoanalytic terms that have filtered into common usage such as ‘neurotic’, ‘obsessive’ and ‘paranoid’ to describe their
feelings and behaviour in the early weeks and months with their baby, when their behaviours; for example not wanting to be physically separated, are very normal and invariably protective.

The dissonance experienced by mothers perhaps reflects the impact of a Western ideology which highly values independence and individualism. Such a belief system informs the prevailing cultural, social and familial norms around early mother-infant relationships which are experienced by mothers as incongruent with their intuitions, drives and emotions provoking anxiety and requiring resolution and reassurance (Stadlen 2004).

Harries and Brown (2017) suggest that the increasing isolation of new parents, who often do not live near their extended family, where previously they may have had both emotional and practical support, has meant that they look to infant parenting books, often written by self-proclaimed ‘experts’, which in turn can induce anxiety when the messages conveyed in the books are at odds with the embodied experience of mothering. For example, externally mediated expectations and parameters around early independence and separation, and rigid schedules for feeding or infant sleep that disrupt the intimate relationship between mother and infant.

The perception of the role of the health professional as the ‘re-assurer’ within the clinic setting, which is presented by the participants attending traditional models of baby clinics in this study, may therefore reflect multiple factors; the medicalisation of motherhood, the increasing isolation of mothers from a wider family unit and a narrative around parenting ‘expertise’ which pervades the media. Normalising the natural worries of early parenthood by sharing experiences with other parents at clinics rather than looking to a health professional alone, may support parents to stop pathologising their feelings or behaviour and value their innate instincts as protective; supporting the physical and emotional wellbeing of both themselves and their infant (Etezady 2012).
A lack of research into the concept of reassurance within public health settings necessitates drawing on models of reassurance derived from primary care to provide insight into the concept. A 2013 systematic review evaluating the evidence from prospective cohorts in primary care (Pincus et al., 2013) presents a tentative model of reassurance, derived from models of persuasion, (Coia & Morley, 1998), which dichotomises the concept into two categories;

1. affective reassurance, where empathy, caring and understanding are used to reassure

2. cognitive reassurance, where the provision of information and education is used as a means to reassure

The review found that cognitive reassurance resulted in more consistent and stable long-term outcomes such as ‘changes in knowledge and understanding, increased sense of control and changes in beliefs’ for patients (p.2415). Affective reassurance however was found to promote changes in short term outcomes such as ‘satisfaction, perceived support and reduced anxiety’ (p.2415). The authors suggest that further research is needed to investigate the relationship between affective and cognitive reassurance in terms of promoting effective, stable outcomes. They also acknowledge that the role of empathy within models of reassurance needs to be explored, particularly in view of a systematic review, (published in the same year as their paper) on the effectiveness of empathy in general practice (Derksen et al 2013), which suggests that empathy is an important factor in ‘strengthening patient enablement’ and improving both physical and psychosocial health outcomes (p.82).

Whilst Pincus et al.’s review looked at reassurance in the field of primary care rather than public health, it raises interesting questions about the approach to providing reassurance for parents in the early years in a way which is empowering and useful.

The accounts of many of the participants in this study suggest that ‘seeking reassurance’ is a core concept within traditional clinic settings. Perhaps however
reassurance within such settings should re-focus and address the psycho-social needs of parents, creating an environment which is reassuringly safe and has the potential to be therapeutically effective by providing:

- Reassurance that when you attend clinic you will be warmly welcomed
- Reassurance that you will be listened to empathically and without judgement and that your parenting style will be respected
- Reassurance that your unique perspective on your parenting journey, the wellbeing of your baby and your relationship with them is important and interesting
- Reassurance that you will be supported to understand your baby’s behaviour
- Reassurance that you will be guided to the current evidence base and supported to apply the guidance to your own life in your own way

An environment which feels reassuringly welcoming, non-judgemental and safe to share and explore both the joys and challenges of parenting may then provide the conditions to foster parental self-assurance and confidence through the promotion of parental self-efficacy, which is an identified core conceptual category of the more socially orientated clinic models that participants attended.

**Weighing**

Weighing is a process that pervades the accounts of the participants interviewed offering an array of insight into how staff and mothers navigate the enduring cultural perception that weight is a primary measure of infant health requiring continual monitoring (Sachs 2005, Webb 2016). Throughout all accounts, weighing was mentioned; either as a description of clinic process, as a mechanism to offer or receive reassurance, or within a critical narrative of the problematic nature of focussing clinic encounters around
weighing; which was perceived to be preventing the exploration of effective support for infant feeding and a more holistic conversation around infant and maternal wellbeing.

Whilst the notion of meeting parental need for ‘reassurance’ with a support structure focussed around weighing was a prominent concept in the accounts of the participants attending traditional clinics, research suggests that this is however, precarious. In a study about the experiences and support needs of adolescent breastfeeding mothers Dykes (2003) categorises the different types of support important for women, into; practical support, informational support, network support, emotional support and esteem support. With reference to Dykes study, Sachs (2005) suggests that receiving a weight alone is poor informational support and may or may not contribute to supporting the esteem of the mother depending on whether the weight ‘conforms to expectations’ (p.173).

For the participants, each time their baby was weighed the process was imbued with meaning and emotion within the context of their unique feeding journey so far. We should therefore be mindful that persistently weighing babies as a means of reassurance is not a benign activity. In fact, Sachs (2005, p.98) identified six different categories of reasons for weighing at baby clinics; medical weighing (concerns about growth), portal weighing (as a means to enter the baby clinic, which may be being attended for other reasons), recreational weighing (curiosity), accountability weighing (to relay the information to family members), keepsake weighing (to have a record of baby weights), grocer weighing (to see whether products which give a weight range such as nappies or car seats, are suitable for use). Recognising the spectrum of reasons, a parent may be seeking to weigh their baby and understanding the historical and cultural influences around which their motivation to weigh has been constructed is an important starting point for services providing baby clinics with weighing facilities, particularly if we are to shift the enduring pre-occupation with weighing to a more holistic assessment of infant wellbeing within baby clinics.
Monitoring

The explicit and implicit focus on monitoring evident in the narratives of a number of the participants in the study suggest that despite the movement from a National Child Health Surveillance Programme (Hall and Elliman 2004) to a Healthy Child Programme (DOH 2009), which shifted the focus of preventative child health services from health surveillance and monitoring to health promotion, there remains an embedded orientation to monitoring in the practice of many health visiting staff and an ingrained expectation of ‘being monitored’ by many mothers. Routine physical developmental ‘checks’ which previously formed part of the child health surveillance programme have been replaced with the assessment of future risk and need within a model that now focusses on the social determinants of child health and wellbeing (DOH 2009). The shift in emphasis from screening for existing developmental problems in children, to trying to prevent them through offering support and guidance around parenting and parenthood and the social and emotional needs of children, reflects a preventative approach aimed at increasing the probability of normal developmental trajectories through childhood (Etezady and Davis 2012 p.124). The successful provision of such support however, requires an approach where health visitors and parents are working in partnership (DOH 2009) and therefore transparency is key, any form of monitoring would therefore need to be made explicit and performed with the consent of parents, with a clear rationale and goals.

Advising

The perennial search for ‘advice’ from health professionals at baby clinics by many of the mothers participating in this research is unsurprising given the considerable physiological and psychosocial adjustments involved in becoming a mother (Bornstein 2016). The transition to motherhood is a period of intense
change, often coupled with fatigue and isolation, all of which can contribute to self-doubt and a lack of confidence in parenting abilities (Buultjens 2012).

Participants attending ‘surveillance’ orientated models of clinic shared accounts which reflect an orientation to practice where health visiting staff are presented as experts in child development and parenting and baby clinics offer ‘ad hoc’ access to their expertise. Although Health Visiting staff work within a framework of strengths based and solution focussed practice (Cowley et al 2013), staff accounts suggest that pressure to provide quick answers to questions from mothers can lead to didactic advice giving and whilst such an approach may alleviate immediate anxieties, it is suggested that it may not be an effective approach in the long run. Parents need to be supported to find their own answers and solutions to the uncertainties of parenting in order to build confidence and resilience (Etezady and Davis 2012 p.9).

There is an inherent power dynamic associated with ‘advising’ which is associated with ‘role power’; that is the power that accompanies a positional role were you have the responsibility and opportunity to offer or apply your professional knowledge and experience to those seeking help (Kagan 2012). It is now widely recognised however that using a ‘directing style’ in advise giving can generate resistance or passivity rather than change and it is more effective to use a ‘guiding style’ (Miller and Rollnick p.34, 35).

Although health visiting staff work within a person-centred framework of practice which has a strong emphasis on listening skills, their responsibilities as public health practitioners necessitate that they support and try to engender, health behaviour change with parents using evidence-based approaches such as motivational interviewing.

The concept of advice giving to support behaviour change is not considered to be inappropriate when utilising motivational interviewing techniques, although MI does focus on ‘evoking solutions from clients rather than providing them’ (p.148). When it is appropriate to provide advice it is suggested however that it should not be unsolicited and should be offered using ‘autonomy supportive
The effectiveness of focussing on advice giving at traditional baby clinics and the style in which this is conducted is therefore an important area of reflection for health visiting services.

**Process of serial reassurance**

The notion of weighing infants as a ‘ritual of reassurance’ was first posited by Magda Sachs (2005, p.165) in her ethnographic study of the influence of routine baby weighing on breastfeeding women in a north west England town. Similarly to the findings of this study, Sachs found that both mothers and health visitors felt ‘reassurance’ was the desired outcome of weighing a baby with health visitors also suggesting that reassurance was a ‘goal of clinic encounters’ (p.171). Rather than moving towards a goal of building parental self-assurance and confidence in their parenting skills however, the ritualistic process was found to be a recurring process of seeking external reassurance.

She writes: ‘*For breastfeeding women it also signals participation in external evaluation of their ability to sustain their infants through their milk*’ p. 176, reflecting a lack of confidence that many women have internalised through social and cultural norms and messages, in their ability to sustain their baby from their body alone. Sachs suggests that by relying on the metric of weight as the primary signal that the baby is thriving, mothers and health visitors ‘are tied into a process of serial reassurance’ (2005 p.165). Twelve years later, analysis of the accounts of participants of this study, who had experienced traditional models of clinic delivery where the emphasis was on weighing, echo the findings of Sachs research, suggesting that reassurance is an important and enduring concept to explore in research around health visitor led baby clinics.
**Sharing**

In contrast to the concept of ‘seeking reassurance’ which was a conceptual category identified from the narratives of mothers attending traditional models of baby clinics predicated on weighing, monitoring and advising, mothers attending more socially orientated clinics, where the focus was on engendering reflection and self-compassion, provided narratives that focused on the process of seeking opportunities to share their thoughts, feelings and experiences with other mothers and staff.

The preference for social contact with other parents in order to share experiences and feelings around parenting echoes research in 2008 that explored parents’ recommendations for the content of parenting programmes (Svenson et al 2008). Two categories identified in the qualitative study were ‘Seeing and Hearing the Real Experience’ and ‘Sharing and Supporting Each Other’, with the primary aim being social; to explore expectations, what is normal, and to develop peer support networks (Svenson et al, 2008 pp.39, 41).

Some of the participants interviewed for this study who had attended traditional models of clinic, expressed an unease at the thought of more loosely structured, socially orientated groups for fear of group norms prevailing which may be at odds with their own parenting style or current evidence-based practice. Interestingly however, such a narrative was not evident in the accounts of participants attending socially structured clinics where a culture of reflection, compassion and humour created a safe space for sharing to occur, where mothers could practice navigating a range of parenting styles and orientations. This again echos Svenson et al’s research (2008) in which group members are described as providing ‘a rich source of material for parents’ to enable them to observe ‘the strengths and limitations of a range of parenting styles’ (p.46).
Caring
Communicating warmth, positive regard and an explicitly compassionate and caring character are qualities of a person centred approach (Rogers 1961) that is central to the health visiting role (Cowley 2013). For the participants attending socially orientated clinics however, the concept of caring extended beyond simply the communication skills of the health visiting staff and included the atmosphere in the room and the ethos of the clinic model. They shared rich descriptions about the ‘feel’ of the room, their first impressions around feeling welcomed and the pleasure of encountering a warm, caring and safe place for chatting with other mothers. Etezady and Davis (2012) suggest that when mothers feel safe, they are able to talk more openly and ‘when mothers feel heard, they are better at hearing what their children are expressing’ (p.47). An explicitly caring approach from staff which permeates the ambience of the room may therefore create the appropriately safe atmosphere for reflective and honest discussions with parents and the modelling of the importance of emotional warmth with children.

Layering
The ‘layering’ of information at baby clinics is a conceptual category that was constructed as a result of multiple references in the accounts of the participants at socially orientated clinics, to visiting and revisiting information topics from different perspectives and in different ways. Inherent within the idea of ‘layering’ information was the understanding that parents need time and space to assimilate, question and utilise (or disregard) the large amounts of information that they are presented with (Woolfolk 2004). Also the recognition that we each have different preferences and tolerances for how we receive new information, ideas or concepts and that can shift and
change depending on our mood and the level of engagement we are capable of at any one time (May 2018).

Svenson, Barclay and Cooke (2008) suggest that ‘information transfer’ should not be the focus of parenting education, rather it should provide opportunity for an exchange of information and the opportunity to acquire skills in order to practice desired behaviours’ (p.3). This was reflected on in the accounts of staff delivering socially orientated clinics who valued the opportunity to use affirmations with parents about how they interacted with their babies and this was usually done through adopting the voice of the child and expressing delight at moments of attuned interaction.

Participants accounts also suggest a process of ‘reframing’ also contributes to the ‘layering’ process and this is a concept which is also acknowledged by Etezady and Davis (2012). Mothers concerns about their infants behaviour, for example around sleep are actively listened to, acknowledged and validated. An alternative explanation is then offered through reframing the infant’s behaviour as a way of seeking proximity and connection. Expressing curiosity about what the mother thinks her baby’s behaviour means is also a useful technique to stimulate reflective thinking in parents (Etezady and Davis 2012).

**Repairing**

The narratives of the participants attending more socially orientated clinics suggested an element of emotional ‘repairing’ was occurring within the clinic process, with parents leaving feeling a little more balanced and resilient than when they arrived. It appeared that through engendering an atmosphere of warmth and kindness at the clinics and an ethos of self-reflection and self-compassion, mothers were able to safely share their feelings and experiences around parenting and parenthood. The validation of all experiences shared coupled with the reminder that parenting is an imperfect process requiring a flexible and compassionate approach appeared to support mothers to reflect, facilitating some degree of re-regulation.
This echoes Svenson et al (2008) study findings where it was suggested that ‘a group can lessen a parent’s feelings of blame and guilt as participants listen to each other’s struggles with their children’ (Svenson 2008 p.46).

The process of ‘repairing’ through compassionate connection with others has similar associations to Siegel’s process of dyadic ‘rupture and repair’ (1999) that is considered to be an important part of how children develop regulator capacities; building a secure attachment and emotional resilience. Rupture is thought to occur when there is a break in nurturing connection between a parent and a child and repair occurs through the parent showing insight and awareness of the rupture and offering meaningful, healing reconnection. In this way the child begins to learn that life is full of moments of mis-connection that can repaired and that whilst people are imperfect they are also ultimately dependable; fractures can mend. It is thought to be the process of repair that builds healthy emotionally regulation and resilience in children (Siegel 1999).

The idea that parental uncertainty or dysregulation followed by reflection is an important process is discussed by Etezady and Davis (2012), who suggest that parents need to be supported ‘in the balance between knowing and being uncertain’, as if you believe that you are supposed to be entirely competent as parents, it is possible to become fixated on having all the right answers. The authors suggest however that ‘the process of trying to figure it out is more important than having to get the correct answer’ (p.9). In this way a more resilient, forgiving orientation to yourself as a parent can be engendered, which in turn will influence the style of parenting that you adopt with your child (Etezad and Davis 2012).
Promotion of Parental self-efficacy

Westbrook and Kennerley 2016 suggest that the search for externally mediated reassurance can often prevent us from learning to assure ourselves, making us dependent on others, as seen in the models of clinics in this study that focussed on providing reassurance through weighing, monitoring and advising. Conversely, the socially orientated clinics that participants described, appeared to focus on promoting parental self-efficacy in an effort to build individual and community capacity and resilience around early parenting.

The concept of parental self-efficacy (PSE) is informed by the wider concept of self-efficacy, defined by Bandura (1997) as an individual’s belief in their ability to succeed in accomplishing a task with a favourable outcome. PSE encompasses the parents level of perceived knowledge about a topic and their degree of confidence in their ability to accomplish tasks relating to parenting their child. Measures therefore reflect the parents perceived competence in their parenting ability on a range of issues which has been shown to be important in terms of parental resilience and child outcomes (Crncic, Barnett and Mathey 2008 p.443).

The promotion of parental self-efficacy is therefore an appropriate approach to adopt by preventative services working with parents and may be an important focus for new models of health visitor led baby clinics to explore and measure.

The measurement of PSE requires a psychometrically robust tool which is both valid and reliable and scales measuring PSE with the greatest validity generally include task specific measures tailored to the age of the child, such as ‘I am good at soothing my baby when she becomes restless’ (Barnes and Adamson-Macedo 2007 p.556) rather than more general measures of parenting which lack sufficient sensitivity.

There are however currently no PSE tools that appear to be suitable to use to evaluate the promotion of this construct at baby clinics. The Karitane Parenting Confidence Scale is suggested by the Institute of Health Visiting (IHV) as a
potential measure of self-efficacy. Published in 2008 it does however utilise a question which suggests an orientation towards outdated first wave behaviourist approaches to sleep training: ‘I am confident about helping my baby to establish a good sleep routine’ (Crncec, Barnett and Mathey p.446).

The implication that infants should be establishing ‘good’ routines necessitates the question, “good for who?”; the needs of the infant or the expectations of parents based on wider social norms? Such subtleties of language are important to address in order to ensure that any development and measurement of self-efficacy is truly reflective of our current knowledge of child development and the concerns of today’s generation of parents.

A study in 2005 which explored the experiences and views of mothers, health visitors and family support centre workers on the challenges and difficulties of parenting found qualitative differences in the importance given to parenting topics between health visitors and parents (Bloomfield et al 2005). This suggests that a greater understanding of what parents perceive to be their major challenges during the time that they may be accessing baby clinics for support will be needed in order to inform and develop a valid self-efficacy tool to measure the promotion of this concept at baby clinics.

When Cowley (1995) in her analysis of health visitors accounts of health, linked child health outcomes to the personal development of the mother in the mid 1990’s, biographical models of health visiting, focussing on the personal growth of the mother, were thought to lack clarity of outcome and therefore would be hard to justify funding (Robinson 2003 p.117).

The concept of encouraging the personal growth of the mother in order to support child health and wellbeing outcomes is of course now widely accepted as worthy of investment with programmes such as Solihull (Whitehead & Douglas, 2005; Bateson & Delaney 2008) providing a framework for therapeutic communication between health visitors and parents to explore parenting skills. The health visiting relationship is now seen as therapeutic in itself (Cowley et al
with solution focussed approaches such as Promotional Guidance (Day 2014) and Motivational Interviewing (Hirdle and Vaughan 2016) now widely utilised by health visiting services. In fact, guidance for educational standards for health visiting practice published by the Institute of Health Visiting (IHV) in 2015 include a standard around ‘working therapeutically to effect change with children and families’ (Bishop et al, 2015).

In recognition of the importance of the parent / health visitor relationship and the consequential need to identify and measure this construct, a series of recent research papers published from qualitative doctoral research into health visitor /parent relationships (Bidmead 2013) has set out the process of establishing and piloting a set of instruments to measure indicators of the parent / health visitor relationship (Bidmead, Cowley and Grocott 2017) which can be used in future research and evaluation.

Regular syntheses of evaluations of parenting programmes by the Early Intervention Foundation is also providing greater clarity for commissioners and services about classifications of effectiveness and anticipated outcomes from parenting interventions. Baby clinics have therefore much ground to cover in terms of defining their purpose, model and means of evaluation if they are to keep pace with the movement towards evidence-based practice in this field.

**Exploring current guidance and evidence with parents**

Many of the mothers participating in the study shared a sophisticated understanding of evidenced based practice and the nuances of receiving effective support at baby clinics. They were able to access evidenced based information independently however wanted emotional or practical support from professionals and peers to assimilate, contextualise and apply this knowledge. Other parents sought guidance from health visitors at clinic on where to access evidence-based information and some parents saw their health visitor at clinic
as a primary source of information and guidance which could be accessed in an ad hoc way.

The value of being able to access a drop-in baby clinic where up to date evidenced based information and guidance is available on health and parenting topics was clearly communicated by the participants. There were also however, reservations from some parents about the quality of information and guidance on offer.

The health visiting profession has ‘a long history as a vehicle for conveying to families at an individual level, institutionalised social norms and values concerning methods of child rearing and family life’ (Elkan et al 2000, p.199). Much of which has continued to focus on first wave behavioural approaches that originated in the early 1900’s when behaviourist principles of ‘operant conditioning’ and the modification of voluntary behaviour began being applied to child rearing (Beekman, 1977). Such approaches, applied in isolation, are rules based and underpinned by the concepts of manipulation and control which can feel at odds with the physiological and emotional needs of mothers and infants.

A burgeoning of research in the 21st century around the impact of early relationships on brain development, emotional regulation and resilience has however now provided a broad evidence base to support a sensitive and responsive approach to parenting which focusses on the quality of the parent-infant relationship. It also challenges entrenched social conditioning around parenting practices, such as early separation and first wave behavioural approaches to ‘baby training’ and discipline which have been features of many parenting books (Harries and Brown 2017).

The UNICEF Baby Friendly Initiative (UK) programme and the evidence and rationale for the standards underpinning the programme (Entwistle 2013) have provided important national structure and guidance through which to increase the knowledge and skills of health visitors. The standards address not only
current guidance around supporting infant feeding, infant sleep, family foods and early relationships but also the process of providing support; such as approaches to conversations, offering an underpinning ideology that focusses on cultivating therapeutically effective relationships. The standards provide an underpinning philosophy of practice around supporting infant feeding and a wealth of synthesised evidenced based information that could be effectively harnessed and utilised by health visitors at baby clinics to provide a service which supports parents to have connected, responsive relationships with their children and an enjoyable infant feeding experience.

The narratives of the participants suggest that the content of guidance shared by staff at clinics may also be influenced by the manner in which it is delivered. For example one to one support elicited on a specific issue seemed to more frequently generate a rules based, problem solving answer whereas conversations that took place in groups were more often described as orientated around parenting approaches or philosophies, with multiple approaches acknowledged which could be flexibly applied to individual circumstances. This may be an intuitive approach adopted by staff linked to the context and dynamic of each conversation or perhaps a more general orientation to their practice within their service, it would however be an interesting area of research to pursue in order to explore this further.

From ‘first wave’ to ‘third wave’ Behaviourism

The accounts of the participants engaging in a more socially orientated model of baby clinic which has been defined in this research as a primary prevention model, reveal both a qualitatively different approach to delivery and a qualitatively different experience for mothers attending compared to the surveillance model identified.

Delivered with an underpinning philosophy of parenting as an imperfect process, requiring flexibility and self-compassion, the approach shared by the participants
can be theoretically aligned with the philosophy of Acceptance and Commitment Therapy (ACT) as applied to parenting support.

ACT is a value based ‘third wave’ behavioural therapy which has become increasingly popular in recent years and is now being used to support effective parenting in the early years, (Coyne and Murrell 2009, Whittingham and Douglas 2014). It encourages a shift away from problem solving and control towards mindful awareness and action, encouraging clients to accept their thoughts, feelings and experiences with compassion.

In supporting parenting, it encourages parents to reflect on their basic principles and values and consider how they would like to bring up their children, acknowledging that we will all make mistakes and that we can recover and move forward when things have gone wrong. It moves away from first wave behavioural approaches emphasising rigid schedules and control, so often applied to parenting and is in fact being applied to infant sleep in Australia (Whittingham and Douglas 2014) offering an alternative conception and approach which prioritises the innate biological and emotional needs of mothers and infants.

A model of clinic which promotes heuristic learning is in essence applying values of ACT in its approach to learning, when practitioners utilise schema such as ‘principles’, ‘orientations’ and ‘intuition’ rather than didactic rules in discussion with parents. This approach can support parents to self-reflect in order to find their own solutions to problems, which may not always be optimal, but reflect their current capacity and values and are able to flex as situations change (Harris 2009).

Where baby clinic service provision has not changed in many years, in line with the principles of ACT, I would encourage services to compassionately reflect on the model of clinic being delivered in your area, reconnect with the goals and values of the health visiting profession in the 21st century and adopt a model which aligns with those goals; restructuring clinics in a way which maximises
opportunities to engender meaningful conversations and reflection with parents.

**Group facilitation and individual consultations**

A significant obvious difference between the two models of baby clinics identified in this research is the orientation towards individual consultations versus group facilitation. In fact the models constructed from the narratives of the participants have much in common with an Australian study published in the Journal of Perinatal Education in 2004.

The study explored mothers experiences of facilitated peer support groups compared with individual nursing support and found that facilitated peer groups appeared to ‘promote peer relationships, de-emphasise the power and expertise of the professional and increase community networks’ (Kruske et al p.37). Similar to the findings of this UK study, the Australian mothers attending the peer groups with their babies back in early 2000’s welcomed the interaction with other mothers and through observing, listening and sharing found solace in normalising their experiences. The ability of other mothers to understand and empathise was valued and women described an increase in self-esteem and confidence.

The authors highlight that a key lesson from the project was the importance of adequately training staff in group facilitation as mothers had found some nurses to be more controlling within a group setting than others. Group facilitation is not a core component of health visitor training in the UK. Students are likely to cover some theory on group dynamics and have group facilitation modelled by their lecturers, however if they then enter a service where the delivery of group interventions adopts a traditional didactic approach, such as offering ‘weaning talks’ the opportunity to practice their skills and witness the impact of a facilitative approach is limited.
The NCT have significant experience in training postnatal group facilitation and could perhaps offer a rich source of information, training and support to services wishing to upskill their health visiting staff in this approach.

The participants accounts revealed a ‘layering’ process happening within the groups, where information was re-visited from multiple perspectives, challenged, re-conceptualised and contextualised by health visitors and mothers. Such processes appeared to be happening spontaneously within the groups when mothers felt safe to share, explore and challenge experiences and information and health visitors understood and valued the facilitation process.

Frykedal and Rosander (2015) describe a similar approach in parent education groups; where rather than knowledge being didactically imparted by an expert, the facilitation of effective group discussions enables knowledge to be jointly constructed. The adoption of what they describe as an ‘investigative approach’, requires the facilitator to utilise their wealth of knowledge, experience or expertise, but in a responsive way, guided by the context of the group discussion and the groups’ ‘circumstances, expectations and needs’. It is suggested that the point at which any knowledge is shared should be guided by an intuitive sensitivity to the dynamic needs of individuals or the group and underpinned by the belief that learning will benefit if knowledge is shared at that point (Frykedal and Rosander 2015 p. 1970).

Of course, not all women enjoy group experiences and in common with the Australian study (Kruske 2004) this research also found that women who preferred one to one consultations had a greater focus on checking on the health of their baby through weighing. They also sought answers to specific questions from health professionals rather than seeking general guidance on topics. Similarly, the Australian study found that ‘For the women who used the individual consultations, there appeared to be no expectation of preventing problems from occurring or a need to prepare mothers for what was ahead’ (p.35).
The need for one to one discussions with some parents at baby clinics is of course acknowledged, however the degree to which baby clinics are structured around individual consultations or group facilitation needs consideration. This is perhaps particularly important when wishing to provide effective support for infant feeding where mothers may benefit from safe, supportive spaces where they can explore the joys and challenges of feeding their baby with other parents.

**Infant Feeding and peer support**

Infant feeding is a relational process which provides frequent opportunities for intimate contact between mother and infant in the early months and can engender an attuned and sensitive approach to parenting. Supporting all mothers and infants to have a positive feeding experience is therefore an extremely important public health goal contributing to both the short and long-term health and wellbeing of mothers and infants.

Accounts of a number of the participants in this research highlight the absence of effective support for breastfeeding at the baby clinics they visited where weighing was prioritised. Traditional clinic structures with queuing and short time slots with health visiting staff were not conducive to observing breastfeeds or engendering peer support, many parents in this study therefore sought support from other services and voluntary organisations.

Research by Trickey and Newburn (2012) suggests that a priority for action in terms of support for infant feeding is to develop models of support that are mother centred and proactive: ‘structuring services with minimal initial categorisation of mothers according to feeding behaviour or feeding intention’ and ‘integrating breastfeeding peer support alongside access to health professional services in existing settings frequented by new parents’ (p.80). Baby clinics have the potential to offer more effective peer support for infant feeding.
for all parents through offering an ‘individualised and non-dichotomised’ model of support (Trickey and Newburn 2012 p.87) within a relaxed social setting.

A UK study in 2002 which examined client’s recall of any discussions held with a Health Visitor in child health clinics, revealed that 67% of issues raised by the mothers were about feeding. This figure did not include other topics closely related to feeding such as infant sleep, colic, reflux, rashes, oral health, crying, responsive parenting etc. Plews and Bryer (2002).

Health led baby clinics are therefore potentially an important area where effective support for infant feeding could be offered, however models need to evolve so that feeding rather than weighing and proactive support rather than monitoring become the focus. Models should also focus on supporting parents to recognise, cultivate and utilise the resources available to them as parents, (both internal; such as their own skills, practices or abilities, and external; such as guidance or emotional or practical help and support).

**Assets for health and wellbeing**

The two process models constructed from the participants narratives in this research suggest that if health visiting services are to focus on primary prevention rather than surveillance, clinic models need to evolve from a problem focussed monitoring agenda, towards a salutogenic approach, fostering assets for health and wellbeing.

Health assets are any resources (internally or externally derived, innate or acquired) which may protect us against negative health outcomes and promote health (Harrison et al 2004). Such assets for example, may include focussing on improving knowledge and understanding about infant development and behaviour, supporting parental self-efficacy or building social support networks, all of which may contribute to psycho-social wellbeing.
The concept of health assets is not new to health visiting; in the mid 1990’s when there was little research or theoretical explanation about how health visiting services promote child health, Cowley found that many health visitors appeared to be intuitively conceptualising health as a ‘process’, focussing on the socio-cultural context of the families they supported (Cowley 1995) and supporting them to develop ‘a personal capacity for resourcefulness’ (Cowley and Billings 1999, p.994).

Rather than focussing on ill health or wellbeing, Cowley and Billings (1999) suggested that Health Visitors focus on fostering ‘resources for health’, which could be internal such as emotional, cognitive or physical or external support from family, friends or the local community, in order to support parents to engage in the ‘health creating processes of their own lives’ (p.996).

Such concepts have been theoretically rationalised and integrated into current models of health visiting (Cowley et al 2013) and are informing the practice of practitioners. It is, however, important to reflect on how traditional clinic models structured around surveillance and monitoring are effectively fostering ‘resources for health’ where, as described by the participants in this study, parents are invariably queuing and being called one at a time to have their baby weighed and have a brief conversation with a health visitor or community nursery nurse. In fact, the accounts of many of the health professional participating in the study suggest that their personal orientation towards their work is somewhat confined in a clinic environment by the structure and focus of the service being delivered.

Antonovsky’s Sense of Coherence theory (1979), which is embedded in a salutogenic model of health, suggests health and wellbeing is inherently linked to the sense of optimism and control that people possess over their own lives. In essence, it is suggested that people need to be able to contextualise their experiences and coping mechanisms around their health and wellbeing within their social sphere and culture to make sense of their situation and build
resilience. A strong sense of coherence enables a person to utilise their available resources to respond in a way which helps them to cope with day to day stressors and maintain wellbeing.

A paper by Super et al in 2015 which explored how health promotion activities may be able to strengthen people’s sense of coherence, suggests however that focussing on building health assets such as knowledge, self-beliefs or intentions around health activities is an insufficient approach on its own, to positively influence health. The paper suggests that a reflection process also needs to be supported whereby people are encouraged to understand their situation, reflect on the resources available and react to stressors in a way which is functional and self-empowering (Super et al 2015).

Reflections may elicit mobilisation or mindful acceptance, depending on the issue facing the parent. Such an approach seems intuitively persuasive within parenting support where interdependence rather than independence and flexibility rather than control are beginning to inform an alternative conception of autonomous action.

The concept of autonomy is something which has received much attention in literature around the provision of health services and is central to the ‘medicalisation critique’ (Lupton, 1997 p.96) i.e. that patients should not have their autonomy limited by more powerful health professionals.

Dominant interpretations of the concept of autonomy have however, been historically embedded in notions of independence and the freedom of the individual, which can be problematic when applied to the lives of mothers caring for children. Sherwin (1998) proposed an alternative conception of autonomy which she describes as ‘relational’, although she also suggests that the terms ‘socially situated’ or ‘contextualised’ autonomy would be equally descriptive (p.19). Interdependence, mutual support and flexibility rather than independence, freedom and control inform relational accounts of autonomy.
which it is suggested ‘are more relevant to the lives of many women’ (Christman 2004 P.143)

Donetto and Maben (2014) explore the concept of relational autonomy in relation to health visiting support outside of the home, such as in children’s centres and suggest that socially orientated support can help parents to foster self-trust and create the conditions for practicing autonomy skills. In line with previous research (Russell 2008), a number of the participants attending socially orientated clinic models made reference to the importance of having a choice of who to speak to at a clinic and also having the opportunity to explore how they discussed topics relating to their parenting choices with wider family and friends. The concept of being able to informally discuss and rehearse how you tackle challenges from wider family and community within a safe environment with other parents suggests that the idea of practicing autonomy skills is a valuable and important support mechanism.

Similarly, Donetto and Maben (2014) found that the sharing of parenting experiences and common difficulties informally with staff and other parents was found to positively influence parents’ sense of self-worth. With this in mind health visiting services are encouraged to reflect on the degree to which clinic models facilitate or impede relational autonomy.

A focus on engendering and identifying health assets and encouraging a reflective process in order to be able to understand, contextualise and utilise them to improve health and psycho-social wellbeing would therefore seem an appropriate goal for clinic models.

The findings of this preliminary research suggest that potential areas of focus may be supporting an embodied, contextualised understanding of parenting and the physical and emotional needs of children and parents, building social networks and supporting parental self-efficacy. This may be achieved through encouraging mothers to share their experiences, reflect on current guidance and their own unique circumstances and assimilate or construct an orientation to
parenting which utilises the health assets available to them. The underpinning principles of Acceptance and Commitment Therapy which encourages reflection and flexible thinking, may provide an appropriate theory based philosophical approach which could inform an orientation to practice to facilitate this health promoting process. The ultimate aim of which would be to foster psycho-social wellbeing and resilience in parents leading to improved childhood experiences, health and wellbeing.

Limitations and epistemological reflexivity

This qualitative study has offered two process models of baby clinics, constructed from the in-depth accounts of 24 participants across two local authority areas in the South West of England.

It is acknowledged however, that the choice of a social constructionist grounded theory research method in exploring this topic, my own professional background and the orientation of the services experienced by the participants have constructed a distinct set of data and findings.

No fathers were interviewed for this study and whilst this does not limit the validity of this study which focusses on a service accessed primarily by mothers, the experiences of fathers at baby clinics would be an interesting and valuable piece of further research. The study is also not representative of a health visiting service providing services to families of a varied ethnic mix as both local authority areas where the research took place had less than 10% ethnic mix of population (Census 2011).

The focus of the research question has defined and limited the study to the participants experiences of baby clinics and their perceptions of the purpose and value rather than exploring the perceived potential of baby clinics. The results therefore reflect two existing service orientations, which have engendered, through a social constructionist approach to grounded theory methodology, the
construction of different social processes with different underpinning analytic concepts; reassurance and self-efficacy.

Self-efficacy is an analytical construct from a pre-existing theory; Bandura’s social cognitive theory (Bandura 1997) and is now a widely accepted measure of healthy psycho social functioning. There are however, many other theoretical concepts which are assets for health and wellbeing and may be useful to consider as potential constructs to measure salutogenic approaches to baby clinic delivery.

As a piece of research from a social constructionist perspective, language is acknowledged to play an important role in the construction of knowledge. This research recognises the powerful influence of the historical narrative around baby clinics and parenting in general, in constructing the experiences of the participants, however it is not a focus of the study. Research exploring language and narrative, including the use of story-telling at baby clinics would offer an interesting insight into the impact and potential of message framing when offering preventative public health services.

This study has therefore opened a conversation around the purpose and value of baby clinics and their potential underpinning theoretical focus. It offers a perspective based on the unique perspective of the researcher and the chosen research method and invites a wider exploration from alternative perspectives and research methods in order to enrich our understanding of this service and it’s potential.

Further Research

Further research into the processes constructed in this study, conducted in other localities is suggested, together with an exploration of potential key outcome measures, such as a self-efficacy measurement tool. An exploration of parental perceptions of the challenges of early parenting which could inform the
development of valid and reliable self-efficacy measurement tool, specifically applicable to health visiting clinics would be very valuable.

It is also suggested that researchers consider the exploration of a therapeutic orientation to baby clinics based on the concepts of Acceptance and Commitment Therapy, to support the transition into parenting from a values based, flexible narrative. This may help parents reflect on their embodied experiences, identify their goals and values as parents and align their parenting style flexibly to meet those goals. It may also support a transition away from first wave behavioural approaches to early parenting which advocate rigid scheduling and rules based behavioural approaches to infant feeding and care.

Implications for practice

It is suggested that organisations providing a health visiting service centred on universal primary prevention, who seek to enhance the efficacy of support offered to parents and children at clinics should consider aligning clinics to deliver a psychologically informed, heuristic model. This should focus on the promotion of parental autonomy and parental self-efficacy through the relationally based therapeutic approach of health visiting staff, facilitated informal peer support and more socially orientated clinic environments.

Weighing

Weighing is a highly culturally embedded ritualistic tradition at clinics but is also a useful part of a wider picture of wellbeing for young babies. It is therefore suggested that weighing is not removed from baby clinics, but de-emphasised and de-prioritised, with scales being available without clinic models structured around them.
Clinic Environments

Clean, warm, welcoming and enriching environments are key to engendering wellbeing and social interaction at clinics and parents participating in the research expressed a desire for organised informality. For participants; feeling relaxed within a social model of clinic also meant knowing how to access the scales if they would like to and knowing how to speak individually to a health visitor if they would like to.

Health Visiting skills

A clinic model structured around group facilitation and interaction requires health visiting staff to be confident in the underpinning theory and philosophy of the model, the process of delivery and the anticipated outcomes. Health Visitors should therefore be supported to develop their facilitation skills and their understanding of heuristic and experiential learning and group dynamics with such skills being highly valued by clinical leads.

Infant Feeding

With the reduction of funding for breastfeeding support groups in many areas health visiting services have an important responsibility to utilise baby clinics to provide effective support for infant feeding for all parents. Traditional models of clinics structured around weighing, that were experienced by some of the participants in this research, were not however found to be providing a suitable environment or structure through which effective support could be delivered or received.

Sachs (2005) suggests replacing weighing with an ‘alternative ritual’ perhaps an assessment tool that supports a discussion around effective feeding and takes an holistic approach to supporting the embodied process of feeding, addressing the ‘physical, biological, social and emotional’ experiences of mothers (Sachs p.211). Whilst Sachs’ focus was the experience of breastfeeding mothers, all mothers could potentially benefit from an holistic approach to feeding
assessment and the use of the UNICEF BFI (UK) breastfeeding and formula feeding assessment tools could form the basis of an empowering discussion around feeding which mothers could then continue to use in their own homes, building confidence in their ability to feed their baby appropriately.

**Working in partnership with children’s centres**

The delivery of more socially oriented baby clinics in collaboration with children’s centres services is an obvious partnership, however to avoid simply co-locating services, it is important for all staff to have a robust shared understanding about the philosophy and approach of the model being delivered and the mechanisms by which defined outcomes may be achieved.

**Conclusion**

This study sought to illuminate the experiences of mothers and professionals attending clinics and the grounded theory outlined provides conceptual insight into the process of support sought and offered at baby clinics. Implications for practice are considered and with limited research to inform national or professional guidance on the delivery of baby clinics, provider organisations delivering health visiting services are encouraged to reflect on their service objectives and adopt a model of service delivery with an appropriate rationale and focus, underpinned by a psychologically informed process model. Where process models underpinning clinic delivery are clear and fidelity to the model and effective implementation can be established, research evaluating the effectiveness of such models should then be conducted to continue to progress this service element to an evidence base.
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UWE (2014) ‘Research, data protection and data security: guidelines for staff and students’ Available at: File:///C:/Users/Jo/AppData/Local/Packages/Microsoft.MicrosoftEdge_8wekyb3d8bbwe/TempState/Downloads/Data-protection-staff-guidance.pdf


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While, A (1990) Child health clinic attendance during the first two years of life Public Health 104, pp. 141 -146


Appendix A

A systematic review of the effectiveness of universal Visited Child Health Clinics in promoting the healthy development of pre-school children and reducing health inequalities.

Jo Webb, UNICEF Baby Friendly Initiative Lead, Health Visiting, Bath & North East Somerset

Introduction

Despite the widespread presence of health visitor-led "baby clinics" across the UK, which provide significant health visiting hours, there is very little published research about their model, purpose or effectiveness.

When health visiting was commissioned nationally during the health visiting reorganisation plan (phase 1, 2011-2015), there did not appear to be an explicit expectation that baby clinics were delivered as part of the health visiting core service offer (National Health Visiting Service Specification 2014/15).

In fact the national guidance currently exists about how and if, health visiting led baby clinics should be conducted. Clinical leads and practitioners are therefore left to their own professional instincts and experience for guidance.

Baby clinics appear to be an historically embedded model of service delivery with a traditional focus on wellbeing babies, with no explicit framework on analysis of their purpose or value.

The move from a national programme of child health surveillance in the UK in the late 20th century to a holistic, psychosocial approach to child health promotion now requires professional reflection and research on the value and purpose of baby clinics and how they might best support the delivery of the Healthy Child Programme (2009, updated 2013) within health visiting services.

Systematic search

<table>
<thead>
<tr>
<th>Search strategy</th>
<th>Database searches</th>
<th>Reference searches</th>
</tr>
</thead>
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</table>

Inclusion Criteria

<table>
<thead>
<tr>
<th>Publication date</th>
<th>Quality assessment of included studies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Data extraction and analysis

Extracted data included details of the participant selection criteria and sampling proportion, methodology, data collection and analysis techniques, results, conclusions and recommendations and a quality assessment.

All included studies were qualitative and the appraisal criteria was based on May and Pope Quality Guidance (2001).

The quality of the studies was variable; however no studies were excluded based on quality issues; inclusion was based on relevance. Thematic analysis was performed to establish key themes of the included research papers and a thematic synthesis was performed to identify the key contribution of studies to the final themes.

Data from included studies are presented in the systematic review.

Flowchart showing the retrieval process of studies included in the systematic review

Themes

<table>
<thead>
<tr>
<th>Health surveillance</th>
<th>Health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

Discussion

The themes of the 2009 report included in the review that of improving the quality of baby clinics. A systematic review was conducted of mixed-method studies evaluating the effectiveness of health visiting led baby clinics in improving the quality of baby clinics and the health of their clients. The review included 11 studies, 5 of which were randomized controlled trials (RCTs) comparing baby clinics with usual care. The results of the review showed that baby clinics were associated with improvements in children’s health and wellbeing, reduced hospitalizations, and increased parental satisfaction. The review also highlighted the potential for future research to focus on the most effective strategies for improving the quality of baby clinics.

Conclusion

The lack of evidence to support the overall effectiveness of baby clinics in improving the quality of baby clinics and the health of their clients was identified as a limitation of the review. Further research is needed to investigate the potential for future research to focus on the most effective strategies for improving the quality of baby clinics.

References

<table>
<thead>
<tr>
<th>Reference</th>
<th>Source</th>
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<tr>
<td></td>
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</table>

Further Information

For further information, please contact

University of the West of England
Appendix B

BABY CLINICS – WHY AND HOW?

From reassurance to parent-focal efficacy: lay and professional perceptions of the purpose and value of health visitor-led child health clinics

Jo Webb, Infant Feeding Lead, Health Visiting, South Gloucestershire

I think for many health visitors, because of the monitoring culture we’ve created within the service, the fear of missing something and not recording it is greater than the motivation to provide a service that prevents it...

(Health Visiting Clinical Lead)

Discussion

Health Visiting serious focus on preventative work within a model of progressive universal (C’) plus, working from a strength’s based, solution focused approach with a combination of relational and functional practice. It is therefore suggested that health visiting services are viewed in different light by different stakeholders and greatly affected by the culture of service delivery (Gower et al., 2018).

The current model of service delivery within this region has been modified over the last 5 years to deliver a psychologically informed, task-specific model which encourages shared responsibility between health visitor and parent.

Implications for practice

It is suggested that professional relationships within health visiting services should be based on empathy, support and respect to ensure that the professional role is perceived more positively and that this is more conducive to providing a psychologically informed, task-specific model which encourages shared responsibility between health visitor and parent.

Worrying that the trend towards a more medicalised approach to health and well being services in recent years has resulted in a reduction of the role of health visitors in the community, it is therefore suggested that this might be more positively perceived if health visitors are viewed as an innovative and positive change agent in order to explore the potential to continue to promote and provide services in a supportive manner.

Clinic Environments

Clinic environments offer a safe, warm, welcoming and stimulating environment for health visitors to work in. The health visitor is able to provide a range of services in a busy and friendly environment, which is conducive to working in a supportive manner.

Health Visiting Skills

A focus model produces a group facilitation and interaction in which health visiting staff are able to develop a relationship with each other. This focus is a result of the shared experiences of the health visitor and the way in which they work together to achieve a common goal.

Conclusion

The process of providing the experience of mothers and professional providing within the health visiting service is of paramount importance. This paper has provided an insight into the process of providing support and effective care.

References

[Provide references here]

Results

Process models

Two different support models are developed which reflect two models of care providers: a surveillance model, focusing on ongoing monitoring and a primary carer model focusing on parent’s own reflection and support.

Figures 1 & 2: Surveillance model – a descriptive approach underpinning a model of continuous reassessment

Methods

Informational semi-structured interviews were conducted with 24 participants, including health visiting staff and parents across two local authority areas in the South West of England. A constructed grounded theory methodology was used to support the data.

‘Not everything about our work needs to be seen in public health messages... If we want parents to understand fully with their babies then we need to try to create an environment where that feels possible and healthy (Health Visitor)’
Appendix C

A systematic review of the effectiveness of universal Health Visitor led Child Health Clinics in promoting the healthy development of pre-school children and reducing health inequalities.

Jo Webb

February 2016

Module: USPJHK-30-M

Word Count: 6000
Abstract

This paper presents the findings of a systematic review undertaken to assess how effectively health visitor led child health clinics (aka ‘baby clinics’) contribute to the promotion of pre-school child health and the reduction of health inequalities.

Despite the widespread presence of baby clinics across the UK, there is little published research about this model of care, its purpose or effectiveness. No national guidance exists about how or indeed, if, baby clinics should be conducted; local services are therefore left to consult their local service specification and their own professional instincts and experience for guidance.

The initial search produced 559 articles, after duplicates were removed, 175 abstracts were assessed against the inclusion criteria and 24 were identified as relevant to the review. No studies were excluded based on quality issues, however the quality of included studies was variable. All 24 of the included papers were qualitative studies, with thematic analysis used to organise and interpret the range of data.

Although the review presents a synthesis of research over the last 30 years, there is a clear lack of evaluative research about the structure, process and anticipated outcomes of baby clinics or indeed their perceived value or purpose, which makes it impossible to draw any conclusions about the effectiveness of the service offer.

In light of the move from a national programme of child health surveillance over the last century to a holistic, psycho-social approach to child health promotion, findings would suggest professional reflection and research on the value and purpose of baby clinics within health visiting services are now needed.
Whilst good evaluation studies with clear outcome measures are sought, it is clear that the theoretical processes by which baby clinics may promote positive outcomes need to be established first.

**Introduction**

The first child health clinics were set up in the UK in the late 1800’s, primarily to supply uncontaminated modified cow’s milk and support mothers with infant feeding and nutrition. With the advent of the NHS in the mid-20th century, clinics became part of mandatory local authority provision and developed an educational outlook aimed at providing advice around childcare, development and health (Plews 2001).

Whilst the value of Health Visitors in providing this service was acknowledged in the Sheldon Committee report into the function of the child health clinic in 1967, their contribution was subsumed by the emerging wider medical remit of the clinics which focussed on immunisations, screening, growth monitoring and particularly the frequent weighing of babies. Research primarily focussed on the uptake of secondary preventative programmes leaving the advisory role of the health visitor within clinics largely unexplored (Plews 2001).

The move from a national programme of child health surveillance to an approach based on primary prevention through health promotion engendered significant professional reflection and development of the health visiting service, which in turn led to a reduction in the level of screening and physical growth monitoring by health visitors (Healthy Child Programme 2009, updated 2015).

A continued focus on weighing at clinics (Barlow & Coe 2011, Burgess-Allen 2010, Russell 2008, Sparrow 2005, Sachs 2005, Plews and Bryar 2002), against a backdrop of professional progress towards more holistic approaches to health promotion raises the question of whether a focus on weight monitoring at clinics
is preventing this service element from evolving in line with the rest of the Health Visiting Service offer.

A national survey of health visiting activities and service organisation published in 2007 (Cowley et al) reveals that, at that time, baby clinics were a core service being delivered by 98% of the 968 caseload holders included. The only other service having such a high prevalence of delivery being the ‘new birth’ home visit by health visitors.

It is clear therefore that historically, a significant number of health visiting hours have been used in the delivery of baby clinics. However Cowley et al (2013), in the literature review ‘Why Health Visiting?’ found insufficient research on this topic to demonstrate whether clinic work should be deemed as a ‘core practice’. Clinics are therefore, it seems, continuing to be offered as a service with no explicit model, framework or analysis of their purpose or value.

Given the lack of a theoretical basis, clear process or clarity around the purpose, expectations or value of baby clinics it is unsurprising that they were not mentioned in the review of health-led parenting interventions in pregnancy and early years (Barlow et al 2008) conducted to inform the structure of the Healthy Child Programme (2009).

In fact, when Health Visiting was commissioned nationally during the Health Visiting Implementation Plan phase (2011-2015), there did not appear to be an explicit expectation that clinics were delivered as part of the Health Visiting Core service offer (National Health Visitor Service specification 2014 /15). Despite this, baby clinics continue to be routinely offered by many service providers, raising the important question of how effective they are in promoting the healthy development of pre-school children and reducing health inequalities.

In order to address this gap, this paper presents the findings of a systematic review undertaken to assess the impact and effectiveness, in terms of either process or outcome of health visitor led baby clinics.
Methodology

Systematic search


The following broad search terms were used to ensure a wide spectrum of literature was included:

(“health visit*” OR ”specialist public health nurs*” OR “specialist community public health nurs*”) AND (“baby clinic*” OR “child health clinic*”)

The literature search extended from 1985 to June 2015. The rationale for a 30-year period was to explore a generation of research, potentially revealing evolving models of health visitor led baby clinics and their respective effectiveness. It was felt this may help contextualise more recent research and highlight the traditions and rituals underlying an historically embedded service provision.

Search selection / Inclusion Criteria

Citations and abstracts were filtered based on the following inclusion criteria:

Publication date: Since 1985

Study focus: Health Visitor service provision in child health clinics (aka baby clinics) and / or lay or professional views on the purpose or value of baby clinics

Type of studies: Qualitative and quantitative studies, including survey of views, observational data, commentaries from clinicians, parents and others, audit
results, reviews of research, small scale studies and recommendations of practice
(Not all original research evidence)

Country: Studies of UK child health clinics

The initial search produced 559 articles. Duplicate studies were removed and 175 abstracts assessed against the inclusion criteria, 24 were identified as potentially relevant to the review and full papers were obtained (Figure 1.) Studies were included based on relevance to the review question rather than study type or quality. No studies were excluded based on quality issues, however the quality of included studies was variable.

The 24 studies meeting the inclusion criteria are detailed in Table 1.

Figure 1: Flow chart showing the retrieval process of studies included in the systematic review
Data collection and analysis

Data was extracted systematically using a specifically designed data extraction form and classified according to study type (Appendix A). Extracted data included details of the participant selection criteria and sampling procedure, methodology, data collection and analysis procedures, themes or key findings, author explanations and recommendations and a quality assessment.

All included studies were qualitative and the appraisal criteria was based on Mays and Pope Quality Guidelines (2000) (Appendix B). Each study was scored and assigned a quality range:

Low quality 0 - 10
Medium quality 11 – 20
High quality 21 - 30

The quality of the studies was variable; 9 studies in the lower range, 6 studies in the medium range and 9 studies in the high range. Appendix C includes the quality score of each study.

A ‘sensitivity analysis‘ was performed after the thematic analysis of data to establish if the included papers were aligned with the themes identified. Whilst all papers contributed to the themes, a number of the earlier descriptive surveys contributed little more than an historic snap shot of clinic structure and attendance. However, an understanding of clinic structure and practice in the last 30 years contributes a valuable insight into the enduring culture of weighing within the clinic setting and sets the context for the process of change discussed in the more recent, evaluative research included.

Thematic analysis

The review used thematic analysis (Attride-Sterling 2001) an approach which has been successfully used in other systematic reviews of qualitative studies (Tomas & Harden 2008).
The aim was to identify patterned meaning across the data. It was felt that thematic analysis, above other methods of qualitative synthesis, provided sufficient flexibility to examine, organise and interpret the eclectic range of qualitative data. This included both primary and secondary data; parent’s experiences; practitioner’s comments; and the interpretations and explanations of researchers and authors. An inductive approach was taken whereby the ‘coding’ of data using ‘gerunds’ (Charmaz 2006) informed the construction of basic themes. A clear progression was evident between the themes of the earlier included studies (≤1999) and the later research included (≥ 2000). This led to a thematic comparison being conducted of older, descriptive evidence with newer more critical and interpretive research. This approach is in line with the method adopted by Cowley et al 2014, in the paper ‘Why Health Visiting?’

Thematic analysis was also felt to be an appropriate tool to enable the qualitative data retrieved to be summarised with sufficient clarity to convey meaningful findings through this review.

The thematic progression identified suggest that the potential value of community based family support within universal clinic settings is now being recognised in research literature and there is potential to transform clinics into valuable community assets focussing on supporting early parenting. The theoretical processes by which this support might be delivered and received appears to be relationally and socially constructed and the review provides formative themes on which theories of change or models of delivery may be focussed and tested in the future.

**Results / Findings**

24 studies were included in the review (table 1). The included studies are summarised in Appendix C.

No evalutative studies were identified through database searches and all relevant studies included were qualitative, it was therefore appropriate to adopt a qualitative approach to the synthesis of data.
Thematic analysis was conducted comparing studies ≤1999 with ≥2000 studies. This approach was adopted because of a clearly emerging thematic progression across the research papers linked to the time period in which the studies were published. This represents both a service in transition and also the changing attitudes and approaches to parenting and parenting support over the last 30 years. It also signifies the emerging recognition in the last 15 years of the value of high quality qualitative research.

Early research explored (≤ 1999) largely consists of descriptive surveys which represent a clinic model based on health surveillance and weight monitoring with health visitors adopting a didactic, advisory role.

Later research papers (≥ 2000) encompass a range of high quality, analytic foci, including the identification of key processes (Bidmead 2013), an analysis of service users views of health visiting (Donetto et al 2013), an exploration of a theoretical concept (Donetto and Maben 2014) and an illumination of the historical, economic and social constructs impacting on the experiences of parents’ attending clinics (Sachs 2005).

A diagrammatic representation of the themes is shown in Figure 2.

Two main themes were identified:

1. The pre 2000 studies revealed a thematic focus on secondary ‘health surveillance’:
   ‘The purpose of the child health clinic has traditionally been seen as one of medical surveillance’ (Sefi and Macfarlane 1985 p.129)
   ‘Clinics were seen as places to visit to weigh the baby’ (Knott & Latter 1999 p.580)

2. The post 2000 studies revealed a thematic focus on primary ‘health promotion’ within the clinic environments:
'the central role of the HV (at clinics) should be to elicit and respond to the agenda that the mother brings, rather than opportunistically giving advice according to their professional agenda’ (Plews & Bryer 2002 p.34)

‘Practical and emotional support for breastfeeding needs to be embodied within well baby services such as clinics with limits to the medical need for weighing being clearly established’ (Sachs 2005 p. 214)

Twelve sub themes were constructed (six ≤1999 studies; six ≥2000 studies) and are organised as a progression across the two main themes.

The sub themes have no hierarchy or weighting in terms of importance and are shown in the diagram as a flat structure in no significant order (Figure 2).

Table 1. Table of included studies

<table>
<thead>
<tr>
<th>Authors (year)</th>
<th>Title</th>
<th>Journal</th>
<th>Volume, Issue, Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donetto &amp; Maben (2014)</td>
<td>‘These places are like a godsend’: a qualitative analysis of parents’ experiences of health visiting outside the home and of children’s centre services</td>
<td>Health Expectations</td>
<td>18 (6) pp. 2559 - 2569</td>
</tr>
<tr>
<td>Donetto et al (2013)</td>
<td>Health Visiting: the voice of service users Learning from service users’ experiences to inform the development of UK Health Visiting practice and services</td>
<td>National Nursing Research Unit, King’s College London</td>
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</tr>
<tr>
<td>Bidmead (2013)</td>
<td>Health Visitor / Parent Relationships: a qualitative analysis</td>
<td>This study is part of a larger doctoral thesis in progress and was published as an Appendix to the report entitled ‘Why Health Visiting?’ (2013,</td>
<td></td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Journal</td>
<td>Issue</td>
</tr>
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<td>-----------</td>
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</tr>
<tr>
<td>Russell (2008)</td>
<td>Left Fending for Ourselves – A report on the Health Visiting Service as experienced by mums</td>
<td>Netmums (online social networking site)</td>
<td></td>
</tr>
<tr>
<td>Sachs (2005)</td>
<td>‘Following the line’: An ethnographic study of the influence of routine baby weighing on breastfeeding women in a town in the Northwest of England</td>
<td>University of Lancashire, Department of Midwifery Studies</td>
<td></td>
</tr>
<tr>
<td>Finch &amp; Whitefield (1997)</td>
<td>Setting up a Saturday morning Child Health Clinic</td>
<td>Care of Mother and Child</td>
<td>7(3)</td>
</tr>
<tr>
<td>Sefi &amp; Grice (1993)</td>
<td>Parents’ view of clinics</td>
<td>Health Visitor</td>
<td>66(10)</td>
</tr>
<tr>
<td>Sharpe &amp; Loewenthal (1992)</td>
<td>Reasons for attending GP or health authority clinics</td>
<td>Health Visitor</td>
<td>65(10)</td>
</tr>
<tr>
<td>Author(s)</td>
<td>Title</td>
<td>Journal</td>
<td>Volume</td>
</tr>
<tr>
<td>---------------------------------</td>
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</tr>
<tr>
<td>McIntosh (1992)</td>
<td>The perception and use of child health clinics in a sample of working class families</td>
<td>Child: care, health and development</td>
<td>18</td>
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<td>While (1990)</td>
<td>Child Health Clinic Attendance During the First Two Years of Life</td>
<td>Public Health</td>
<td>104</td>
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<tr>
<td>Betts &amp; Betts (1990)</td>
<td>Establishing a child health clinic in a deprived area</td>
<td>Health Visitor</td>
<td>64(4)</td>
</tr>
<tr>
<td>Sefi &amp; Macfarlane (1987)</td>
<td>Increasing Health Visitor Involvement in Child Health Surveillance</td>
<td>Health Visitor</td>
<td>60</td>
</tr>
<tr>
<td>Karmali &amp; Madeley (1986)</td>
<td>Mothers’ attitudes to a child health clinic in a deprived area of Nottingham</td>
<td>The Society of Community Medicine</td>
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<td>Turya &amp; Webster (1986)</td>
<td>Acceptability of and need for evening</td>
<td>Child: care health and development</td>
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</table>
Figure 2: Diagrammatic representation of themes

<table>
<thead>
<tr>
<th>Health surveillance</th>
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<th>Health surveillance</th>
<th>Health promotion</th>
<th>Health surveillance</th>
<th>Health promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surveillance &amp; social control</strong></td>
<td><strong>Building social capital &amp; adding social value</strong></td>
<td><strong>Advisory role</strong></td>
<td><strong>Facilitative, guiding role</strong></td>
<td><strong>Outcome / problem oriented</strong></td>
<td><strong>Process / relationship centred</strong></td>
</tr>
<tr>
<td>- Clinic environment precludes socialising</td>
<td>- Clinic environment facilitates social interaction</td>
<td>- Health Visitors believe their role is to impart advice</td>
<td>- Facilitating discussions between parents</td>
<td>- Focus on parents’ experiences of support at clinics</td>
<td>- Focus on supporting infant feeding &amp; sensitive, responsive parenting</td>
</tr>
<tr>
<td>- Fixed on weighing measuring &amp; tracking</td>
<td>- Prioritising opportunities for parents to share experiences &amp; offer mutual support</td>
<td>- Mothers seek reassurance &amp; advice</td>
<td>- Guiding parents to the evidence base</td>
<td>- Focus on tracking / plotting weight</td>
<td>- Needing an alternative to the ritual of weighing at clinics</td>
</tr>
<tr>
<td>- Monitoring of maternal competence</td>
<td>- Valuing lay &amp; peer support</td>
<td>- Authoritarian approach by clinic staff</td>
<td>- Supporting parents to understand &amp; consider their options</td>
<td>- Focus on measuring clinic attendance</td>
<td>- Needing social spaces to support all forms of infant feeding without dividing parents</td>
</tr>
<tr>
<td>- Conforming to perceived social norms of infant behaviour</td>
<td>- Health Visitors to have facilitation skills relevant to group &amp; social setting</td>
<td>- Mothers doubt their own mothering abilities</td>
<td></td>
<td>- Perceived pressure to conform to weight norms</td>
<td>- Replace following the weight chart with understanding infant behaviour</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical health of baby</th>
<th>Health &amp; psycho-social wellbeing of mother-infant dyad &amp; family unit</th>
<th>Parents passive in clinic process</th>
<th>Promotion of parental autonomy</th>
<th>Focus on weighing</th>
<th>Focus on supporting infant feeding &amp; sensitive, responsive parenting</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Medical model of care</td>
<td>- Bio-psycho-social model of support</td>
<td>- Parents wait in line to be called to the Health Visitor</td>
<td>- Clinic layout informal &amp; encourages parents to socialise</td>
<td>- Weighing an admission ticket to the clinic</td>
<td>- Needing an alternative to the ritual of weighing at clinics</td>
</tr>
<tr>
<td>- Progress measured through weighing</td>
<td>- Focus of parent - infant interaction</td>
<td>- Babies weighed by Health Visitor</td>
<td>- Parents involved in any process of developmental assessment</td>
<td>- Weighing prioritised</td>
<td>- Needing social spaces to support all forms of infant feeding without dividing parents</td>
</tr>
<tr>
<td>- Baby’s health disembodied from wellbeing of mother-infant dyad</td>
<td>- Focus on parenting support</td>
<td>- Health Visitor’s agenda</td>
<td>- Discussing parent’s agenda</td>
<td>- Weighing a progress check</td>
<td>- Replace following the weight chart with understanding infant behaviour</td>
</tr>
</tbody>
</table>
An exploration of the sub themes

The sub themes are discussed in an order which provides the best descriptive flow.

Moving from physical health of baby to the health and psycho-social wellbeing of mother - infant dyad & family unit


In fact, in a paper published in 1999 mothers express the view that health visitors appear uninterested in the wellbeing of mothers. Clinics are perceived to be for weighing babies and not for contact with health visitors:

... you get the impression they are not worried about you. I mean they don’t weigh you when you go (Knott & Latter 1999 p.583).

Across the research, weighing is given as the reason for clinic attendance and is conceptualised by parents as an indication of an infant’s progress (Sefi and Macfarlane 1985, Turya and Webster 1986, Cubbon 1987, Sharpe and Lowenthal 1992, McIntosh 1992, Sachs 2005).

A study by Sachs (2005), suggests that weighing has become privileged in our understanding of how to evaluate the health and wellbeing of babies and may prevent other important means of assessment from being discussed with parents.

A shift in emphasis away from weighing towards mother-infant interaction is suggested by Barlow and Coe 2011 and a focus on parenting and family support
at clinics is identified as a need across many of the later papers (Donetto and Maben 2014, Barlow and Coe 2011, Burgess-Allen et al 2010, Sparrow et al 2005, Plews and Bryar 2002).

In fact, a paper looking at service provision in clinics concludes that ‘traditional child health clinics addressing the physical needs of pre-school children are at odds with the expressed psycho-social needs of parents and carers’ (Sparrow et al 2005, p.299).

This resonates with participants’ comments from both earlier and later research:

*I think I get more out of clinic than he does….I think you come more for a parent’s peace of mind* (Cubbon 1987 p.185).

*It was nice to talk about myself and my partner too, rather than the baby which everyone else seemed to only want to know about* (Russell 2008 p.34)

The thematic movement identified suggests that perhaps community based family support at clinics should focus on promoting a positive psychosocial adjustment into parenting.

**Moving from surveillance and social control to building social capital and adding social value**

The perceived focus on surveillance at clinics extends beyond the physical health of babies to the monitoring of maternal competence with parents feeling a sense of social control underlying the clinic encounter:

*I’ve noticed when you take her to the clinic you need to strip her…. they look under their arms and in between their legs and things like that. They’re looking for marks*’ (MacIntosh 1992, p. 139)

This sense of social control is also evident in research focussing on support for breastfeeding at clinics. Sachs (2005) suggests that the structure of clinic encounters are predicated on the conception of breast milk as a disembodied
'product' rather than infant feeding being a relational process. She describes the focus on weighing and monitoring as analogous to a ‘production line’ with health visitors acting as ‘quality controllers’, drawing on the historical impact of the industrial revolution and the associated economic and cultural constructs of production, output, measurement and control.

The sense of social control is also implied through formal clinic environments, with chairs organised in a regimented way, precluding parents and children from socialising (Gillespie et al 1992, Betts and Betts 1990, Kilpatrick and Mooney 1987).

An understanding of the importance of the social function of clinics is evident throughout all the research and a number of the papers describe successful attempts to revitalise clinic attendance by making changes which encourage a more social environment (Gillespie and Hanny 1992, Betts and Betts 1990, Kilpatrick and Mooney 1987).

Weighing is described as almost an ‘admission ticket’ to the clinic, which may mask other reasons for attendance, such as the need for reassurance and contact with other mothers (Sefi and Macfarlane 1985, Sharpe and Loewenthal 1992):

‘The biggest benefit is talking over little worries with other mothers’
(Sefi and Macfarlane 1985, p.129)

The need for contact with other mothers is echoed in a quote from a 2008 paper (Russell) demonstrating how a mother attempts to balance her undisclosed need for contact with other mothers within the framework of a clinic structured on weighing:

‘I started going to get my baby weighed weekly (just to get out of the house and to meet other mums) I was told that I didn’t need to keep going, so I started going fortnightly and then she told me in no uncertain terms that I really, really didn’t need to keep coming just to get my baby weighed.’ (Russell 2008 p.68).
Whilst the included research suggests that socialising is an important element of the clinic setting, a 1987 study in Belfast suggests that mothers need to have an explicit purpose to come to the clinic rather than just to socialise (Kilpatrick and Mooney 1987). The need to clearly define the purpose and value of clinics, over and above the act of weighing was also highlighted in a study in 1999 (Knott and Latter).


In fact mothers in a study in Glasgow in 1992 expressed a clear preference for lay as opposed to professional advice around child care and considered mothering to be a ‘lay skill’ acquired through instinct, practical experience and guidance from other mothers (McIntosh 1992).

**Moving from parents’ passive in clinic process to the promotion of parental autonomy**

The early descriptive research suggests that clinics structured around surveillance and perceived social control place parents in a passive position. Recommendations of later research acknowledge the importance of creating a less formal environment in order to promote parental autonomy:

*The layout of clinic rooms should encourage interaction between parents, an informal atmosphere and greater parental control* (Burgess-Allen et al 2010)

The research suggests that the manner in which babies are weighed is also a potentially disempowering activity for mothers.

*‘They weighed him but that’s all they really did. Anyone can weigh a baby’* (Knott, 1999 p.584).
Sachs (2005) suggest that weighing babies without an appropriate, knowledgeable conversation which supports parents to understand and contextualise the information can undermine the confidence of mothers. The author provides an illuminating breakdown of the categorisation of baby weighing, suggesting that the reasons for weighing babies are varied and often driven by social or familial norms rather than being clinically indicated.

Acknowledging the range of reasons and support needs of parents seeking to use the scales could provide the context within which scales remain in the clinic setting without disempowering parents. A number of studies recognise that parents should be given the opportunity to weigh their own babies (Sparrow et al 2005, Plew & Bryer 2002, Burgess-Allen 2010)

A prevalent theme of the research was the role of the Health Visitor in giving ‘advice’. This is initially framed as progressive moving the clinic encounter beyond a monitoring and surveillance model to one where Health Visitors have an advisory role (Sefi & Macfarlane 1987, McIntosh 1992, Plews & Bryer 2002). An ‘expert’ led approach where health visitors bestow ‘advice’ to parents is however, simultaneously criticised in a number of the papers with the patronising or authoritarian approach of staff undermining parents’ confidence (McIntosh 1992, Knott 1999). A lack of clarity about the purpose and function of clinics and the health visiting role within them were also found to place parents in a passive position within clinic encounters, making them more reliant on professionals (Burgess-Allen et al 2010).

More recent research begins to ‘unpick’ the process of promoting parental autonomy at clinics. Donetto and Maben (2014) suggest that relational readings of the concept of autonomy may provide a more appropriate conceptualisation of this construct for families and urge more research into the theoretical processes underlying community based family support.

The importance of building relationships with parents and providing safe and supportive community spaces where parents can ‘rehearse agency and
judgement’ is thought to support autonomy (Donetto and Maben 2014 p. 2566, Donetto et al 2013). The opportunity for parents to observe positive, non-judgemental discussions with health visitors is an important process in supporting autonomy:

‘Hearing other people asking questions....it builds confidence in me as well because I can see how they (health visitors) respond to other people’s questions and it makes me feel confident in asking my own silly questions’ (Bidmead 2013 p. 21).

Whilst continuity of staff at clinics was found to build relationships (Bidmead 2013), other studies also highlight the important role that clinics with multiple staff play in enabling parents to choose their own support networks and distance themselves from styles of support they find unhelpful (Donetto et al 2013, Donetto and Maben 2014).

‘If you find you don't "click" with your health visitor, so long as you have the option to speak to someone else it’s fine.’ (Russell 2008 p.35)

Moving from an advisory role to a facilitative guiding role

A progression is evident throughout the research with earlier studies describing the potential for the health visitor role at clinics to move beyond one of weight surveillance and screening to an advisory role (Cubbon 1987, Sefi & Macfarlane 1987, Morgan et al 1989, Plews 2002).

A common theme throughout the early research is that staff, believing their role to be ‘advice giving’ (Sefi and Macfarlane 1987), had a tendency to be patronising and authoritarian in their approach (McIntosh 1991).

A paper by Plews and Bryer (2002) which evaluated the advisory role of Health Visitors within clinics, suggest a partnership approach where health visitors elicit and respond to the mother’s agenda rather than giving opportunistic advice,
which is often unsolicited and unwelcome. This is also evident in the primary data of other research papers:

‘It was just nattering .....I could have read in a book......it wasn’t useful information’ (Knott 1999 p.584).

Later research reframes the concept of advice giving at clinics with offering opportunities for families to access a wide range of information (Barlow and Coe 2011). Data generated from parents’ discussions at focus groups in 2005 suggest that health visitor facilitated drop ins, where parents could be guided to the evidence base when topics were raised, would be preferable to groups which were led by health visitors (Sparrow 2005).

Linked in with the theme of mothers seeking professional advice at clinics is an additional theme which suggests that mothers often seek reassurance at this transitional stage in their life and need safe social spaces where they can build positive perceptions of their ‘new or renewed parent identities’ (Donetto and Maben 2014 p.2563).

Sachs describes the process of acquiring the changing role of a mother as ‘liminal’:

‘The time after giving birth is liminal for women.....crossing over from one social role into another (Sachs, p.176 2005)

In the early research, reassurance is provided in the form of weighing. Sachs (2005) writes ‘receiving a weight which conforms to expectations may support esteem even if it is also giving poor informational support’ (p.173). She suggests that such reassurance may prevent women from seeking further information and may in fact prioritise the feelings and work schedule of the professional above the support needs of the parent.

Later research papers focus on the objective of creating the conditions at health visitor drop ins which increase parental confidence and foster self-trust. Supporting parents to seek and evaluate both information and sources of

Moving from outcome / problem oriented to process / relationship centred

The studies included show a clear progression from early descriptive papers focussed on measuring outcomes such as clinic attendance, screening or immunisation uptakes, to more recent research focussing on identifying and understanding the processes of community based family support and parent’s experiences of support at clinics.

A problem oriented approach to clinics is described in many of the earlier studies (≤ 1999), with health visitors effectively filtering ‘problems’ for GP’s:

*Many parents received advice from health visitors and clinical medical officers at clinics on whether problems were serious enough to be taken to their GP* (Cubbon 1987 p. 185)

A required outcome that infants conform to weight norms is evident throughout much of the research with clinic staff ritualistically tracking and plotting weight in an attempt to identify infants at risk of falling outside of the confines of the weight charts.

A number of studies (particularly later papers) are critical of the primacy of this measure (Barlow & Coe 2011, Burgess-Allen 2010, Sachs 2005, Knott & Latter 1999) and a shift in focus towards understanding the relational processes through which parents’ access community based support is evident (Donetto and Maben 2014, Donetto et al. 2013, Bidmead 2013).

Bidmead (2013) suggests that continuity of staff can enhance relationships between parents and health visitors, whilst busy clinics with no staff continuity are a barrier to relationship building. Donetto et al (2013) also highlight that
repeated one to one contact with the same professional is an important element of satisfaction, whilst noting the value in parents being able to meet different health visiting team members in a clinic or group setting to ‘identify and access the professional with whom they felt most comfortable and in tune’ (p.42)

It is also interesting that clinic attendance was shown in one study to be related to primary contact with a health visitor rather than ongoing contact with the same health visitor (While 1990). This suggests that there is a potentially crucial relational connection with the service being made at the primary visit, which may influence future informal contact.

The importance of a relationally focussed approach to community based support also extends to the relationships between staff at clinics. Barlow and Coe (2011) suggest that an important distinction exists between the co-location of services and true partnership working where staff embody shared aims, values and philosophies. For example, they suggest that in order for health visitors to work in true partnership with other agencies at clinics a pragmatic shift away from a focus on weighing babies to a focus on mother – infant interaction would need to be made.

Moving from a focus on weighing to focussing on infant feeding and sensitive, responsive parenting

The emphasis on weighing at clinics is a theme that pervades the entire research included in this review.

The older, descriptive research (≤ 1999) depicts a service where weighing is ritualistically prioritised and regarded as a progress check by staff and parents.

Even in 2005, Sachs laments:
'The measure of success is weight gain which conforms to expectations, not the quality of the breastfeeding relationship or the emotional relationship between baby and mother, or wider family.' (Sachs 2005 P.169)

In fact, in twenty years later, the description of weighing simply shifted from ‘an admission ticket’ to the clinic (Sefi & Macfarlane 1985) to health visitors describing it as ‘the carrot to get women to attend clinics regularly’ (Sachs 2005 p.213).

The thematic movement across the studies suggest that an alternative to the ritual of weighing at clinics is needed and the purpose and potential value of clinic attendance needs to be made explicitly clear to parents.

Donetto et al (2013) highlight that drop-in clinics and support groups are different forms of support to home visiting, but are potentially complementary to the home visits parents receive, providing a valuable opportunity to access social support for early parenting (p.72). Whilst providing clean, warm and safe spaces for parents and their babies to socialise is considered an extremely valuable element of community support across the research, it is also suggested in Kilpatrick & Mooney (1987) that parents will invariably need a primary reason other than to socialise, in order to encourage attendance.

A number of suggestions are made, including: re-focussing clinics on mother-infant interaction (Barlow and Coe 2011); prioritising relationally based support to encourage parental autonomy, esteem and self-trust (Donetto and Maben 2014, Donetto et al 2013, Bidmead 2013); and building social capital through facilitating parent to parent support (Donetto and Maben 2014, Donetto et al 2013, Bidmead 2013, Barlow and Coe 2011, Burgess-Allen et al 2010, Sparrow 2005).

A number of papers suggest that social spaces are needed to support all forms of infant feeding without dividing parents (Burgess-Allen et al 2010, Russell, 2008 Sparrow et al 2005):
‘the breastfeeding groups was ‘ideal’, but there was nothing similar for parents who bottle fed’ (Sparrow et al 2005 p.28)

Promoting an understanding of innate infant behaviour may encourage parents to adopt a more responsive and sensitive approach to infant feeding and parenting which may be being undermined by the primacy of the weighing scales at clinics. In fact over ten years ago Sachs (2005) advocates rearranging clinics to include, but not impose weighing and replacing following the weight chart with focussing encounters at clinics on ‘relational aspects and holistic infant development’ Sachs 2005 p. 208.

Discussion

Applying the inclusion criteria to the results of the searches identified 24 qualitative papers for inclusion in this review of literature since 1985, however only 9 of the included papers were published in the last 15 years, despite the prevalence of clinics across the UK utilising significant health visiting hours.

The broad search criteria combined with searching of reference lists of included papers and consulting with five academics in the field of health visiting research, who reviewed the list, supports the conclusion that all relevant research was included and the conclusions are therefore based on a synthesis of all available evidence.

The review found no evidence papers with robust evaluations of process or outcome measures, potential models or any wider evidence for baby clinics, which makes it impossible to draw any conclusions about the effectiveness of this service offer. In view of the lack of evaluative research, and the qualitative approach of the papers found, a qualitative synthesis of the studies was therefore required.

The value of conducting the search for evidence across a 30 year period became apparent in the analysis of the papers obtained where thematic content analysis
was conducted comparing older, descriptive evidence (in this review ≤1999) with newer more critical and interpretive research. This approach provided a valuable temporal view of the structural context of services and historical culture of practice in clinics, which still influence current practice.

It is clear that community based family support is under-theorised in health visiting literature, with little research into the psycho-social processes around which effective universal parenting interventions should be focussed. The results of this review are in line with the conclusions of a recent narrative review of literature examining the potential public health benefits from health visiting practice (Cowley et al 2014) which suggests that in general there is a lack of evaluative research about the mechanisms by which the service promotes health and reduces health inequalities.

The persistence of clinics, without national guidance or a theoretical evidence base is reflected in the findings of this review; clinics appear to be an historical tradition with a ritualistic focus on weighing babies, which is an embedded cultural expectation of the service.

The emergent themes of the post 2000 research included in the review; that of clinics moving towards being relationally centred, facilitated social spaces which promote parental autonomy and build social capital, fit with the emphasis on parenting support and integrated services within the Healthy Child Programme (2009, updated 2015).

Moving on from the advisory role of health visitors in clinics, depicted in the early descriptive research reviewed, the guiding approach that emerged as a style preferred by parents is consistent with models of anticipatory guidance suggested by Barlow’s review on health led parenting interventions (2009). Facilitating discussions between parents and supporting parents to understand and explore the context of their infant’s behaviour offers the potential to address all six of the early year’s high impact areas within the clinic setting.
(Watts 2014) in a guiding and participative, rather than didactic style, which would enable parents to explore their own agenda for information and support.

The progressive thematic movement identified in this review suggests that community based family support at clinics should be focussed on promoting a positive psycho-social adjustment into parenting. This is a common goal of all services supporting children and families in the early years and supports the physical and emotional wellbeing of infants and children, which it is universally recognised, has long term benefits on an individual, familial and wider social scale.

Typical measures of psycho-social wellbeing from a strengths based approach which focusses on individual and community resilience (UNICEF 2009) include some measurement of:

- the acquisition of knowledge and skills
- improved emotional adjustment
- improved social well being

Such measures could include:

**Knowledge and skills**: Understanding infant behaviour and development; infant feeding; normal infant sleep; positive play and interaction; where to access information and how to discriminate between sources of information

**Emotional adjustment**: Building resilience, confidence and self-efficacy, supporting an attuned style of parent-infant interaction, promoting sensitive and responsive parenting, adjusting expectations and improving coping mechanisms through this life course transition

**Social well-being**: building support networks, promoting relational autonomy, adding social value, building social capital and navigating perceived social norms around parenting and infant behaviour
The mechanisms by which such change could occur within a health visiting led, community based offer, appears to be socially and relationally based however the theoretical process by which such support might be delivered needs to be explored and examined.

**Conclusion**

The lack of evaluative research into the structure, function and process of baby clinics means that a conclusion about their effectiveness as a universal service offer cannot be reached. It seems clear however, that the lingering pre-occupation with weighing at clinics is preventing this service element from evolving in line with the rest of the Health Visiting Service offer.

The primacy of the weighing scales at clinics advocates a continued underlying emphasis on surveillance and monitoring and a problem-oriented approach, which is at odds with the expressed psychosocial support needs of parents attending (Burgess –Allen 2010, Russell 2008, Sachs 2005, Sparrow 2005, Knott and Latter 1999, McIntosh 1992).

Lack of evidence of effectiveness does not necessarily mean evidence of ineffectiveness and Donetto et al (2013) highlight ‘the importance of consolidating a health visiting service that combines home visiting with opportunities for support and advice outside the home’ (p.91).

This review suggests that professional reflection and research into the focus, structure and function of clinic models and the theoretical process of community based family support within the health visiting service is now needed in order to progress this element of universal service provision to an evidence base. The review provides formative themes on which potential theories of change or models of delivery may be focussed and tested in the future.
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## Appendix A: Extraction Form

<table>
<thead>
<tr>
<th>EXTRACTION ITEM</th>
<th>DETAILS</th>
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<tbody>
<tr>
<td>CITATION</td>
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<tr>
<td>REVIEWER</td>
<td>Jo Webb</td>
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<td>COUNTRY</td>
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<td>PRIMARY RESEARCH?</td>
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<td>PARTICIPANTS</td>
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<td>SAMPLE</td>
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<td>DATA COLLECTION</td>
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<td>DATA ANALYSIS</td>
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Appendix B: Form to assess methodological quality of included studies based on Mays and Pope (2000) quality guidelines

Methodological quality of included studies

Key to results:

0  Low clarity and quality as assessed by the reviewers
1  Reasonable clarity and quality as assessed by the reviewers
2  Reflects a finding of high clarity and quality as assessed by the reviewer

NC  Not clear or not available from the paper

Name of paper:

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<tr>
<td>1. <strong>Worth or relevance</strong></td>
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<td>Was this piece of work worth doing at all?</td>
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<td>Has it contributed usefully to knowledge?</td>
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<td>2. <strong>Clarity of research question</strong></td>
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<td>If not at the outset of the study, by the end of the study was the research question clear?</td>
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<td>3. <strong>Appropriateness of the design of the question</strong></td>
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<td>Was an appropriate method used?</td>
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<td>(For example, if a causal hypothesis was being tested, was a qualitative approach really appropriate?)</td>
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<td>4. <strong>Context</strong></td>
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<td>Is the context or setting adequately described so that the reader could relate the findings to other settings?</td>
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<td>5. <strong>Sampling</strong></td>
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<td>Did the sample include the full range of possible cases or settings so that conceptual rather than statistical generalisations could be made?</td>
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<td>(For example, more than convenience sampling?)</td>
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<td>If appropriate were efforts made to obtain data that might contradict or modify the analysis by extending the sample</td>
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<td>(For example, to a different type of area?)</td>
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<td>6. <strong>Data Collection and Analysis</strong></td>
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<td>Were the data collection and analysis procedures systematic?</td>
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<td>Was an ‘audit trail’ provided such that someone else could repeat each stage, including the analysis?</td>
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<td>How well did the analysis succeed in incorporating all the observations?</td>
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<td>Did the analysis develop concepts and categories capable of explaining key processes or respondents’ accounts or observations?</td>
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<td>Was it possible to follow iteration between data and theory?</td>
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<td>Did the researcher search for disconfirming cases?</td>
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<td>7. <strong>Reflexivity of the Account</strong></td>
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<td>Did the researcher assess the likely impact of the methods used on the data obtained?</td>
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<td>Were sufficient data included in the reports of the study to provide sufficient evidence for readers to assess whether analytical criteria had been met?</td>
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</table>
Appendix C: Summary of included studies and quality score

<table>
<thead>
<tr>
<th>Reference</th>
<th>Aims</th>
<th>Setting</th>
<th>Quality Assessment (low, medium or high ranges)*</th>
<th>Method (sample, design)</th>
<th>Relevance to Systematic Review</th>
<th>Key ideas / comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donetto, S. and Maben, J. (2014)</td>
<td>‘These places are like a godsend’: a qualitative analysis of parents’ experiences of health visiting outside the home and of children’s centre services.</td>
<td>UK</td>
<td>High</td>
<td>A secondary analysis of data from a primary study of parents’ views of their experiences with health visiting services in two geographical areas in England (Donetto et al 2013 below)</td>
<td>The study analysis suggests: • Activities at community centres involving or integrated with health visiting provision can counteract social isolation and promote access to other services through contact with other parents and health visiting practitioners.</td>
<td>Community based family support is largely under theorized in the health visiting literature. It is suggested that Health Visiting research would benefit from applying the theoretical lens of ‘relational autonomy’ along with other complementary lenses such as theories of social capital, social support, self-efficacy</td>
</tr>
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</table>

*Quality Assessment ranges: low, medium, high
<table>
<thead>
<tr>
<th>Health Expectations pp.1-11</th>
<th>relational autonomy as a theoretical lens for understanding the mechanism through which this support operates.</th>
<th>‘Early Implementer Sites’ of the new Health Visiting service vision in England. The data was analysed using thematic analysis, with the coding informed by grounded theory principles.</th>
<th>• Socially orientated drop ins involving a mix of health visiting staff may enable parents to distance themselves from professional advice that they perceive to be undermining and support parents to explore new relationships and pursue interactions that are more likely to build and reinforce self-trust. • Group activities which facilitate socialisation with other parents and more informal encounters with members of the health visiting team can create the conditions for parents to practice autonomy skills and foster self-trust.</th>
<th>and self-determination to contribute richer conceptualisations of the value of community based support for families from the health visiting service and children’s centre services. Group activities which facilitate socialisation with other parents and more informal encounters with members of the health visiting team can create the conditions for parents to practice autonomy skills and foster self-trust.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Donetto et al (2013) Health Visiting: the voice of service users Learning from service users’ experiences to inform the development of</td>
<td>To briefly review the academic literature on service users’ views of health visiting and to provide</td>
<td>UK</td>
<td>High</td>
<td>The study comprises two main components: a review of the academic literature on service users’ experiences of health visiting and a primary qualitative empirical study based on interview data gathered at two</td>
</tr>
<tr>
<td>UK Health Visiting practice and services</td>
<td>an in-depth analysis of service users’ accounts of their experiences of engaging with health visiting services.</td>
<td>Early Implementer Sites in England. The literature review draws together background information about what is already known about service users’ views and experiences of health visiting, using a narrative approach. Qualitative data primary data from individual semi-structured interviews with 44 parents who had experienced some sustained contact with the health visiting teams at two Early Implementer Sites in England. The data was analysed using thematic analysis, with the coding informed by grounded theory principles.</td>
<td>home visiting offered by health visitors and should be considered ‘as a fourth core practice to be added to the existing triad of practitioners’ ‘orientation to practice’ p.99 communication styles and preferences. We recommend that health visiting support continues to be organised in a way that ensures rich and flexible combinations of support at home and support outside the home’ p.100.</td>
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<tr>
<td>Row</td>
<td>Name</td>
<td>Reference</td>
<td>Methods</td>
<td>Findings</td>
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<tr>
<td>3</td>
<td>Bidmead, C. (2013)</td>
<td>Health Visitor / Parent Relationships: a qualitative analysis Kings College, London</td>
<td>Primary research / descriptive study using theoretical sampling, six health visitor / parent dyads were recruited for an in depth analysis of their relationships. Three parents and seven health visitors were also invited to take part in subsequent discussion groups to further validate the analysis of the qualitative data. A qualitative analysis software package QSR N-vivo 8 was used to code, categorise and map the data in order to theorise.</td>
<td>- The author suggests that clinics with staff continuity are a facilitator for relationships and busy clinics with no staff continuity are a barrier to relationship building. The research suggests that when a relationship with a health visitor is not formed, mothers preferred to attend clinics rather than be visited at home. Health Visitors do not see clinics as a suitable place to deal with sensitive issues or distressed parents. The research highlights the importance of asking what the key processes are within Health Visiting which promote child health and this is explored through specifically focussing on effective parent / health visitor relationships. The study reinforces the importance of promoting parental autonomy and building parental confidence. One way in which this may be achieved at clinics is through parents hearing and seeing other parents ask questions and have positive, non-judgemental responses from health visitors, which in turn supports them to feel confident in asking their own questions.</td>
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</tbody>
</table>

This study was published as an Appendix to the report entitled ‘Why Health Visiting?’ (2013, Cowley et al, Department of Health Policy Research Programme)
|   | Barlow, J. and Coe, C. (2011) | Integrating partner professionals. The Early Explorers project: Peers Early Education Partnership and the health visiting service Child: care, health and development 39(1) pp.36-43 | To explore stakeholder views and experiences of two Early Explorer clinics located in areas of high deprivation. [Early Explorer clinics are a model of partnership working between statutory (health visitors) and UK (In two areas that are among the 20% to 30% most deprived in England. | High | Primary research / descriptive study Purposive sampling of 25 participants: 8 PEEP staff, 7 Health Visiting staff, 10 service users Qualitative data using semi structured interviews with each participants. The data was transcribed and analysed using thematic analysis (using data analysis package NVivo8) | - Discussion of the data suggested that a more social and interactive environment at the clinics provided a basis for forging relationships between and with, service users - There was consensus from participants in the study that the new style of clinics offered increased opportunities for families to access a wide range of information and to increase parental confidence | The study suggests that whilst there is considerable scope to enhance health visitor led baby clinics through partnership working with the voluntary sector, there is an important distinction to be made between the co-location of two services (a centre based service delivery model) and a true partnership working with a shared philosophy and aims and objectives. The author suggests as an example; that the primary purpose of clinics would need to shift away from weighing babies towards more of a... |
| 5 | Burgess-Allen, J., Formby, E. and Hirst, J. (2010) *A qualitative exploration of the role of baby clinics in supporting infant feeding in the UK* (Stockport, in the North of England) | High | Primary research / descriptive study A single focus group at an existing mother and baby group was conducted early in the research process and the themes emerging from the discussion | The authors suggest that baby clinics have the potential to offer valuable infant feeding support and social support, however this potential is currently not being maximised | It is suggested that an alternative model of baby clinic is considered, which drops the word ‘clinic’ and where the primary aim is to provide social support and advice to parents. The layout of the room should encourage focus on mother-infant interaction. |

Table: a voluntary sector organisation (PEEP – Peers Early Education Partnership). Early Explorer clinics are located within traditional child health clinics and run alongside the clinics.

To elucidate users’ perspectives on baby clinics and their role with regard to infant feeding in the UK (Stockport, in the North of England). A single focus group at an existing mother and baby group was conducted early in the research process and the themes emerging from the discussion.
| Stockport NHS Stockport / Sheffield Hallam University | feeding (breast or formula feeding) | informed the design of the study, particularly the topic schedule for the semi-structured interviews which followed. A purposive sample of 16 women in the third trimester of pregnancy and 5 fathers were interviewed. One mother dropped out and 15 follow up interviews were conducted when their babies were between 3 and 5 month old. A series of participant observations were undertaken at baby clinics across Stockport. A selection of the data was transcribed and subjected to detailed thematic analysis from a | • It is suggested that traditional baby clinic models focusing on weighing and surveillance are ‘disempowering for parents, rendering them more reliant on professionals and less confident of their own abilities’ interaction between parents, an informal atmosphere and greater parental control – for example where all parents feel comfortable to feed their baby, fathers are welcomed and parents may weigh their own child if they wish. Health visiting staff would be available for advice and support. It is suggested that such a drop in could replace existing baby clinics and breastfeeding groups and would avoid the risk of segregating parents according to how they feed their baby. |
|   | Russell, S. (2008) | To explore what mothers’ feel a health visitor should be able to do for them, what experience they expect and how they want to be supported. | UK | Medium | Primary research / descriptive survey | Whilst the focus of this survey was not baby clinics there are an abundance of references to clinics as a point of contact with health visitors in the comments made by parents. | The large number of mothers surveyed across the UK for this study gives a valuable insight into some of the common recurring thoughts and experiences parents had around baby clinics at this time. Recommendations included clinics being sufficiently staffed to:  
• Allow a health visitor to engage with a mother on more than just the baby’s weight  
• To provide the opportunity for relaxed, informal and private discussions  
• And to allow parents to be encouraged to talk with each other  |
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<tbody>
<tr>
<td></td>
<td>Sparrow, G. et al (2005) Service</td>
<td>To ascertain the views of UK members of ‘Netmums’</td>
<td>UK</td>
<td>Medium</td>
<td>Primary research / descriptive study</td>
<td>The data generated from the parent’s discussions at the UK clinics</td>
<td>The author provides a concise and insightful summary:</td>
</tr>
</tbody>
</table>

|   | Joanne Webb 08030373 |   |   |   |   |   |   |

|   |   |   |   |   |   |   |   |
| Provision in Child Health Clinics
Journal of Community Nursing 19(5) pp.26-30 | users and non-users of child health clinics and the services provided | Purposive sampling of 14 parents (13 mothers and 1 father) from the HV’s caseloads, including mothers who attended clinics and those who did not.

Two focus groups were held, discussions were non-directed and facilitated by the author and an experienced facilitator.

The data was analysed using content analysis and grounded theory methods.

Focus groups suggests that the generation of social and peer support through health visitor facilitated drop ins would be a model welcome to parents. It was not wished that Health Visitors would ‘lead’ the group but could guide parents on the evidence base when topics were raised.

The needs of fathers and grandmothers looking after children should be catered for and there was consensus that the primary need of parents was for reassurance and the opportunity to compare experiences with others and offer mutual support.

Parents felt that scales should be available to use themselves if they choose and whilst breastfeeding “this study confirms the impression that traditional child health clinics addressing the physical needs of pre-school children are at odds with the expressed psychosocial needs of parents and carers. The main perceived needs of parents and carers of preschool children in relation to child health clinics is for support and information for themselves rather than the physical aspects of preschool child health for which the clinics were originally intended” |
<table>
<thead>
<tr>
<th>No.</th>
<th>Title</th>
<th>Authors</th>
<th>Methods</th>
<th>Study Area</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>‘Following the line’</td>
<td>Sachs, M. (2005)</td>
<td>Primary research / narrative review</td>
<td>UK, North West of England</td>
<td>In view of the pervasive focus on weighing at baby clinics, this research provides a valuable insight into the historical, economic and social constructs behind this practice and the impact on the experiences of parents attending clinics.</td>
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<td>• It is suggested that whilst weighing can provide important information in evaluating the physical health of babies &amp; the efficacy of breastfeeding, it can mask other ways of investigating these same issues and has become privileged in our understanding.</td>
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<td></td>
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<td></td>
<td>• An alternative to the ritual of weighing &amp; the</td>
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Participants were recruited through the Health Visiting service. Two phases of fieldwork were conducted:
1. Participant observations in a child health clinic – a total of 30 hours over 20 clinic sessions (this included short interviews with breastfeeding women and longer interviews with health visitors) and observations / discussions at a breastfeeding group with 17 women.
2. 14 breastfeeding women were interviewed several times.

To illustrate how routine weighing impacts on the breastfeeding experiences of women.
Theoretical sampling was used to inform the data collection. A grounded theory methodology was used to analyse the qualitative data. The author acknowledges that a feminist / critical enquiry / constructionist approach informs her approach to the study. Constraints of following the confines of the weight chart at clinics is encouraged to be sought.

- The author suggests that practical & emotional support for breastfeeding needs to be embodied within well baby services such as clinics with limits to the medical need for weighing being clearly established.

| 9 | Plews, C. M. C. and Bryar, R. M. (2002) Do we need health visitors in the child health clinic? Clinical Effectiveness in Nursing 6. Pp.27-35 | To review clients’ reports of a single visit to the Child Health Clinic and examine clients’ recall of any discussions held with the health Visitor and | UK | High | Primary research / descriptive study | The study looks at the nature of the advisory role of the Health Visitor in the child health clinic by analysing the content of the interactions between service users and health visitors. | The study looks at the nature of the advisory role of the Health Visitor in the child health clinic by analysing the content of the interactions between service users and health visitors. |

| | | | | | Seven Health Visitors who represented seven health localities into which the trust was divided enabled the researcher to access seven clinics through which 120 service users were enrolled into the study. | 63% of the issues discussed at the clinics were related to feeding |

This research suggests that mothers utilise clinics to access support, reassurance and advice from health visitors and feeding is a prevalent and important topic on which mothers seek support. While the majority of mothers give weighing as a reason for attending the clinic, this may reflect the
their evaluation of the encounter. To evaluate the advisory role of Health Visitors within Child Health Clinics.

Part of a larger PHD Thesis looking at the work of health visiting in child health clinics and during home visits (2001)

Data was collected through non-participant observation at the clinics and semi-structured interviews with 99 participants.

Content analysis was used to code the data

- 49% of mothers felt the most important topic they discussed was feeding.
- Over half of the mothers gave weighing as the most important reason for attending the clinic however the data showed a mismatch between the stated intention for visiting the clinic (weighing) and the actual outcome i.e mothers who attended for weighing were either given unsolicited advice or knew that weighing included a discussion with the health visitor
- The number of issues discussed during clinic visits ranged from 1-5 with a mean of 2 issues per visit – interestingly the fewer issues discussed, the greater the structure of clinic encounters with health visitors which are initiated over scales.

The researcher concludes that health visitors should adopt a partnership approach, eliciting and responding to the agenda that the mother brings, rather than opportunistically giving advice according to their professional agenda.

It is also suggested that consideration should be given to parents weighing their own babies in order to avoid placing them in a passive position in the clinic process.
|   | Knott, M. and Latter, S. (1999) Help or Hindrance? Single, unsupported mothers’ perceptions of health visiting Journal of Advances Nursing 30(3) pp.580-588 | To investigate the views and understanding that single, unsupported mothers have of the health visiting service, to discover their perceptions of their needs in the first year after having a baby and to explore | UK | High | Primary research / descriptive study  
A convenience sample of 15 potential participants were approached and 12 agreed to be interviewed for this study.  
They were all single, unsupported parents with children between the ages of 9 and 21 months.  
The average age was 21 and the age range was from 16 – 29 years.  
Data was collected using structured interviews and then analysed using thematic content analysis | • Participants perceived Health Visitors to primarily focus on the health of the baby and to be uninterested in the wellbeing of the mother  
• Weighing was perceived to be the primary focus of clinics rather than a contact point with a health visitor  
• The parents wanted to be treated in the same way as every other mother, but perceived health visitors to be judgemental about their status as young, single mothers  
• Participants considered that health visitors should be friendly, interested and able to promote their | The author suggests that health Visitors should assess their practices in clinics and make clear the clinic’s purpose – ‘unless health visitors themselves have clear objectives over and above the act of weighing within the clinic, their clients will be dismissive’  
Non-judgemental attitudes and good communication skills should extend to the clinic setting. |
whether the health visiting service met these needs.

Finch, P. and Whitefield, C. (1997) Setting up a Saturday morning Child health Clinic Professional Care of Mother and Child 7(3) pp. 61-62

To respond to the needs of working parents by setting up a Saturday morning child health clinic.

UK
Southeast England

Low

Descriptive survey

A random sample of the next 175 clients with whom the health visitors had contact with.

A survey questionnaire was used to ascertain the views of clients on the proposal to set up a child health clinics outside of normal working hours. An evaluation of attendance was undertaken after one year. Data was simply described.

Whilst this study was a relatively simple descriptive survey of clients’ views it suggests that parents value the opportunity to access support outside of the normal working week. There was a positive response by parents to the service offered and all staff involved in the project found Saturday working to be less pressured and more fulfilling as clients could be given more time. The study involved a clinic model which incorporated health visiting consultations, immunisations and developmental assessments all carried out by the health visitors with GP support available if necessary. Uptake of the service was by both working and non-working parents. It was suggested that the clinic would give working fathers a greater opportunity to be involved, however the uptake of the service by fathers is not reported.


UK

Low

Descriptive survey

This simple survey provides some insight into parents’

The majority of parents came to the clinics to have their
view of clinics
Health Visitor 66(10) p.62

views of child health clinics in 1988/89 – some of the results were compared to a 1981 survey of mothers
Southeast England

A controlled random sample of mothers from the birth register in Oxfordshire were sent a postal questionnaire
525 parents were surveyed and 348 mothers responded
Data was simply described
views of clinics at the time, although it is unclear how the questionnaire was structured to illicit responses.

1


To obtain feedback from clinic users relating to the child health clinics held within Kingston and Esher
UK Southeast England

Descriptive survey
Parents of all new births from June – August 1990 (which represents infants of 7-9 months of age inclusive) were sent a postal questionnaire for completion
564 service users were contacted with a response rate of 65%
The questionnaires were a mixture of ‘fixed alternative’ and ‘open ended’ questions
There were too small a sample of ‘non-attenders’ to draw any meaningful conclusions about why parents don’t attend clinics however the majority of mothers (93.2%) gave ‘weighing’ as their reason for attendance and there was a high level of ‘satisfaction’ with the clinics.
The author agrees with previous research that suggests that weighing may

baby weighed and negative comments about the clinics reflected an uninviting clinic which lacked toys and refreshments and inhibited mothers from mixing easily

The author accepts that although high levels of ‘satisfaction’ with the clinic services are reported, this is an indirect measure of the quality of the service.
In fact failure to define and clarify what signifies ‘satisfaction’ limits our understanding of what clients may be describing or what the researcher is aiming to discover.
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<tbody>
<tr>
<td>1</td>
<td>To observe the function, operation and environment of a well-baby clinic.</td>
<td>Descriptive study using participant observation. The data was collected by observations by each of the three researchers, based on observations around three key areas. 1. The general impressions clients received as they entered the clinic 2. Seating arrangements 3. The weighing area.</td>
<td>The study provides an insight into the structure and environment of the clinic in this study. Little attention had been paid to the layout and ‘flow’ of the room, the acoustics and the signage. Chairs were organised in a regimented way which created a formal environment, discouraging parents and children from socialising.</td>
<td>The research observations in this study showed that the range of universal care activities as defined by Leininger (1988) i.e. concern, interest, involvement, comfort, stress alleviation and support are all relevant to baby clinics and Health Visiting practice should take more account of these issues at clinics.</td>
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Data was simply described be seen as an ‘admission ticket’ to the clinic and this may mask other unstated reasons for attendance such as meeting mothers. For example: no mothers mentioned the social function of the clinic as a reason for attendance, however mothers did mention this as a positive benefit.
| 1 | McIntosh, J. (1992) The perception and use of child health clinics in a sample of working class families | To investigate, prospectively, the transition to motherhood and practices of infant care in a sample of first time mothers | UK, Glasgow, Scotland | High | Descriptive study Eighty women were randomly selected from three Glasgow antenatal clinics – the number had declined to sixty by the end of the study. The study is based on the sixty participants who remained throughout the research period. Contact with the participants began at the seventh month of pregnancy and continued until the child was nine months old. | Positive changes were made to the environment of the clinic and the clinics processes as a result of the observations, including playing culturally sensitive music and encouraging parents to socialise. | Participants in the study wanted a form of service provision in which they could initiate consultation in accordance with their own perceptions of their needs as opposed to having gratuitous and often unwelcome advice thrust upon them. The majority of mothers considered mothering to be a lay skill which was either part of every woman’s ‘natural’ inheritance or acquired in the natural course of practical experience with infants, usually under the guidance of
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<th>Each participant was interviewed on six occasions: once antenatally and five times during the postnatal phase at approximately two month intervals. Data is described in tables and through the use of quotes. Statistical significance tests were applied to quantitative data.</th>
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<tr>
<td>1</td>
<td>While, A. (1990)</td>
<td>Child Health Clinic Attendance During the First Two Years of Life</td>
<td>To understand child health clinic attendance during the first two years of life.</td>
</tr>
<tr>
<td></td>
<td>Descriptive survey</td>
<td>A survey of health visitor and child health clinic records in three districts in the London area was undertaken. Three sample groups were derived from a series of cohort months – all children known to be resident in the selected geographical areas and having a birthday within.</td>
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<td>• The survey confirmed previous research which showed the greater use of child health clinics during the first year of infant life. Clinic attendance in the first year was found to be predictive of attendance in the second year.</td>
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<td>• The author suggests that health visitors play an important role in women who were themselves experienced mothers.</td>
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<td>The author suggests that ‘drop in’ centres offering a more informal client initiated form of service provision may be a preferable alternative to the traditional clinic. Such drop-ins could provide a base for the development of postnatal support groups.</td>
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<td>Although the author states ‘for the purposes of this research, no distinction was made between seeing a doctor or a health visitor at the child health clinics‘ this large scale survey provides useful data regarding the link between clinic attendance and the primary contact with a health visitor.</td>
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<td>Betts, G. and Betts, J. (1990) Establishing a child health clinic in a deprived area <em>Health Visitor</em> 64(4) pp. 122-124</td>
<td>The study describes an initiative to improve clinic attendance rates of mothers on the caseload of a health visitor for the council</td>
<td>UK, Glyndon, a deprived inner city area in London, South East England</td>
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<tr>
<td>17</td>
<td>Joanne Webb 08030373</td>
<td>the selected cohort were included in the sample (parameters of cohort selection not stated) Socio-demographics of sample: Inner city ( (n = 756) ) Suburb ( (n = 127) ) Affluent suburb ( (n = 96) ) Data is described</td>
<td>advertising clinic services and crucially contact between the health visitor and the family shortly after the birth of their infant was of primary importance. This was indicated by the finding that lack of health visiting knowledge about the family’s view of the childbirth was associated with reduced clinic attendance.</td>
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estate in Glyndon, an inner city area in South East London. The initiative involved re-locating a child health clinic from a health centre to a community centre to provide a more local clinic with a less formal atmosphere and a wider range of activities on offer. The aim of the initiative was

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<th>The main changes addressed were:</th>
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<td>• The parents had less distance to travel to attend the new clinic</td>
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<tr>
<td>• The atmosphere was less formal and less institutionalised</td>
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<tr>
<td>• The new clinic was at a location that had a cafeteria where mothers could access refreshments and sit comfortably in groups rather than around the edge of a room against the walls</td>
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To analyse in more detail the results from the Oxfordshire Child Health Clinic Survey (Sefi and Macfarlane 1985) and to collect further data from 10 health visitor advisory clinics (staffed by health visitors only) and compare with the original survey.


**UK, South East England**

Low

Descriptive survey describing primary data and comparing it with secondary data from a previous similar, but larger scale survey

81 mothers were interviewed across 9 clinics in Oxfordshire.

50 Health Visitors were interviewed.

Convenience sampling implied but not stated

Questionnaires were used to interview mothers and health visitors.

Data is described in numerical tables and as quotes.

The survey represented an update on a larger scale survey conducted by the same researchers in 1985.

The study found, more strongly than in the first survey, how much importance mothers attach to socialising with other mothers and children at the clinics.

The authors write: ‘The mothers themselves greatly appreciated the more relaxed, informal atmosphere of the advisory sessions, sitting around in groups talking to a health visitor. They felt it was a place where they could be welcomed with a small child’ (p.223)

The Health Visitors interviewed also valued the

**This study highlights the social function of the clinic from both Health Visitors and parents’ perspectives.**
Clinics for the opportunity to give advice and reassurance and the informal and non-medical atmosphere. The majority of the health visitors interviewed believed clinics serve an important social function.


To survey the views of users of child health open clinics in Grimsby

UK, Grimsby, North East England

Medium

Descriptive survey using an interviewer administered questionnaire

The interviewer spent a day at each of the clinics in Grimsby (no. of clinics not stated).

592 of the 650 people that attended the clinic were interviewed (91.1%)

The data was described numerically & with the use of quotes.

- The majority of children brought to the clinic were under a year old
- The majority of subjects went to the clinic for reassurance about the progress of their baby
- Weighing was frequently given as the reason for attending and it was classified as reassurance about progress

The author suggests that the importance that subjects attached to weighing may be a result of impressions gained at the clinic

The author also acknowledged that parents were often hesitant when asked how they benefitted from the clinic – this may be linked to ‘a lack of any definitive expectations with regard to the clinic and to an unquestioning attitude to its services’

**21** Kilpatrick, R and Mooney, P. (1987)

To identify why

UK, Belfast,

Low

Descriptive study using questionnaires

The research indicated that the mothers participating in

The author suggests that the mothers taking part in this
<table>
<thead>
<tr>
<th>Study Title</th>
<th>Setting</th>
<th>Methodology</th>
<th>Findings</th>
<th>Conclusion</th>
</tr>
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<tbody>
<tr>
<td>Tea and Sympathy: A campaign to improve mothers’ involvement in a local baby clinic</td>
<td>Northern Ireland</td>
<td>The study setting was a large working class housing estate in East Belfast, four miles from the city centre. All households on the estate with children of two years or under were visited by the researcher and invited to take part in the study. All 56 households took part. Data is described</td>
<td>The study went to the baby clinic for two main reasons: 1. To have their baby weighed 2. For a social outing</td>
<td>The author suggested two areas needed to be addressed: 1. The basic facts about the clinic needed to be made very explicit (opening times / benefits of attending) 2. The environment within the clinic needed to be improved so that it encouraged mothers to socialise – refreshments were also considered to be an important element within the setting</td>
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<td>Karmali, J and Madeley, R. J. (1986) Mothers’ attitudes to a child health clinic in a UK, Nottingham urban, Medium</td>
<td>Descriptive study using a structured questionnaire consisting of pre-coded and open-ended questions.</td>
<td>The study found that the major reason for poor clinic attendance in the deprived area of Nottingham was that those who rarely or never</td>
<td>The author suggests that the reasons for underutilisation of clinic and health visitor services by parents do not lie in confusion or lack of</td>
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<td>deprived area of Nottingham</td>
<td>and non-attendance at a child health clinic in a deprived area of Nottingham</td>
<td>inner city</td>
<td>Study population: 203 mothers with children aged 1-2 years. A purposive sample of 90 mothers was selected on the basis of their frequency of clinic attendance: 11 never attenders, 33 rare attenders, 46 attenders. 71 mothers were interviewed (10 refused and 9 were unavailable). Statistical tests were applied to the data which is collated in tables attended simply felt less in need of what the clinic had to offer than more frequent attenders and did not believe the services provided by the clinic to be useful, important or relevant to them. The most commonly expressed reason, both for infrequent and non-attendance was that respondents saw no need to go to the clinic. The value of clinic attendance is therefore not self-evident.</td>
<td>attended simply felt less in need of what the clinic had to offer than more frequent attenders and did not believe the services provided by the clinic to be useful, important or relevant to them. The most commonly expressed reason, both for infrequent and non-attendance was that respondents saw no need to go to the clinic. The value of clinic attendance is therefore not self-evident.</td>
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<td>Turya, E. B. and Webster, J. N. (1986) Acceptability of and need for evening community child health clinics</td>
<td>To assess the need for, and acceptability of, an evening community child health</td>
<td>UK, London, South East England</td>
<td>Low</td>
<td>Descriptive study collating a mixture of primary and secondary data (clinic records) 552 children attended an evening clinic during a 12 month period. Information • Similar to day clinics the main reason for attendance was for weighing • 49.6% of mothers attending were either in employment or at college</td>
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</table>

The author concludes:

‘While the epidemiologist may be able to estimate the relative risk to a population of non-uptake of clinic services, the absolute risk of harm from default of preventive activity as perceived by the individual mother is very low’ (p.164)

The survey suggests that evening clinics were useful to working parents surveyed and were well received.
A research health visitor visited 103 clinics, each run by a doctor and at least one health visitor. Approximately 10 mothers were interviewed using a structured questionnaire at each clinic. This represented a total sample of 999 mothers. The data collected is described by the authors. This large scale survey provides a description of the perceived function and value of clinics for mothers at this time. The author provides an insightful summary: 'Although the purpose of the child health clinic has traditionally been seen as one of medical surveillance....the results suggest that for many mothers the child health clinic can provide an important additional social function of the clinic and the role of the health visitor in introducing parents to each other. They also highlight an observed discrepancy between the described reasons for attending clinics (primarily weighing) and the perceived benefit (meeting other mothers).
function. This though may not initially be revealed by mothers who use the popular reason for attendance of ‘weighing’ as almost an admission ticket to the clinic.’

*Quality scores were based on Mays and Pope (2000) methodological quality assessment guidelines (Appendix B). All papers were scored and allocated a quality score according to the following score ranges:

<table>
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<tr>
<th>Score Range</th>
<th>Description</th>
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<tbody>
<tr>
<td>0 – 10</td>
<td>Low quality score range</td>
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<tr>
<td>11 – 20</td>
<td>Medium quality score range</td>
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<tr>
<td>21 – 30</td>
<td>High quality score range</td>
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</table>
Appendix D

Interview topic guide

Opening interview question:

‘Can you tell me about your experience of baby clinics?’

The following topics will be used as prompts:

- Purpose of visiting or running clinics
- Clinic process – what happens at a clinic? (to encourage comment on physical, psychological or social processes)
- Clinic environment
- Relationships with staff
- Relationships with parents
- Autonomy / ownership of clinic space
- Value of visiting clinic – what difference did it / does it make?
Dear Jo

Application title: Lay and professional perceptions of the purpose and value of health visitor led child health clinics: How do baby clinics promote positive outcomes for pre-school children?

Your ethics application was considered by the Faculty Research Ethics Committee and, based on the information provided, has been given ethical approval to proceed with the following conditions:

1. Please add the UWE logo to the information sheet and consent form.

You must notify the committee in advance if you wish to make any significant amendments to the original application using the amendment form at http://www1.uwe.ac.uk/research/researchethics/applyingforapproval.aspx.

Joanne Webb 08030373
Please note that any information sheets and consent forms should have the UWE logo. Further guidance is available on the web:

http://www1.uwe.ac.uk/aboutus/departmentsandservices/professionalservices/marketingandcommunications/resources.aspx

The following standard conditions also apply to all research given ethical approval by a UWE Research Ethics Committee:

1. You must notify the relevant UWE Research Ethics Committee in advance if you wish to make significant amendments to the original application: these include any changes to the study protocol which have an ethical dimension. Please note that any changes approved by an external research ethics committee must also be communicated to the relevant UWE committee.

2. You must notify the University Research Ethics Committee if you terminate your research before completion;

3. You must notify the University Research Ethics Committee if there are any serious events or developments in the research that have an ethical dimension.

Please note: The UREC is required to monitor and audit the ethical conduct of research involving human participants, data and tissue conducted by academic staff, students and researchers. Your project may be selected for audit from the research projects submitted to and approved by the UREC and its committees.

Please remember to populate the HAS Research Governance Record with your ethics outcome.

We wish you well with your research.

Yours sincerely

Joanne Webb 08030373
Dr Julie Woodley
Chair
Faculty Research Ethics Committee
c.c. Rachel Gillibrand
Dear Joanne,

Re: 2017/008  Lay and professional perceptions of the purpose and value of health visitor led child health clinics: How do baby clinics promote positive outcomes for pre-school children?

On behalf of Sirona Care & Health we are pleased to inform you that the R&D governance review has been successfully completed by Bath R&D for the above project. Please accept this letter as assurance to Sirona that the project meets nationally agreed research governance criteria.

Please note:
1. The research should be conducted in accordance with the Research Governance Framework for Health and Social Care and, if applicable, with ICH-GCP.
2. Project monitoring and outcome information should be provided at least annually and a copy of your final report or dissertation should be submitted following study completion. Please note that a random audit of this research may be conducted.

If you need any further support or information, please do not hesitate to contact me at the above address, quoting our reference number.

Yours sincerely,

Irene Blair
Research Governance Facilitator
Bath R&D

21 February 2017
Study title: Lay and professional perceptions of the purpose and value of health visitor-led child health clinics

As a parent with a baby or child under 4 years, you are being invited to take part in a research project about health visitor-led baby clinics.

Before you decide it is important to understand why the research is being done and what taking part will involve for you. So please consider this leaflet carefully. If anything is not clear or you would like more information, please ask.

Why are we doing this research?

I would like to know more about your experience of baby clinics; how you feel about them, what it feels like to attend and if you feel they are useful. I would like to know more about this so that we can gain a better understanding about how baby clinics might best meet the needs of parents and children.

Who would we like to agree to take part?

Joanne Webb  08030373
Any parents who have attended baby clinics in the last year.

**Do I have to take part?**

No, taking part is voluntary; it is up to you if you would like to take part.

**What if I change my mind?**

You are free to change your mind at any time without giving a reason, nobody will mind if you decide not to take part. Similarly if you do take part and you would then like to withdraw your interview material that is entirely up to you.

**What will I be asked to do if I take part?**

If you decide to take part I will ask if you would sign a form agreeing to take part. You will be given this information sheet and your signed form to keep.

I will contact you in order to arrange an interview at a time convenient to you. The interviews will be take place at a Children’s Centre near to you which will be a baby and child friendly venue. You will be able to keep your baby with you during the interview if you wish and we can pause the interview at any point if you need to meet their needs in any way, or if you would like to stop for any reason.

The interviews will last about an hour and will be recorded using a voice recorder, when the study is finished the recording will be erased once it has been transcribed.

What you choose to share in the interview is entirely up to you – I am very grateful that you have agreed to take part and you can talk as little or as much as you like, there are no right or wrong things to say.
Will my personal details, thoughts & experiences be kept confidential?

Your information and the recordings from the interview will be kept strictly confidential and will only be used for the purpose of this study. Your name will not be used when I write about the research, so no one will be able to link the thoughts and feelings that you share in the interview with you personally.

The only reason why the information you share would not remain confidential is if you discussed something that suggested that you, your baby, your family or professionals working with you were at risk of harm. If this did happen, you that the relevant information would be passed onto the local safeguarding team.

What are the possible disadvantages of taking part?

Sometimes talking about your personal experiences can make you feel emotional; if you feel upset at any point during the interview you can have a break or stop completely. Nobody will mind if you decide not to continue. If you feel that you need any additional support around any aspect of parenting I can give you information about how to access this.

What are the possible benefits of taking part?

While there are no direct benefits to you in taking part many parents find it useful to share their experiences about the support they have received with someone who is very interested in listening.

In addition I hope that this research will help us improve the support parents receive at baby clinics and sharing your experiences will be very valuable in understanding how health professionals can do this.

Who is organising the research?

Joanne Webb  08030373
The research is being organised by Jo Webb, at the University of the West of England (UWE). I am conducting the study as part of my Professional Doctorate in Health Psychology qualification at UWE and I am working under the supervision of Rachel Gillibrand, a Senior Lecturer in Health Psychology.

**Who will be interviewing me?**

I will carry out the interviews. I work for Sirona Care & Health as an Infant Feeding Lead, however I am conducting this study as a UWE student and not as part of my professional role with Sirona.

Sirona staff or management will therefore not be made aware of your participation in the research or have access to the information you share in the interview.

**Who has reviewed the study?**

The study has been reviewed by the G M South Research Ethics Committee and the University of the West of England, Bristol (UWE) Research Ethics Committee.

If you have any further questions about the study or about what you are being asked to consider please contact me on 07595091836 or webbjoanne@yahoo.com.

The researcher is receiving regular supervision for this project from a senior lecturer and experienced researcher at UWE; Dr. Rachel Gillibrand. You can contact Dr. Gillibrand via e-mail on Rachel.Gillibrand@uwe.ac.uk

**Sources of additional support**

If, as a result of talking about your experience of baby clinics you have any concerns which you wish to discuss with a health visitor, you can find the contact details of your local service on the Sirona website:
https://www.sirona-cic.org.uk/services/health-visiting-service/

or by telephoning: 01225 831 794

Alternatively, if you would prefer to talk things through with someone outside of Sirona’s health visiting service, you can contact the NCT’s Postnatal Helpline which is staffed by trained postnatal leaders:

The Postnatal Helpline number is 0300 330 0773, open 9am-1pm Monday–Friday. Calls are charged at local call rates.

If you would prefer to talk to other mothers who have had similar experiences to yourself you can contact NCT’s Shared Experiences Helpline which is staffed by volunteers. The Line puts callers in touch with other parents who have experienced similar difficulties to offer support and a listening ear.

NCT’s Shared Experiences Helpline on 0330 330 0774 (Tuesday, Wednesday and Thursday 9am–3pm). Calls are charged at local call rates.

**Comments, Concerns or Complaint?**

If you have any comments or concerns about the study, please email me at:  

[Joanne Webb](mailto:webbjoanne@yahoo.com) or my supervisor [Rachel Gillibrand](mailto:Rachel.Gillibrand@uwe.ac.uk), alternatively you can contact the Head of Health Visiting:  

[penny.hazelwood@sirona-cic.org.uk](mailto:penny.hazelwood@sirona-cic.org.uk)

Thank you for reading this information
Appendix H

Information Sheet – professionals

Study title: Lay and professional perceptions of the purpose and value of health visitor-led child health clinics.

As a professional or volunteer working with pre-school children you are being invited to take part in a research project about health visitor-led baby clinics.

Why are we doing this research?

There is limited research into the purpose and value of baby clinics and I would like to gain a better understanding of how baby clinics might best meet the needs of parents and children.

I would therefore like to know more about your experience of baby clinics; how you feel about them, what it feels like to be a professional delivering a clinic and if, how and why you feel they influence outcomes for pre-school children.

Who would we like to agree to take part?

Any professional or volunteer involved in the delivery of baby clinics over the last year.

Do I have to take part?

No, taking part is voluntary; it is up to you if you would like to take part.

What if I change my mind?

You are free to change your mind at any time without giving a reason. Similarly if you do take part and you would then like to withdraw your interview material that is entirely up to you.
What will I be asked to do if I take part?

If you decide to take part I will ask if you would sign a form agreeing to take part. You will be given this information sheet and your signed form to keep.

I will contact you in order to arrange an interview at a time and place convenient to you.

The interviews will last about an hour and will be recorded using a voice recorder, when the study is finished the recording will be erased once it has been transcribed.

What you choose to share in the interview is entirely up to you – I am very grateful that you have agreed to take part and you can talk as little or as much as you like, there are no right or wrong things to say.

Will my personal details, thoughts & experiences be kept confidential?

Your information and the recordings from the interview will be kept strictly confidential and will only be used for the purpose of this study. Your name will not be used when I write about the research, so no one will be able to link the thoughts and feelings that you share in the interview with you personally.

The only reason why the information you share would not remain confidential is if you discussed something that suggested that you, or a family that you worked with, were at risk of harm. If this did happen I would discuss with you the importance of passing the relevant information onto the local safeguarding team.

Who is organising the research?

The research is being organised by Jo Webb, at the University of the West of England (UWE). I am conducting the study as part of my Professional Doctorate in Health Psychology qualification at UWE and I am working under the supervision of Rachel Gillibrand, a Senior Lecturer in Health Psychology.

Who will be interviewing me?

Joanne Webb 08030373
I will carry out the interviews. I work for Sirona Care & Health as an Infant Feeding Lead, however I am conducting this study as a UWE student and not as part of my professional role with Sirona.

Sirona staff or management will therefore not have access to the information you share in the interview.

Who has reviewed the study?

The study has been reviewed by the GM South Research Ethics Committee and the University of the West of England, Bristol (UWE) research ethics committee.

If you have any further questions about the study or about what you are being asked to consider please contact me on [redacted]

[redacted]

The researcher is receiving regular supervision for this project from a senior lecturer and experienced researcher at UWE; [redacted]. You can contact [redacted]

If you have any comments or concerns about the study, please email me at:

[redacted]

Thank you for reading this information
Appendix I

Participants

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<td>Infant Feeding Specialist, 2</td>
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<tr>
<td>23</td>
<td>Senior SCPHN Lecturer</td>
</tr>
<tr>
<td>24</td>
<td>NCT Postnatal Leader</td>
</tr>
</tbody>
</table>
Participant Consent Form

Title: Lay and professional perceptions of the purpose and value of health visitor led child health clinics: How do baby clinics promote positive outcomes for pre-school children?

Please read the following statements and circle yes or no in answer to each:

- I have read the information sheet and feel that I understand the explanation of the study  YES / NO
- I feel that I have received enough information about the study  YES / NO
- I feel that I have had enough time to consider my decision to take part in the study  YES / NO
- I understand that I am free to withdraw from the study at any point up to 3 months after interview and that I do not need to give a reason  YES / NO
- I agree to the interview being audio recorded  YES / NO
- I agree to the use of anonymised quotes in publications  YES / NO
- I agree to participate in the study  YES / NO

Name of participant  Date

Signature
Appendix K

Debrief

Title of study: Lay and professional perceptions of the purpose and value of health visitor led child health clinics

Thank you for taking part in this study; if you have any questions about the study or would like to say anything about your experience of participating then please feel free to discuss this with me.

Please remember that you have the right to withdraw the information collected about you at any time during or up to 3 months after being interviewed. All you have to do is email me giving your ID number (which can be found at the top of your Participant Information Sheet) and your data will be removed from the study.

Sources of additional support

If, as a result of talking about your experience of baby clinics you have any concerns which you wish to discuss with a member of Sirona management or with staff support services, the following information may be useful:

Employee Assistance programme (EAP)

EAP is a confidential service and a member of the British Association for Counselling and Psychotherapy (BACP)
Confidential Counselling & Support for Sirona Care & Health Employees

Contact: 01225 825960 or 824484

Contact Details of Head of Health Visiting

Comments, concerns or complaint?

If you have any comments, concerns or a complaint about the study, please email me at:

or my supervisor or alternatively you can contact the Head of Health Visiting

Thank you once again for participating in this study
Appendix L

Debrief

Title of study: Lay and professional perceptions of the purpose and value of health visitor led child health clinics

Thank you for taking part in this study; if you have any questions about the study or would like to say anything about your experience of participating then please feel free to discuss this with me.

Please remember that you have the right to withdraw the information collected about you at any time during or up to 3 months after being interviewed. All you have to do is email me giving your ID number (which can be found at the top of your Participant Information Sheet) and your data will be removed from the study.

Sources of additional support

If, as a result of talking about your experience of baby clinics you have any concerns which you wish to discuss with a health visitor, you can find the contact details of your local service on the Sirona website: https://www.sirona-cic.org.uk/services/health-visiting-service/
or by telephoning: 01225 831 794

Alternatively, if you would prefer to talk things through with someone outside of Sirona’s health visiting service, you can contact the NCT’s Postnatal Helpline which is staffed by trained postnatal leaders:
The Postnatal Helpline number is 0300 330 0773, open 9am-1pm Monday – Friday. Calls are charged at local call rates.

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NCT's Shared Experiences Helpline on 0330 330 0774 (Tuesday, Wednesday and Thursday 9am – 3pm). Calls are charged at local call rates.

**Comments, concerns or complaint?**

If you have any comments, concerns or a complaint about the study, please email me at:

[redacted] or my supervisor [redacted] or alternatively you can contact the Head of Health Visiting [redacted]

**Thank you once again for participating in this study**
Appendix M

Research Title: Lay and professional perceptions of the purpose and value of health visitor led child health clinics

Procedure in cases of disclosure

The researcher recognises that there is a small chance that in one of the interviews, a participant may disclose material which raises ethical, legal or safeguarding issues.

In such cases confidentiality would only be breached if a participant disclosed that there was a risk of significant harm to themselves or their baby (as defined and outlined by The Children’s Act 1989). Permission would be sought from the participant and in the absence of permission the participants would sensitively be made aware of the researcher’s responsibility to pass any such information onto the local safeguarding team (www.swcpp.org.uk).

In circumstances where a disclosure indicates the participant may benefit from specialist support however a risk of ‘significant harm’ is not indicated, the researcher will sensitively signpost the participant to a relevant support agency or organisation. For example if anxiety or low mood is indicated, the participant will be encouraged to discuss this with their health visitor to access support to address this.
Appendix N

<table>
<thead>
<tr>
<th>Transcript</th>
<th>Open codes</th>
<th>Focussed codes</th>
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<tbody>
<tr>
<td>Interview 4 16031704</td>
<td>Seeing parents one at a time</td>
<td>Queuing and waiting</td>
</tr>
<tr>
<td>Jo: Can you tell me about your experience of baby clinics as a professional?</td>
<td>Being very busy</td>
<td>Having one to one conversations</td>
</tr>
<tr>
<td>NN: So, I would say I did a few around different areas.....they were based in a big room in a doctors surgery and people would come into the waiting area and then there would be desks with the myself (NN) at one desk and an HV at the other desk and they would come up to the desk one at a time. They were always very busy and popular.....parents would come over and have their baby weighed – the conversation would always start off about weight and then it would lead onto other things, I would talk to them about anything within my area of knowledge or I would refer them on to the HV if it was something I couldn’t answer. They were one by one appointments they weren’t particularly private because we were all in the same room and it was quiet.....it was more of a medical model, tracking and plotting weight.....you had limited time with each parent so you wouldn’t have very in depth conversations.....you probably had less than 5 minutes with each person, it would be basically as long as it takes to weigh their baby, as soon as their baby was dressed they would leave....my role was to weigh the babies.....and I would weigh the baby, plot it in the book and chat to the mum about anything they asked but if they said oh he has a rash or</td>
<td>Weighing babies</td>
<td>Monitoring and plotting weight</td>
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<td></td>
<td>Starting conversations about weight and then moving onto other topics</td>
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<td></td>
<td>Having individual appointments</td>
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<td></td>
<td>Tracking and plotting weight</td>
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<tr>
<td></td>
<td>Having limited time with each patient weighing babies and plotting weight in the book</td>
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<td></td>
<td>Keeping within role boundaries</td>
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</table>
something that I couldn’t comment on then I would refer them to the HV and they would have to wait again to be seen by the HV.

**Jo:** So you were working alongside the HV, doing the same thing but you would refer if it was outside of your area of knowledge?

**NN:** Yes...

**Jo:** So what about your experience of hubs?

**NN:** Well they’re all slightly different in each area, some have taken on the hub model more than other areas. Basically I would greet the parents, introduce myself and check that they know what generally happens during the hub and then invite them to come and have a seat and chat to the other parents. There would be toys out so there’s an opportunity for babies to play then if they want to have their baby weighed or to see myself or the HV, they can do that as well. If they wanted to see me for example I would get them to sit down and we would have a chat together within the group, unless they wanted a really private and chat, in which case we have a separate room. Because the hub has a group feel, if the conversation was about something relevant for example sleep and if they’ve had trouble and I’ve gone over it with them then often I might invite other parents into the conversation to share experiences, if that’s relevant.

It’s worked really well, I’ve had a couple of really good examples, the same with discussions around food, so one example was a family that I saw at home and it
was quite a young baby (about  months) and we talked about expectations and patterns of sleep and although she heard what I was sharing with her, she was still quite anxious that her baby wasn’t sleeping that much and so what was really helpful was doing that in the group, she could then hear that there were a couple of other, even slightly older babies and that was what they were going through as well, so I felt like it reinforced the normal expectations and I noticed afterwards that although she still talked about it, it didn’t seem to be as high anxiety as when I had seen her before at her home.

**Jo:** What is the value of hubs, what difference does it make coming to a hub?

**NN:** I think socially it offers them a chance to meet other parents and it gives them a chance for their baby to play and we can model that on the floor with them so I think that’s a real benefit for parents and a lot of them say that. I would say over the space of time, parents that come to hub regularly, you see them less focussing on the weight and they come to chat rather than just a weight and go. I think they get the benefit of sharing their experience with other parents and I think the benefit is, if they come regularly that I think I have more of an opportunity to have more of a conversation that is ongoing, so if we’re talking about solids I can say ‘oh how’s it going, what other ideas can you share?’ (warm voice) because in a way I feel I’m getting more time with them. Hearing other people’s experiences normalises what they are going through at the time and they can also have private conversations with me or an HV

<table>
<thead>
<tr>
<th>Normalising infant behaviour</th>
<th>Normalising experiences</th>
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<tr>
<td>Reducing normal expectations</td>
<td>Reducing anxieties through sharing</td>
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<td>Reducing anxieties</td>
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| Being able to meet other mums | Meeting and chatting with other mums |
| Modelling play with babies    |                                      |
| Reducing focus on weight – coming to chat | Sharing experiences |
| Benefitting from sharing their experiences with other parents | Layering information |
| Having an ongoing conversation over many weeks | Asking how things are going each week |

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<td>Benefitting from sharing their experiences with other parents</td>
<td>Layering information</td>
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<tr>
<td>Having an ongoing conversation over many weeks</td>
<td>Asking how things are going each week</td>
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</table>
as well if they want to. Compared to the 5 minute appointment that I remember them having before.

Jo: How do you see your role in the hub is it complementary to the HV or very distinct? What is that dynamic?

NN: I think it is quite distinct I would say that I have a clear role within the hub, I’m there to greet everybody and something I haven’t mentioned is the singing at the end....the baby’s love it and even parents who won’t do it at the group, can see how much the babies love it and then they might do it at home...so I will lead that, so my role is more about the group facilitation and making sure everyone is welcomed and feels part of it and then I can talk about things within my areas of expertise whereas the HV tend to have more of a one to one focus. I think it works best to have both in fact it works best when we have a Health Visitor, an EYCP and a breastfeeding peer supporter, because support for feeding comes up a lot. I think we complement each other and build on what each other may have said, we might talk about different topics but with the same underpinning....around being responsive and sensitive

I actually felt at the clinics that I was used as a ‘sub health visitor’ – I wouldn’t have gone into the in depth conversations with parents that I do at the hubs and I wouldn’t have done the play and the singing so people come into the hub asking for me because they

| Normalising experiences through sharing | Building relationships |
| Being able to have private conversations as well | |
| CNN’s having a distinct role at the hubs | |
| Greeting parents | Facilitating group |
| Bringing the group to an end with a song | Being warm and welcoming |
| Seeing babies react to the singing | |
| Leading the singing, modelling interaction | |
| Facilitating group interaction | |
| Making people feel welcomed | |
| Supporting infant feeding | |
| Building on the information that the HV’s have given | Needing to support infant feeding |
| Having an underpinning approach around being responsive and sensitive as parents | Layering information |
| Utilising skill mix effectively | |
Joanne Webb  08030373

<table>
<thead>
<tr>
<th>Know I can talk to them about sleep or introducing family foods....</th>
<th>Not wanting to be used as a pseudo health visitor</th>
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<tbody>
<tr>
<td>Jo: Why do you think people ask for you? Is it reputation? Are you less threatening?</td>
<td>Having your own specialism</td>
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<tr>
<td>NN: I think probably a combination of both, probably the relationship, because I’ the one that’s always there, the HV’s will rotate but I’m consistently at the hubs every week, so I’m familiar. Also I’m usually the one that greets people, you know says hello and then facilitated the group, so they see me as friendly. I think they see me as someone they can confide it, so often mums say to me quietly ‘oh I’ve started giving solids already, but I haven’t told my HV’</td>
<td>Communicating warmth and a caring approach</td>
</tr>
<tr>
<td>I think I do seem to get a lot of parents disclosing things to me that they haven’t yet told their HV and I think that’s because I tend to spend more time with them chatting over one area....so sleep, play or feeding...whereas the HV’s have a lot to cover, mental health and things that take a lot of time.</td>
<td>Having a consistent present at the hubs</td>
</tr>
<tr>
<td>Jo: How does the dynamic of the people working in the hub effect the success of the hub?</td>
<td>Being familiar to parents</td>
</tr>
<tr>
<td>NN: I think it does make a difference, I think it’s really about everyone having the same understanding about the ethos of the hub and how it works best, so for example I’ve worked with HV’s who look at it more as a social group rather than a space for constantly one on one conversations and then sending mums back to the group when they’ve spoken to them....and that works better and is more popular and people come back to it more. Also I’ve noticed that parents</td>
<td>Being friendly and trustworthy – a confidante</td>
</tr>
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<td></td>
<td>Feeling parents are happy to disclose things</td>
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<td>Giving more intense support on a topic</td>
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<td>Having a shared ethos about the purpose of the hub</td>
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<td>Viewing it as a social group rather than a place for serial one</td>
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<td>Feeling parents are happy to disclose things</td>
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<td>Giving more intense support on a topic</td>
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<td>Having a shared ethos about the purpose of the hub</td>
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<td>Viewing it as a social group rather than a place for serial one</td>
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<td>Having a shared understanding of the ethos and</td>
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<td>Topic</td>
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<td>Participate more in the singing and chatting and being involved in ...</td>
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<td>Where as if maybe they have more of a medical model in their head l ...</td>
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For me a hub that works best is recognising the parents needs so a couple of parents their need at that time was to receive reassurance that their baby was doing well and thriving, so by having them in the group you could do that by talking through baby’s behaviour while they were interacting with them, so talking about the signs we’re looking.
for a well baby rather than excluding them out and to get them weighed for re-assurance as it doesn’t give them skills to feel reassured when they leave the group and are at home with their baby, much better to support them to recognise positive signs without relying on weight all of the time (although obviously sometimes that is appropriate)

Jo: So it sounds like the idea of putting the scales in a different room was to de-emphasise weighing because it’s become so prevalent and try to reduce the amount of weighing happening at the hubs, but it sounds as if what you are saying is the way to tackle that is not to remove the scales to a different room but to acknowledge that weighing is something parents still seem to want to do a lot and there are different reasons why parents want to weigh their babies and we can reduce it not by putting the scales in a different room by talking it through with them in a different way and giving them other strategies to know that there baby is thriving and doing well.

NN: Yes exactly, we have come along way but there is still a need coming from the parents to focus on weight so for the parents that come every week and their babies are doing really well it’s really helpful to lessen that focus on weight and the focus on weight generally. But it needs to be done as a conversation within a group so you’re not isolating parents. I suppose that I’m just trying to highlight that the success of the hub depends on the ethos of the practitioner rather than whether you’re an EYCP or an HV that makes a group work. But I think having the skill mix together makes for a better hub as it

| Recognising parents needs and providing appropriate support which empowers them to understand their baby’s behaviour |
| Supporting parents to recognise positive signs of wellbeing without relying on weight |
| Giving parents the skills to reassure themselves about their baby’s wellbeing |
| Focussing on inclusion |
| Giving parents the skills to understand how to assess their baby’s wellbeing without relying on weight |
| Offering a skill mix and choice of practitioner |
offers a broad range of expertise for the families.

One of the Health Visitors had a good idea of talking to parents about weighing, why we weigh, how often, why we don’t weigh too often, what it can tell us, what it can’t tell us and how it’s only part of a wider picture about health and wellness.....so having that conversation before you start to get into a routine of mechanically weighing a baby with a family each week.....and it seems to be working really well

**Jo: So what do you feel is the purpose of running hubs?**

NN: I think the purpose is as a social group, a point of contact for the parents to meet other parents and the HV or EYCP. Also it needs to be within their community, so it needs to be community based but also to me it’s an opportunity for us to take what we talk about, the messages we give such as responsiveness to babies, normalising expectations and we can model that so it’s like a joint effort – we can do one to one home visits and talk about this is what we do for play or this is how it’s important to respond to your baby but I think what the hubs do really beautifully is gives us the opportunity to bring the messages that hopefully they’re all having, to model that through a group setting. So modelling being warm, responsive and sensitive to the mums and their babies.....

**Jo: So what do you think the value of clinics is – what difference do they make to children and parents?**

<table>
<thead>
<tr>
<th>Avoiding isolating parents</th>
<th>Understand weighing</th>
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<tr>
<td>Offering parents a skill mix and range of practitioners at the hubs</td>
<td>Offering contact with professionals and other parents</td>
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<tr>
<td>Explaining weighing to parents</td>
<td>Layering information through normalising and modelling</td>
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<td>Giving parents access to the health visiting service</td>
<td>Giving parents access to other parents</td>
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<td>Giving parents normalising expectations</td>
<td>Normalising expectations</td>
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<td>Modelling interaction and play</td>
<td>Modelling interaction and play</td>
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<tr>
<td>Having the opportunity to model being warm, responsive and sensitive</td>
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NN: I think it encourages them to come out of the house and the fact that they are going to be welcomed into a group setting....it’s aimed at every family, it’s not targeted you don’t have to meet criteria to come and you don’t have to pay....so one of the very few groups around now where that is the case....there’s the opportunity to mix people that wouldn’t necessarily mix together and becoming a parent is a great leveller in many ways.....all parents have similar concerns and worries....the value is that they get to talk to a health professional or practitioner about any concerns they have about their baby and they get the opportunity to talk to other parents about their experience I think they get to just have somewhere where they can come and sit down and let their baby play which is safe and often parents watch them playing and they say ‘oh he or she does this or that’ and at home that might be an anxiety but at the hub you can quickly reassure them. They can get information on lots of different things like introducing solids, sleep....

Jo: Do they come more for support around their transition into parenthood or is it more about the baby’s health?

NN: I would say it’s a mixture of the two because in supporting their transition into parenthood includes their babies health....it supports their baby’s health and wellbeing because their getting information but it also supports their confidence and understanding about where to get good information....

NN: With the old clinics it was definitely more focussed on health, there was some support with the transition into

| Encouraging parents to get out of the house | Socialising with other parents |
| Being open to all parents | Sharing experiences |
| Mixing families that wouldn’t necessarily mix together | Increasing parental confidence |
| Parenting being a great leveller | Accessing information and support |
| Having similar concerns and worries | Supporting parents to navigate early parenthood |
| Sharing experiences with other parents | |
| Having a safe space – proving reassurance for any concerns | |
| Increasing confidence | |
| Accessing information on lots of different topics | |
| Supporting both health and the transition into parenthood | |
| Supporting parents’ confidence and understanding | |
parenthood but because of the time they got you had to be really focussed, so quite a directed conversation. So when parents are in an environment where they feel more relaxed and supported, more things can come out.....

Jo: Are the hubs an important aspect of the service which complement the home visiting? What are your thoughts?

NN: Definitely they complement the home visits, at the moment they’re an essential part of the health visiting service because I think they get to talk to their health visitor with others in a way that you wouldn’t with a home visit. You get to see mums in their home environment and also in a group setting which is useful for the Health Visitor to understand a fuller picture of what that mum’s support needs might be. Also what it enables us to do is to help them transition on into other social groups that will equally support, for me it’s an essential part – it certainly helps my work as when I do a 6 week support package on sleep for example with a parent, I may have already met them at a hub and started the conversation...and at the end of the package they can share their experience and knowledge with others at the hub and they are still able to touch base with you so it’s an easier transition after 1 to 1 weekly support....

Jo: Some HV’s have suggested that you need to have a set of scales to elicit conversations from parents, that they act as a stimulus to promote conversation.....what is your view on that?

Supporting parents navigate parenthood

Having to have quite short, directive conversations with old clinic styles

Feeling relaxed and supported and able to share

Complementing home visits

Being an essential part of the HV service offer

Getting a fuller picture – seeing mums in a social setting

Preparing them to transition on into other social groups

Sharing / pooling the knowledge and skills of parents

Easing the transition from 1 to 1 home support

Encouraging sharing through relaxed conversations

Complementing home visits

Layering and contextualising information
NN: I disagree, where hubs are done well, you know, being really warm and making parents feel really welcomed and discussing what’s on their mind, I don’t think you need to have scales to get people to open up...if you’re less confident as a professional the scales might make you feel more confident as a way of opening up a conversation....but I think when you have a skilled practitioner you shouldn’t need them, you don’t need them when you have a home visit and it’s no different at a hub....scales are an extra thing to be used or not used depending on the parents preference but shouldn’t be a gateway to an HV or an NN.

I think a lot of HV’s feel like the new social model is quite time intensive and you don’t always feel as if you’ve made much progress if you haven’t told someone what to do or processed lots of parents through the scales.....facilitating discussing between parents can be quite hard and sometimes you feel as if you’re not doing something that is really useful, but if you keep going you really see the positive effects of supported relationships between parents and helping them to figure out things for themselves....I think it has longer term benefits for parents and health professionals which aren’t always immediately evident....some HV’s really get it and others are harder to convince – they like the order of clinics and one to one conversations with an expert and a parent......the new social model is a lot messier and you need to be confident in your facilitation skills...

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<tr>
<th>Being really warm and welcoming</th>
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<tr>
<td>Discussing what’s on your mind as a parent</td>
<td>Relying on scales</td>
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<td>Needing scales as a way to open a conversation if you are less confident</td>
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<td>Not using scales as a gateway to an HV or NN</td>
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<td>Being time intensive as a social model</td>
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<td>Processing parents through the scales</td>
<td>Processing parents through scales</td>
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<td>Not valuing facilitation as much as being directive</td>
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<tr>
<td>Supporting relationships between parents</td>
<td>Building community capacity</td>
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<tr>
<td>Figuring things out for yourself as a parent</td>
<td>Encouraging self-efficacy</td>
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| Feeling the messiness of a social model  
| Needing to feel confident in your facilitation skills | Needing good facilitation skills as a practitioner |