

**How can I/we support the development of family-centred  
health visiting for improving wellbeing and reducing social exclusion?**

Collaborative enquiry report

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**Bath and North East Somerset Primary Care Trust  
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### **Introduction**

This is an account of my learning as facilitator of an action research project to develop the family centred public health role of health visitors through collaborative enquiry in Bath & North East Somerset Primary Care Trust (B&NES PCT) from November 2003 - 04. It does not represent the views of all my health visiting colleagues who participated but documents my developing understanding arising from facilitating the project. I also practice as a health visitor. A collaborative enquiry was planned in response to questions arising from the local response to the Hall Report (*Hall, Elliman, 2003*) about the value of some universal health visiting services to promote the health of children and calls for refocusing priorities. This involves targeting children in families with greatest need, increasing partnership with families and developing multi agency and community partnerships for tackling inequity and social exclusion. In this report I shall:

- explain why a self-study action research method of development was chosen.
- describe the action research process
- explain insights emerging from the enquiring process and outcomes for health visiting in B&NES PCT.
- explain the value of co-enquiry for developing and evaluating practice and meeting clinical governance requirements.

I shall use an action research format to structure this report.

### **What were my concerns leading to this enquiry and why was I concerned?**

My concerns focused on two themes: The first was around developing health visiting in response to public health expectations ranging in perspective between population-based approaches, community development, group activity and family home visiting. My concern was that valuable but hitherto poorly explained aspects of practice already in place could be lost in the search for new ways of working. Second, was my concern about how I would go about introducing a new form of practitioner enquiry in a health care trust where self-study to develop and illuminate practice knowledge was new.

Let me explain my first concern about developing health visiting within a new Department of Health (DH) public health agenda. I share concern about the need to modernise health visiting towards better outcomes for children and families in the climate of changing health needs and social challenges (*The NHS Plan, DH, 2002; Children's NSF, DH, 2004*). I agree that it is integral to progress that greater involvement of individuals and communities in deciding their own health needs and care is needed (*Strengthening Accountability, DH, 2003a*). I recognise the value of integrating individual and family work with community-based approaches to health through multi-agency partnerships in order to maximise the impact of family-based work (*Health visitor and School nurse practice development pack, DH, 2001*). I also recognise that the growing social, economic, ethnic, disability and gender inequalities in health should be tackled not only by addressing short-term health consequences but also the longer-term causes of inequality experienced by people who carry the greatest burden of ill health (*Tackling Inequalities, DH, 2003b*). *It is developing practice to tackle social inclusion under all of these circumstances that is prime motivation for this project.*

What then, were my concerns about this first theme? I wanted to avoid health visiting being drawn into responding to new demands in ways that overlooked good practice already held within a mature but inadequately explained profession. I believed the policies, those interpreting them and health visitors appeared unable to fully understand and explain the value of what was already being practised. This arises because accepted methods of searching for explanations and for evaluation can not capture the practical knowledge of individual practitioners working in unique contexts, leaving it unexplored and undervalued. In health research there is an inability to hold together the broad complexity of health needs faced across communities, particularly the practical meaning social exclusion has for people, with the knowledge and skill needed for tackling it. I acknowledge policy-makers' difficulty when, because of its tacit nature, this knowledge is so poorly articulated or even fully understood by practitioners themselves. *A function of this project is to contribute to the knowledge base of health visiting by stimulating exploration of the embodied knowledge of practitioners.*

The Hall Report recognised the importance of professional decision making in identifying families most in need but how can we explain *how* we do it without the assessment tools some see as unreliable or even harmful (Cowley, Houston, 2003). To be drawn away from home visiting because weighing babies and universal screening is seen as having little measurable value is to discard a valuable means of maintaining contact with all families with varying needs for preventive help and those living with fractured relationships and social exclusion. Health visiting is recognised as relationship-centred practice meaning that "being there" in relationship is a most worthwhile resource that can be offered all families learning to cope with the changing and challenging needs of children. For families who have never or seldom known respectful, encouraging and stable relationships, health visitors offer an acceptable opportunity to experience and practise the kinds of relationships they are expected to create with their children. *I wanted the development of health visiting to take full account of the involvement of relationships in human growth towards personal responsibility.*

From my previous research, I recognised that my motivation to undertake whole population public health activity and 'grassroots' community development work emerged more from needs identified while visiting families than from formal caseload profiling (Pound, 2003). Developing my understanding of families by getting to know the diversity of what makes them up began to clarify health needs and motivate useful action. I was concerned that health visitors would feel obliged to deny their considerable knowledge of human development in its social context and skills working with families, to become involved in educational groups with the people who were likely to attend, and professional-led activities of dubious value in the name of public health. Grass roots community development in response to locally identified need demands skills not widely developed at this time. I believed the health visitors most able to engage the socially isolated in community development activities would emerge from those who already worked effectively as home visitors. The two roles call on similar qualities. I saw a mature and experienced workforce that is already developing good practice but without the means to articulate it. *For this reason I wanted to support my colleagues in making their own enquiries into tackling changing health needs and to ground it in the embodied values and practical skills already guiding them.*

My second concern about introducing a new form of practitioner enquiry was made easier by the insight of the Directors of Primary Care Development and Public Health in the PCT and senior lecturers at the University of the West of England (UWE) in supporting my proposal. Discontinuance of the child screening programme, which previously provided structure for our home visiting, wobbled health visiting confidence causing confusion about how to proceed. My colleagues were pulled between looking for help in deciding how to proceed while also resisting being told what to do. We have history of considerable professional autonomy. Frustration arose from feeling the work we know we do well with families, but cannot fully explain, appeared not to be valued in the changing expectations.

Removal by the Nurses and Midwives Council of 'health visitor' from the register as a protected title that recognises our unique primary preventive role in health further unsettled confidence. I felt my colleagues' fears might be well placed when a senior manager commented that some health visitors would never be able to change and would always want to go on weighing babies. I saw this as a sign of the different perspectives through which health needs and the worth of how we meet them, was seen. We should now place importance on finding ways to explore our influence on health improvement in families and across communities.

Uncertainty grew about what 'public health' and 'community development' means to those looking from different perspectives. Some health visitors see these as additional ways of addressing the health needs they find. For these practitioners activity could take various forms in response to needs declared or observed in families and across communities. Action is assessed and modified as health needs and learning changes. Other health visitors expect public health activity to arise from formal profiling to identify health needs suggested by DH definitions or targets. My experience was that profiling can become an absorbing and time consuming data collection activity in itself that does not automatically lead to useful health improving action that changes anything for families. Profiling for statistical evidence is currently the dominant method of finding out and validating knowledge in health care. This paper explores the possibilities of finding out in the process of our undertaking health promoting action.

Having recently completed a 'living theory'<sup>1</sup> (Whitehead, 1989) action enquiry in my practice (Pound, 2003) I recognised the significance of my own and my colleagues' feelings about the changing expectations. My research taught me the usefulness of feelings as barometer for intuitive recognition of contradictions between competing values or between theory and practice. Contradiction is at the heart of living theory action research. Practitioners asking, 'how can I improve my practice?' clarify personal embodied values guiding practice intentions by examining why values are not lived or liveable in some situations. Fear, anger and confusion were triggered for us by contradiction in the form of denial of our individually held, but as yet poorly articulated, values motivating actions learned through our professional development.

The emotional climate amongst health visitors at this time represented a kind of collective knowing experienced by individuals that was hard to articulate because its explanation has rarely been tried or even been possible in current accepted ways of knowing in health care. In my view it is too simple an explanation to say we represent a conservative profession that resists

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<sup>1</sup> By 'living' I mean as lived and explained by practitioners as they practice. Living also means practitioners' explanations expand as new meanings emerge from new experiences and contexts.

change. A more likely explanation is that we recognise risk to our ability to continue doing what we know is useful for children and family health but do not yet have words to explain.

My aim is therefore to support colleagues' in finding explanations about what they hold to be important in their work promoting the healthy development of children, families and communities. During our individual enquiries in collaboration with each other we could begin to account for our actions as we develop healthy practice further. We could generate explanations of the embodied values we live in our relationship-centred practice and the intuitive ways we approach complex family situations that might seldom be met by other professional workers. We could ask questions about contradictions occurring when our values are hard to live or we find they are denied in some situations. By increasing our understanding in this way we can improve what we do. We could develop explanations of good practice that respond to social and political change and influence future services for healthier families and communities.

A more personal concern persisted. In my own enquiry I had help from the educational action research network at Bath University. What do I need to know if I am to offer similar support to my colleagues' and co-facilitators' enquiries and see benefits within one year? *How do I facilitate the emergence of an epistemology that is unknown in health care research and education in a way that will give my colleagues' practice knowledge credibility?*

### **What could I do?**

I could create space for colleagues to explore, develop and explain their embodied knowledge and skills through systematic enquiries by story-telling. I could support colleagues in more fully understanding and valuing what they do already so they can articulate it. I could share the benefits of the enquiry-as-practice that I experienced as 'alongsideness' during my research into supporting family relationships (Pound, 2003). I could help colleagues test the validity of claims to know what they are doing while deepening their understanding. I could find ways to bring this embodied knowledge of practice into the public domain so it can be widely shared as valuable knowledge. Within the PCT I could work towards developing a researching practitioner community that is open to all disciplines and levels of practice.

Educational action research by practitioners asking questions such as, 'how can I improve my practice?' uses living theory methodology (Whitehead, 1989). The newness of this approach in health care and the degree of discouragement I saw amongst colleagues led me to decide I would start by encouraging recognition of positive attributes rather than faults. This is how I now work with families. I asked them to think about what they currently do well. My aim was to help them begin to clarify the values guiding their actions and later work towards narrowing theory and practice gaps when what actually happens is at odds with the values.

Action reflection cycles build from questioning such as suggested by Whitehead:

- I experience a concern when some of my values are denied in my practice*
- I imagine a solution to that concern*
- I act in the direction of the imagined solution*
- I evaluate the outcome*
- I modify my practice, plans and ideas in the light of the evaluation.*

Action research here is the generation and testing of practice values by creating explanatory principles for an individual's professional practice. A fuller explanation of the action planning methodology can be found in the original proposal for this research at [www.actionresearch.net](http://www.actionresearch.net) linked to Robyn Pound's page.

Also see the Action Research Handbook at [www.jeanmcniff.com](http://www.jeanmcniff.com).

### Who could help and how?

I am grateful to B&NES PCT manager Cheryl Wright, and UWE senior lecturers Glenys Hook and Mary Hayward who had insight to see that this proposal might stimulate worthwhile thinking. UWE is the usual provider of in-service training to the PCT. This co-enquiry proposal to develop practice by building on what colleagues already knew was chosen over another action learning option using the *Health Visitor and School Nurse Practice Development Pack* (DH, 2001) to find new ways of working. I was offering an alternative method of practice development to the action learning proposed by UWE. To enable me to share the complex thinking process needed to understand such a different epistemology<sup>2</sup> I developed a mind map of the concerns, possibilities and process involved in tackling our problem. The mind map grew through discussion with a range of colleagues and managers resulting in a decision to use this action enquiry to develop our family-centred public health approach while beginning to build a practice knowledge-base.

The Workforce Development Corporation (WDC) agreed to fund facilitation of the project as a training and research project over a year supported by Glenys and Mary who would also facilitate groups. Health visitors approached through the discussion phase were enthusiastic about the aims but recognised the newness of the process. Without the trust and enthusiasm of my colleagues this project could not have begun. The action research network at Bath University continued to offer me informal support. From this group I recognised similarities with Moira Laidlaw's current project with learner teachers and lecturers in Guyuan in China ([www.actionresearch.net](http://www.actionresearch.net)).

### How will I know when I have succeeded?

- Colleagues' and my own accounts of learning will show development of our new insights as we implement and check ideas with each other and with families.
- Explanations of values guiding our actions may have resonance beyond us individually. Fuller meanings of our insights will be accessible when presented in stories of our individual learning.
- Colleagues' use of values as standards for explaining and checking actions will show developing understanding of the impact they personally have on outcomes for clients.
- Written explanations will help bring our embodied values as practitioners into the public domain as a living<sup>1</sup> resource that can be widely shared.
- Colleagues wishing to take practice explorations further would provide evidence of the value they find in co-enquiry for improving and explaining what they are doing

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<sup>2</sup> Epistemology - a theory of knowledge, its nature, generation and justification. Living theory action research uses dialectical generation of theory from, and tested in, practice. Unusual in health research, contradiction does not negate theory but is embraced in clarifying embodied values of practice. Alongside epistemology is a relational way of knowing, being and creating knowledge in professional practice.

### **What ethical considerations did I find?**

Discussions with the Local Research Ethics Committee (LREC) took six months because the methodology was underpinned by an epistemology and methods unknown amongst health care research. I bothered to insist that what we were doing was research because:

- creating an evidence-base for health visiting calls for explanations of our practice knowledge.
- we can show how effective practice relies on particular kinds of relationship knowledge.
- credibility and transferability needs greater rigor than is usual in action learning.
- improved outcomes, particularly for socially excluded families, requires reduction of theory-practice-gaps.
- clinical governance requires accounting for quality of care
- living theory action research is new for health care practitioners

Beyond methodological questions, the Ethics Committee asked if the project was education or research, if staff were taken away from patient care to undertake research and why it was funded through an education budget if it was research. As research participants, did staff have choice about their involvement in the process? Fuller answers to these questions are available from the author.

### **Recruiting colleagues**

In November 2003 thirty nine (nearly all) health visitors and community nurses for children and older people signed up to six facilitated co-enquiry groups meeting for two hours fortnightly. This frequency was planned so that colleagues could attend as they were able. Glenys and Mary agreed to each lead a group and I led four groups including twenty three of my colleagues. School nurses, invited because of the similarity of their role, were unable to join because of regular commitments and very part time posts.

Throughout the planning discussions and as the project got under way I was aware of the relevance of my values of 'alongsideness' to the process (Pound, 2003). I was moving into a new sphere of activity with different power relationships. I have learnt to find it easy to create alongsideness with clients. In this new role, I did not have power to share in the same way that is part of my health visiting status with clients. In this situation I was amongst peers or people who were my senior and used to being autonomous in their professional roles. I saw signs of need for recognition of their competence and special knowledge. The PhD gave me credibility for undertaking the project but I also recognised colleagues, some with higher degrees, whose need for encouragement and recognition of their personal significance was no less than my own.

I hoped my colleagues' trust and willingness to cooperate would grow as I lived values of alongsideness in ways that met their needs as well as my own. I refer to an energy for cooperative enquiry that can be generated when people feel connected with one another, feel their contribution is valuable and they can progress at their own pace in their own direction. Colleagues helped me recognise that I also needed to take responsibility for the position I had created for myself. I am grateful for this help in acknowledging and dealing with uncertainty in myself and in others as I came across it and for helping me become clearer about what I was trying to do.

Confusion about the direction of health visiting was compounded by uncertainty about what would be required in the groups. Many declared themselves to be reflective practitioners already but some expressed wariness about the depth and purpose of the personal 'navel-gazing' this process might expect. I recall similar feelings at the beginning of my own enquiry when personal exploration felt risky and I avoided it. It is of course possible to undertake action research with out self-reflection but is hard to see how relationship-centred practice can be explored from the point of view of only half the relationship.

Some colleagues asked if the purpose was to provide data for my own research and career enhancement while others questioned hidden motives to take public health in particular directions. Expressing regret at not being included in the initial consultation some were uncertain about the value to them selves and expressed resistance towards doing something they had not chosen. To a degree this last point had some foundation because managerial expectation of whole staff involvement was at odds with the underlying philosophy of reflective self-study. I was concerned that critical reflection requires willingness to examine one's own every day experience and this would not come about if participants were unwilling or felt pressurised.

In line with usual ethical considerations for research, participants should feel free to join or opt out at any stage. This choice was clarified in an 'Information Letter to Colleagues'. Muted concerns continued through the early months leading to self-selection of those who felt able to prioritise enquiry amongst their commitments. The remaining participants were all health visitors. By the end of the year half, eleven of the twenty-three in my groups were still attending. Most of these wish to continue meeting.

### **What did I learnt from the co-enquiry process?**

**How we began.** Here I report my learning about facilitating the project and my emerging understanding of what I found interesting and useful in supporting enquiry-in-practice. My aim here is to share some of the breadth, colour and contradiction I found that informs my approach to future projects. I make no claim to generality because insights are my own coming from my reflective journal, field notes and discussions about drafts of this paper. Participants gave permission for use of their stories.

In the light of the climate of uncertainty amongst my colleagues, I started by asking them to begin by identifying what works well and what is important or interesting to them, by telling stories about experiences. I found that most had never thought about their personal values (as I had not before starting my previous research) and needed help in beginning to think about the impact of *themselves* on what they do.

A literature search is not part of the process at this stage because I wanted colleagues to value their own knowledge and to resist the usual conditioned response in research to look for what authoritative others know. I also wished to avoid stumbling at the first hurdle because some colleagues reported not reading much about health visiting beyond professional journals and although interested, most did not choose to be in an academic process. I wanted the enquiry to be accessible to as many as possible.

Speaking about positive experiences was difficult for many because of the novelty of focusing on our successes in a culture that usually works on solving problems. Interestingly, I have noticed clients' are also hesitant about recognising and expressing satisfaction about their successes. I wonder how preoccupation with failings is perpetuated in our culture. The affirming nature of the experience of valuing ourselves appeared to lift mood and gradually it seemed to be easier to share and question daily experiences in the safe environment we created.

**Complex stories.** Many of the stories colleagues wanted to tell were about experiences with families who have very complex needs and could be described as 'socially excluded'. These stories were complex, emotion-laden and personally worrying because of their risky nature and the difficulty we find in realising healthy change. Health visitors appeared to appreciate talking about these experiences, supporting each other and recognising similarities in their own practice. In terms of gaining insights for improving outcomes for these families, the complexity of the accounts seemed not to take enquiries forward very far. Value from telling them appeared to be in the peer support. The complexity of the stories however, made them unlikely to lead to useful guiding principles for approaching future families without closer exploration than usually occurred. I wondered how to make story telling more useful.

What was obvious was the depth of health and social need amongst families carried in health visitor caseloads across the PCT. Also evident was a depth of understanding and commitment health visitors often showed, amongst the accompanying frustration from not being able to do enough to help. It seemed that no other agency is in place or any more capable of recognising and beginning to meet the complex needs of such vulnerable families over the long periods of time that is necessary. Most families do not meet criteria for social services or CAMHS<sup>3</sup> help.

**How we made it manageable.** The Bath action research network suggested we look at common every day experiences and the qualities of regular relationships before trying to understand working with families living in intractable chaos. How could I have forgotten, this was how I approached my research in 1996. We could ask delving questions about why our everyday experiences were noteworthy. In this way I hoped to help colleagues tease out the essence of what motivates them in working as they do and why it works well. I found myself helping colleagues to interpret the qualities in their relationships as values. Each colleague told stories that began to show their own slant on values that may be widely recognised but held personal significance for them. Some recalled early experiences that lead to the importance that values now hold in their work.

One health visitor, when asked about why she used her own money to buy food for a family on a Friday afternoon, spoke about the regard shown for the welfare of others in her early life. As example she told how she was not allowed to wear her new shiny shoes to school because other children may not be so fortunate. She said she could not eat herself knowing the family may be hungry. Another health visitor spoke about the responsibility she felt for giving parents the information they needed for making decisions about childhood immunizations. One family required an extended appointment and the discussion turned into repeating circles. The parents looked to her to validate their decision. She told them they needed to make their own

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<sup>3</sup> CAMHS - Child and Adolescent Mental Health service

decision. This story helped her clarify the importance she places in taking responsibility for her own actions and the relevance it has for the personal development of parents and children.

Another health visitor reported routinely telling parents before they came for injections that she would act differently during the immunization session because she would have to concentrate and could not be with them in the usual way. Discussion developed around the qualities of relationship that she values that need to be put on hold (denied) so she could attend to the task. We identified competing relationships required of promoting personal growth of our clients and for undertaking nursing interventions. Stories often highlighted both a value held by a practitioner and concern when the value was denied or was hard to live in some situations.

I believe practice development comes from increased understanding about what I am doing and from searching for ways to live my values more fully in my actions. Through my own research I now see that my developmental shifts come more from gradual shifts of understanding about myself and what I am doing, than from giant leaps in trying something different. I wonder if this is because effective health visiting practice is so dependent on the relationships forged and arises from the constancy of who we are as people. My personal interpretation of professional values become standards I use for checking that I actually do as I claim and constitute explanatory principles for explaining my actions. In my experience, embodied values are transferable across life experiences although exploration of contradictory situations leads to the emergence of new values and expanded meanings.

As the groups progressed I noticed that even though everyone had chances to explore stories at length, I continued to retain a prominent role in the discussions that followed. I was concerned that I may have perpetuated dependence on me as someone who knew about action research. When I asked about it, colleagues repeatedly replied that they needed guidance now but anticipated leading their own enquiries in the future. To begin making sense from the stories I began to suggest possible interpretations in the form of values I found in the stories. I wondered if my interpretation was appropriate because it was from my own value-base and might not have been relevant to the story-tellers. Asking about this, I was told that my interpretations moved thinking on to another level and story-tellers were then able to reinterpret as they created their own meaning.

**Difficult professional issues.** Thorny issues emerged that were hard to resolve but showed how professional obligations and values compete and are constantly balanced by practitioners. For example, contradictions in whose agenda we work to. I saw 'ah ha' moments as colleagues lighted on this question for the first time. If we work to a professional agenda prescribed within our professional remit how can we also be client-led and allow parents to decide the focus of our work? If we are client-led what useful part do assessment tools play in identifying other people's health needs? What does public participation really mean in public health and community development approaches? Can we show how we identify and tackle issues in timely ways for all families through regular and universal contacts? What evidence can we collect to show we make a difference?

Another thorny issue lay in how we balance the promotion of health with the protection of children. Our role supporting parents' personal growth, so they are better able to care for children and our role in child protection have competing intentions that call for different ways

of being and different actions. We asked if we sometimes collude with parents. On the other hand, can children always wait for their parents to grow up? Are child protection procedures always the best way of helping children? Some groups began to explore the different relationship qualities called for and the differing ways we each see them. One colleague believed she had not lived her value of honesty because she left a house without saying what she really thought. 'Maybe it is because you really care?' she was asked. After a long pause she said, 'Being heard, that's what's important to me. Because of my own childhood I want to be heard. I notice when other people aren't heard, especially children'. She had identified a value that turned her own unspeakable childhood experiences into an asset she could share as a guiding value. It may not always over ride her professional responsibility to act but may help her understand the dilemma.

**Practice change to meet needs.** I heard health visitors tell how they respond to the changing needs of their caseloads. Some engage communities and other agencies in developing services and activities. A colleague claiming to feel more confident said, 'When I realised I knew a whole family network including young families, older people and their neighbours in all the different types of work I am doing with them and with other agencies, I knew I'd arrived. I hadn't seen it before as a kind of community development'. Several colleagues deliver or support new initiatives to meet specific needs. Sometimes intention is to enhance a sense of community spirit and working together.

It is recent for health visitors to place importance on family relationships for future mental wellbeing of children and to consider their own relationships with families. At the beginning of the co-enquiry process most health visitors named family relationships and parenting issues as a prime concern. A range of skills to support parenting are emerging. Some use a model to understand human emotional needs (Lew, Bettner, 1996), others a composite model (Solihull) or group work. Others are undertaking self-funded counselling, psychotherapy and infant mental health training and many wish to improve their skills to support more vulnerable parents. I anticipate that the value of these activities will come under scrutiny during future enquiries.

**Writing.** I found it hard to get colleagues to write about the variety of work they are doing or to keep reflective journals, although many brought their folders to groups and made notes. I do not see lack of writing as a sign of disinterest, rather that the value of reflective writing is not yet obvious. It is interesting that action research for accredited academic modules that require written reports appear more productive (see [www.actionresearch.net](http://www.actionresearch.net)). I wonder if this is because these people have chosen to do it or if progress is slow for us because capturing the essence of esoteric relationships is just more difficult than researching practice structured around tasks. I believe that keeping colleagues interested and enquiring is a good start. There are no written accounts of outcomes for families as yet but colleagues' verbal explanations indicate patient learning, changed behaviour and enhanced wellbeing.

I wondered how enquiring might have been influenced if the process had been linked to academic accreditation. It was not an option for this initial project because living theory action research is not yet undertaken in health care faculties, but may be possible in the future. It is not appropriate for me to evaluate the groups led by Glenys and Mary using the methods employed here. Unfamiliar with living theory self-study they used their own action learning

approach to exploring practice and planning activities. We regularly discussed our progress and shared ideas but as an outsider I can not report on the learning in these groups.

### **How do my colleagues and I clarify our values?**

It was my intention to live values of alongsidness in the co-enquiry groups and use them to explain and test my 'practice-as-enquiry' relationships. It was not my intention that colleagues should describe their practice in the same ways. I expected their explanations to emerge from their own experiences and learning. Even though the full meanings of values that make up alongsidness for me are lost when abstracted from experiences in which they are grounded, I summarise them here. For me alongsidness is:

- founded on the worth of humanness, in that *all* people are valuable, have useful knowledge and are worth my respectful effort.
- belief that people are living in a 'process of becoming' and with time and resources prefer to move in positive directions.
- an optimistic belief in the creativity of people in searching for solutions.
- the value of self determination for the development of personal responsibility.
- belief in a life affirming energy to be gained from connection between people.

To increase my understanding of alongsidness values in new contexts and to use them as standards of judgment I need to ask my self, 'do I live these values wherever I am?' I frequently asked myself how I balanced elements of alongsidness during the project. Colleagues expressed values similar to those making up alongsidness and some colleagues used 'being alongside' to describe what they were doing. Emerging values often appeared to be recognised across groups and could be called 'core values'. Core values may be described as fundamental to being human, with subtlety of meaning coming from each individual interpretation. The particular significance and nuances of meaning guiding each practitioner's style arose from the experiences in which they were grounded. I found this in my original research (Pound, 2000).

Relationships began to be described as therapeutic and valuable within them selves. 'Being there' for families emerged as important for enhancing wellbeing and for helping them to take responsibility for living healthy lives and caring about each other. Reciprocity and emotional engagement was described as important for good outcomes by some while for others it appeared risky. There is scope for continuing discussion about what 'being there' means, how it changes in different situations and variations of perspective.

Empathy, caring, fairness and honesty were amongst many values implicit in stories that showed the lengths my colleagues regularly take on behalf of families with complex needs. These same values may also be denied in some of what we do ourselves. We may clarify health needs when we see our values denied in the contexts of other people's lives, for example when usual rights are denied. This motivates our action. On the other hand the primary aims of health visiting, identifying and doing something about health needs, may appear in conflict with being non-judgemental and encouraging self determination. This enquiry process is embryonic in its possibilities. Identifying my own values as both guiding and explanatory principles helped me to become clearer in my actions and begin to recognise and explain outcomes for families. It took me seven years to explain myself and I am still learning. I therefore need to be realistic about what could be achieved in one year.

## Conclusions

This report represents my learning about facilitating a co-enquiry process with health visitor colleagues to reduce social exclusion and improve wellbeing of children in families and communities in B&NES PCT. Health promoting practice that holds relationship to be central to wellbeing depends on practitioners thinking about the impact of ourselves on what we do. I do not offer evidence of health improvement but report on a process in which my colleagues began to explore how we enhance health and wellbeing in our work and learn together as colleagues. We found we needed to reflect on the value of what we do to help us understand the complexity of working with families in greater need. By asking why everyday experiences were noteworthy we began to clarify what we individually hold to be important, how we interpret what we see and focus our action. I anticipate future phases of enquiry will include clients as our practice-as-enquiry develops and we feel able to ask them too, 'How can we be more effective here?'

I saw that many colleagues enjoy and can develop their practice while reflecting together on what they are doing. Not all have time or want to this kind of enquiry group however several continue to meet and some intend writing about their findings. Some consider how to involve families in these enquiries. The signs are that a few might join academic research modules to have their evolving practice knowledge accredited. In the spirit of collaborative enquiry it appears likely that reflection-in-action of this kind benefits from facilitators also involved in self-study. I time groups could be self-sustaining. I wonder if in multi-disciplinary enquiry groups added advantages might come from the wider perspectives of different view points and if the needs of patients rather than professions would then be promoted?

Value-based enquiry, although new to health research, shows potential for illuminating aspects of professional practice not captured by other methods. Behind personal perceptions of what is important in practice lie widely recognised core values that sustain worthwhile debate. These core values match the competencies described in the new NSF for Children (DH, 2004a) and the Chief Nursing Officers' recommendations (DH, 2004b). As a practitioner I recognise benefits from my increasing clarity of purpose with families and colleagues as I reflect on what I am doing. As practitioner-researcher I hope my research story contributes to practice theory.

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