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A Study of How Health Visitors Exchange Knowledge in the Context of Organisational and Policy Change

We have spent our history with hard/codified knowledge as a product. We now need to work with soft knowledge as a process.
George Siemens (2006)

Abstract

This paper draws upon selected findings from a small scale qualitative study of the situated practice of health visitors. The study was carried out in a context of local organisational change, after the merger of two primary care trusts in the north of England, and emergence of national policy drivers positioning health visitors in a leadership role in the delivery of integrated services to children and families. The findings from four focus groups give grounded and context specific examples of the types of knowledge that health visitors value and ways in which they exchange knowledge and draw upon the distributed knowledge and expertise of others. The results are interpreted through the lenses of different discourses of knowledge and barriers to change are identified through an iteration between practice-based narrative and theoretical frameworks. These barriers include: dominance of linear and hierarchical transmission models of knowledge transfer rather than promotion of a knowledge sharing/creating culture; a devaluing of context specific and practice based knowledge in comparison to abstract knowledge; bureaucratisation of knowledge; defensive practices emerging from a perceived threat to professional identity; and limited tools and allocation of time for collaborative work within the profession and across professional boundaries. Recommendations and strategies to drive change and enable health visitors to take on leadership roles in multi skilled teams and a multi agency context are underpinned by the argument that what is needed in this context is a transformational model of knowledge exchange and co creation of knowledge that works with tensions between different discourses of knowledge and promotes collaborative dialogue and practice across professional and organisational boundaries.

Key words: Health Visitors, Discourses of Knowledge, Knowledge Exchange, Knowledge Transfer, Transformation, Cultural Historical Activity Theory

Background

The partnership
The idea for the study arose from a partnership initiative between the Open University and a recently merged primary care trust. Initially, the broader aims of working together in an academic-practitioner relationship were related to a knowledge

transfer/exchange model. In this relationship it was thought that the Trust would benefit from access to research expertise to inform the development of evidence based policy and practice and consequently the quality of service provision. The involvement of health visitors in focus groups was envisaged as the beginning of a participatory process that would encourage reflection on practice and promote a research based culture and knowledge to action processes amongst this professional group. The benefits to the Open University were seen to be greater understanding of current practice based issues and learning in practice outside formal academic structures, that would inform both currency and relevance of the curriculum for continuing professional development.

The study
The study had several broad aims. Firstly, it was an attempt to get an in depth understanding of current practices of health visitors and identify any potential barriers to them taking up leadership roles and working across agency boundaries. Secondly, it was recognised within the Trust that health visitors were feeling overwhelmed because of work load and were becoming disaffected and negative in attitude. Involving them as active participants in the process was a way of getting their voices heard and recognising and valuing their contributions and insights. Details of the full study, methodology and results have been published (Brigham, Maxwell and Smith 2012) and are therefore not duplicated here. Selected findings, including the identification of four role tensions in health visitors' work along the dimensions of autonomy/integration, universality/targeting, flexibility/standardisation and quantity/quality, have been included and interrogated from the perspective of different discourses of knowledge and cultural historical activity theory (CHAT).

Policy background
The notion of health visitors taking on a leadership role in the public health arena, in a multi agency and multi professional context, is not a new one and indeed it could be argued that the complexity of the context in which they work makes it somewhat 'policy resistant'. In *Making a Difference* (DH, 1999) there is a strong emphasis on nurses, midwives and health visitors taking on enhanced leadership roles to, '*drive forward interagency and multidisciplinary team working, to improve quality and practice through clinical governance, to lead public health initiatives, to plan and commission services locally through Primary Care Groups and Trusts, and to provide effective management of clinical services and corporate functions*'. This agenda has developed momentum over the intervening years and ten years later in *Getting it right for children and families* (DH, 2009)a five key areas of work for health visitors were defined based on:

- Leading and delivering the universal Healthy Child Programme (HCP) (DH 2009)b
- Being the named health visitor in Sure Start Children's Centres
- Supporting vulnerable families
- Defining the specialist skills in protecting children
- Creating and developing effective teams

The different dimensions of the role were intended to work together to have maximum impact on health improvement alongside the establishment of a sustainable workforce delivering integrated preventative services underpinned by evidence based practice.

Recent changes have been driven by a commitment in the 2010 spending review to invest in 4,200 new health visitor positions by 2015. These new posts are intended to give sufficient capacity to implement the broad range of recommendations in earlier policy documents and the *Health Visitor Implementation Plan* (DH 2011) outlines the key role health visitors will play in providing support to children and families. The approach builds on the notion of progressive universalism introduced in earlier policy documents and ranges from signposting to community services, 'universal' delivery of the HCP, to 'universal plus' for more acute needs through to 'universal partnership plus' for complex and ongoing needs requiring multi-agency input. The role of health visitors in making a contribution to safeguarding and child protection, alongside other professionals, is also flagged. There is greater emphasis placed on building community capacity and taking on community leadership roles than in earlier documents, the public health component of the role is brought into focus, partnership stressed where family needs are more complex, and a continuing theme is interagency work to provide integrated services for young children and families.

Aims of the paper

The aims of this paper are to bring together selected findings from the study including the 'voices' of health visitors, in the form of transcribed extracts of narrative, and examine these and the policy context from the perspective of the broad meta discourses of knowledge outlined below. A specific theoretical framework, Cultural Historical Activity Theory (CHAT) will be drawn upon to give further analytical insight into the specific context of health visitors' practice and barriers to change.

The broader purpose of the paper is to argue that CHAT, as a theoretical framework, can bridge discourses of knowledge and incorporate both the subjective practice based experiences of individuals and their broader structural context. This dialectical approach is the basis for a transformational model of knowledge exchange.

Framework of analysis

This section outlines how the term 'discourse' is being used in the paper, introduces a number of models identified in knowledge to action (KTA) enquiry, maps out discourses of knowledge and describes the philosophical basis of these different epistemologies. 'Knowledge to action' relates to the translation of research based knowledge into practice based actions and has been widely used in the health arena to address concerns that research findings often take a very long time (if ever) before they are effectively embedded in actual practice. (Graham et al 2006)

Finally, CHAT is introduced as a theoretical framework that can potentially incorporate phenomenological and positivist ways of knowing and provide a tool for a transformational model of knowledge exchange applicable to the context of health visitors' practice.

Discourses of knowledge

'Discourse' as a concept is used in the paper to indicate a set of statements, ideas and meanings that have a specific history or genealogy. A discourse can therefore be seen as a set of rules that distinguishes it from other discourses and establishes the boundaries within which a phenomenon can be made sense of and understood. It therefore defines its own truth and 'conditions of possibility' (Abbott and Sapsford 1988: 61-65). Using this conceptual framework the sorts of questions that can be asked relate to how and why some discourses dominate over others and maintain their authority whereas others are relatively silenced (Foucault, 1970). This feeds in to questions of power, empowerment and disempowerment. From a Foucauldian perspective discourse is a system of representation that shapes what can be known about in any particular knowledge area and time. He focused on knowledge disciplines such as law, psychiatry and medicine and referred to these as 'regimes of truth'.

Within the field of knowledge to action (KTA) enquiry there have been various attempts to explicate and classify different models of understanding. For example, Best and Holmes (2010) identify three generations of thinking for conceptualising research-policy-practice (KTA cycle). These are linear models, relationship models and systems models. An approximation of Best and Holmes' categorisation has been used as a starting point for constructing Table 1. This has been abbreviated in places and dimensions added related to philosophical basis and implied models of learning to extend the academic models into broader discourses of knowledge. Additionally, the systems model has been replaced by the interpretive column as the argument put forward is that one specific theoretical framework, cultural historical activity theory (CHAT), that can be broadly located within systems thinking (Senge 1990), has the potential to bridge different discourses of knowledge. Collectively, the first three columns can be seen as logically connected sets of ideas that form overlapping meta discourses about knowledge - they frame and constitute what can be known about knowledge itself. For Foucault, however, discourse is not just about the cognitive world of language and ideas it is inextricably interwoven with practice. As Stuart Hall explains, *'since all practices entail meaning, and meaning shapes and influences what we do – our conduct – all practices have a discursive aspect'* (Hall 1992:291). Knowledge produced through discourse therefore has a very real impact on the world of policy, practice and service provision and is inextricably connected with power relations. Researchers and theorists do not exist outside discourse but can codify different models of understanding the world and initiate discourses that can challenge existing understandings and stimulate changing practice.

Table 1

	Discourses of knowledge			Theoretical framework
	Linear	**Interactional**	**Interpretive**	**Cultural Historical Activity Theory**
Philosophical basis	Positivism	Positivism/Phenomenolgy: Symbolic interactionism	Phenomenology	Dialectical
Concept of	Knowledge as	Knowledge produced from	Tacit	Dialectic

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knowledge	a product, body of knowledge, generalisable and abstract not context specific	multiple sources – research, practice, theory. Context related and must be adapted.	knowledge, knowledge as process – created through interpretation. Context dependent	between abstract and concrete knowledge. Context connected to broader social structures.
Language	Knowledge transfer, global knowledge economy, uptake, dissemination, diffusion	Knowledge exchange	Knowledge from experience	Knowledge creation, transformation
Direction of knowledge flow	Linear - From research producers to research users	Multi directional	Starting point is individual experience	Knowledge networks, ecologies of knowledge
Emphasis	Knowledge generated and codified by experts, scientific method	Broader range of actors involved in knowledge production.	Conscious experience from the subjective or first person, Emphasis on 'meaning making' and point of view rather than abstract universal knowledge	Historicity, collaboration, collective problem solving, co creation of knowledge, dialogue, relational, networked expertise.
Implied model of learning	Knowledge and expertise acquired by individuals	Social theory of learning through participation	Learning from lived experience	Expansive learning

The different discourses of knowledge to action/action to knowledge outlined in the table have been labelled linear, interactional and interpretive. 'Linear' constructs knowledge as a product, something that is produced and published through a peer reviewed process and then has to be disseminated down a one way street to research users e.g. practitioners, policy makers. 'Interactional' recognises greater complexity in production of knowledge and there is a shift towards adaptation to the practice context rather than the more abstract focus on the general rules of 'linear'. The 'interpretive' is about the messy and complex process of lived experience and knowledge is context dependent and related to a specific vantage point.

The philosophical basis of these different sets of ideas or discourses represents very different vantage points or epistemologies (theories about knowledge and how it is acquired) and ontological concerns (beliefs about the nature of reality) for understanding the world (Pope, Mays and Popay, 2007). In broad terms, positivism adopts the position that it is possible to produce objective knowledge about the world and, derived from this premise, that research should be confined to collection of information about phenomena that can be objectively observed, classified and measured. The aim of research is therefore to discover underlying laws of nature or social life i.e. causal relationships, and to construct abstract theoretical models of a universal type. It tends to be associated with quantitative research methodologies such a social surveys using structured questionnaires, random controlled trials, structured observation and more general use of experimental method. Knowledge is seen as being founded on the collection of reliable 'facts' or 'body of knowledge' which can largely speak for itself with a minimum amount of interpretation by the researcher. Phenomenology, on the other hand, privileges knowledge founded on direct experience so, rather than trying to develop abstract universal theories and establish causal relationships, the emphasis is upon how individual 'actors' classify and give meaning to the world and their actions within it. It focuses on the complexity of the lived world and specific contexts. From this perspective it is not possible to study objective 'facts' and the aim of research is to attempt to interpret the actions of participants who are seen holistically, *as complex and resourceful subjects who are simultaneously shaped by social forces and intentionally creating and using forms of knowledge in a dynamic process to transform those social forces'* (Crowley and Himmelweit, 1992:1). This gives a hermeneutic rather than positivist understanding of the world i.e. a different way of knowing. It is associated with ethnographic techniques, in depth interviewing, case studies, autobiographical accounts, focus groups and participant observation. This simplified overview is expanded upon by McWilliam (2010) and it should be noted that there is also a descriptive strand of phenomenology that is not considered in this paper.

The opposition between positivism and interpretive phenomenology drives our understanding of what is meant by knowledge and it also links to concepts of learning. Hakkarainen et al draw upon different theorists to distinguish between acquisition and participation metaphors and propose an additional knowledge creation metaphor (Hakkarainen et al 2004). Acquisition metaphors tend to be more prevalent in specifically educational context such as schools, colleges and universities, although the shift to problem based learning has partially addressed this tendency, and participatory metaphors are biased towards work based settings where the emphasis tends to be on changes in behaviour rather than changes in cognition. The former sometimes uses the concept of the empty vessel in which knowledge can be poured whereas participative approaches are based on social learning theory, exemplified by the idea of communities of practice (Lave and Wenger 1991). The knowledge creation metaphor moves beyond learning the knowledge and practices of a community of practice through participation to provide a model for innovation and creation of new learning and knowledge. The first two metaphors of learning have been located within linear and interactional columns and knowledge creation located in the interpretive column and CHAT. Again, classification isn't absolute but overlapping.

This section relates to the paper and its themes at several different levels. The study utilised focus groups to generate discussion between health visitors and capture

qualitative data about their lived experiences of practice rather than attempting to objectively measure different dimensions of practice. In addition, analysis and interpretation of those discussions indicated that the knowledge health visitors valued was local and contextual rather than abstract and generalised and their references to learning were predominantly participatory and based on engagement within their immediate networks rather than on formal courses or text based learning.

Cultural Historical Activity Theory (CHAT– Bridging discourses of knowledge)
CHAT has been included in the discussion as a theoretical framework aligned to systems thinking that can potentially form a bridge between discourses of knowledge and related ways of knowing associated with positivism and phenomenology. It provides both a theoretical framework and methodology and addresses the micro relations of work based interactions, the organisational and inter-organisational context and broader structural factors. It has a limited presence in public health knowledge to action literature possibly because, historically, it has been primarily associated with the field of education.

(CHAT) is derived from the founders of the cultural-historical school of Russian psychology working in the 1920s and 30s. These founders were L.S.Vygotsky, A.N. Leont'ev and A.R. Luiria. Vygotsky focused on the relationship between human agents and their environment and the use of tools, both physical and conceptual, in mediating action and change (Engeström and Miettinen 1999). Engeström has developed activity theory to look at the collective aspects of activity and built on the notion of an activity system comprised of human agents within a structured division of labour, inhabiting a specific community with its own internal culture. Their activities are focused on a particular 'object' and they engage with that object through mediating tools. Engeström sees work based activities as always associated with ambiguity and tensions with the potential for expansive learning and transformation of practice being driven by internal contradictions, questioning and exploration of differences both within and between different areas of practice, or 'activity systems' (Engeström 2000a, 2000b and 2008).

Anne Edwards has worked extensively within a CHAT framework in the areas of social inclusion and education (Edwards 2005, 2011, Edwards et al 2009) and a particular focus of her work has been at the more micro level of analysis. This has brought the issue of human agency into the framework more strongly and the development of the concept of relational agency in inter-professional contexts is of particular interest in interpreting the following voices from practice.

The health visitor perspective: voices from practice

What is knowledge?
In the focus groups some reference was made to research based evidence and policy documents but the knowledge related dialogue that took place predominantly related to context specific and local knowledge of families, networks, other professionals and services with examples of tacit as opposed to codified knowledge,

So you have got that knowledge as to who is related to whom and which children belong in which family. And you are bringing to the forefront of your brain things that you've seen in other houses and you use it. (Focus group 1)

If you're going to go out and look at the family and you think there's something not right here, I can't see what it is at the moment, but a gut reaction sort of thing. (Focus group 2)

I think if the locality is smaller, we know the social workers, we get to know them, they know who you are, you know the CPNs we get to know everybody don't we…the paediatricians. (Focus group 4)

Explicit knowledge obtained from formal learning processes was recognised but the dialogue was characterised by informal processes of participation to share learning and exchange knowledge.

Although university gave me the paper qualification they didn't necessarily give me what I needed to actually be a ground based worker and I used to turn to them a lot, I used to meet up, have peer group support....and really just talk anonymously over situations, so there was no breaching of confidentiality but we would talk around this scenario, what happened and this is what I did - do you think that was right? You need that reassurance. (Focus group 2)

The value of inter-professional exchange was also stressed in development of knowledge and understanding,

It's learning perhaps to disagree [ ] but also if you agree with it, why have you come to that agreement, where I think sometimes some professionals will just say oh yes I'm happy with what the social worker is recommending but haven't really thought it through as to why they are happy with that. (Focus group 4)

Even from these short extracts it can be seen that the discourse of knowledge that governs health visitors practice is more aligned to columns 2 and 3 than the linear model. Policy documents, on the other hand, tend to be underpinned by a more top down, linear discourse with the emphasis on evidence based practice. The *Health Visitor Implementation Plan (DH 2011)* calls for *'a core programme of evidence based preventative health care'* and there are frequent references to evidence and examples of evidence in the document, nearly all referring to abstract more 'universal' evidence produced within a positivist paradigm. Green (2008) talks about the 'pipeline fallacy' of transferring research to practice and also the 'empty vessel fallacy' and brings attention to the need for more practice based evidence, i.e. evidence that is produced from research closer to actual practice, via practice based research networks, for example. However, discourses of knowledge are not neutral and dominance of one discourse over another has historical antecedents and is embedded in complex relations of power. Therefore shifting the balance can be challenging and requires concerted strategies and interventions over a period of time.

Relational agency

There were some differences expressed about whether or not it was acceptable to admit to not knowing everything once you had been qualified for a number of years but the narrative below illustrates a view of the contingent nature of practice based knowledge which places it at the opposite end of the continuum of a fixed 'body of knowledge'. It also indicates how health visitors draw on the distributed expertise of others. Edwards et al (2009) discuss this understanding of other professionals in local systems of distributed expertise, or 'know who', as an enhanced version of practice. They argue that it offers a very different view of what it means to be professional as individuals are not just reliant on their own resources but can draw on the resources of others and in doing so develop relational agency,

> *When I go to the families I say if there's any questions you want to ask me, I'll do my best to answer them but if I can't I will know somebody who can and I will get back to you [ ].as a health visitor you build up a massive range of contacts and expertise from other people that you work with [ ] You never know what you are going to go into with a family, you can't have preconceived ideas because they'll come out with something, and I think I haven't got a clue..* (Focus group 1)

This concept of relational agency is also illustrated in the way that health visitors work with clients. The following extracts illustrate ways of working that are about enhancing the agency of individuals and building outwards relationally into community development.

> *One thing I like about the Sure Start is because I can actually see mums who I was health visitor for are now working for Sure Start because they started off as being my mums and then they went into my group which was called NESSI at the time and they took on little roles there and then gradually got on and are now working [ ] and it influenced other parents in the area..*
> (Focus group 3)

> *I started off a group where I had parents who came in and we said what do you want to do [ ] and they said oh can we do some cooking, because none of them could cook and it was fascinating listening to the reasons why they didn't cook and it went back to childhood and what they went through and all sorts, anyway we took them from there from having never cooked a thing, not knowing how to make a sandwich, right through to actually running and developing a community café and actually running it. That was public health, nobody's having the opportunity to do that...*(Focus group 1)

The *Health Visitor Implementation Plan* (DH 2011) places emphasis on building community capacity but this is in tension with drivers encouraging different types of working practices. In terms of CHAT the 'object' of activity in the above narratives relates to individual and community empowerment. This is very different to examples of practice given where health visitors are working to change specific aspects of behavior of individuals to meet different targets e.g. cessation of smoking, breast feeding, healthy eating/reduction of levels of obesity. If health visitors are encouraged to reflect on the different 'objects' of activity this gives a more complex and enhanced

understanding, what is referred to within the CHAT framework as 'expanding the object of activity'.

Policy documents over a long period, and health visitors in this particular snapshot of time, refer to lack of role clarity and it appears that no matter what is done in terms of local implementation of policy initiatives and strategically defining and communicating a vision of the health visitor role, that this feeling and lived experience of lack of clarity remains. From a CHAT perspective this can be explained by the fact that the health visitor role requires them to work in multiple activity systems with different 'object motives', different tools to work with, different professional discourses providing different 'sets of rules' e.g. medical and social models of health, and they also engage with different communities of practice. Health visitors are positioned at the boundaries between nursing, public health and high input safeguarding, between general practice and Children's Centres and between the NHS, Local Authorities and the voluntary sector. The diagram below represents a model for analysing one activity system but the complex context they work in would require analysis of multiple activity systems each with a slightly different orientation towards the 'object'.

Mediating artefacts:
Tools and signs

Subject   Object

Rules   Community   Division of labour

Second generation activity theory model (Engestrom 1987)[1]

Role tensions
The health visitors gave many examples in the focus groups of valued ways of working that entailed building relationship, with each other, with other professionals,

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[1] Slightly simplified diagram adapted from one presented in Edwards et al (2009:197)

with managers and supervisors and with clients. Frustrations were expressed when workload issues, organisational or regulatory constraints operated against these valued ways of working and a range of role tensions were identified in the analysis of the transcripts from the focus groups. These related to, flexibility/standardisation and quantity/quality, autonomy/integration, universality/targeting. If these tensions are examined discursively each of these areas is the site of intersecting discourses, either 'meta' discourses of knowledge or more specific professional discourses.

For example, a key feature of regulatory frameworks to which health visitors and other professionals are accountable, are quantifiable performance targets and indicators. These tend to standardise practice and reduce both the flexibility of practitioners and their autonomy as professionals to make decisions outside established frameworks. One example of this was pressure to comply with the number of visits specified in policy guidelines conflicting with professional judgements about priorities,

> *Yes, well if you're really short staffed and you're managing a caseload, actually for me the priority is going to be a mum who's ringing up with post natal depression before carrying out a routine nine month check..we've always done that in years gone by and now we are being told otherwise.*
> (Focus group 3)

There were also concerns expressed by health visitors that the 'eureka moments' would not be captured by quantitative performance measures, These are critical moments of practice when it all comes together and the experienced practitioner 'knows' that the cumulative effect of their practice has had a positive impact on the children and families they are working with. This type of 'knowing' is not captured in performance indicators and health visitors flagged the importance of research to capture patient stories '*the only true way that you are going to get good quality data, is through patient's stories*' (Focus group 2).

Universality/targeting was an area that related to the tension between providing universal services in the delivery of the *Healthy Child Programme* (DH 2009)b and high input safe guarding. The latter brought health visitors into much closer partnership work with social services rather than health and an associated dilemma was identified. If services are seen to be targeted they could also be seen as stigmatizing from a client perspective. What health visitors see as good practice is the opportunity to build relationships of trust with all families so that if more intensive support is needed this is more likely to be accepted, '*You've got to develop that relationship before anything goes wrong really*' (Focus group 2). These relationships are developed in some of the more health promotion type activities such as mother and baby groups, promoting healthy eating/cooking skills, therapeutic group work. As one health visitor said '*It's not about being weighed it's what you talk about over those scales*' (Focus group 3). In other words it is these universal services that have both a broader health promotion function and can lead to early preventative interventions, thereby reducing the need for subsequent targeted 'safeguarding' measures. There was some resistance to delegating these tasks to community nursery nurses as they were seen as very important, skilled and essential parts of the health visitor role but there was also a sense of being overwhelmed by trying to do it all. In other words, there is insufficient capacity to be able to do everything and there is not

yet a shared vision about how progressive universalism could be achieved within multi-skilled and integrated teams in a way that resolves the universal/targeted dilemma. An associated issue is another element of resistance related to fears about loss of professional identity if health visitors are working across agency and professional boundaries. The process currently underway to increase health visitor capacity will not address tensions and reduce resistance unless work is done to bring different activity systems into alignment and work on some of the internal contradictions identified.

The methodology utilized in CHAT is based on developmental work research, or the Change Laboratory, where practitioners participate in analysing some of the internal contradictions they have identified in their own localised practice (Engeström 1999). This can potentially lead to expansive learning which radiates outwards from small scale discrete innovation to transformational organizational learning and system change.

Bureaucratisation of knowledge and tools of practice
There was a lot of discussion in the groups about the tools that health visitors had to work with. One that was raised in every group was the Common Assessment Framework, a tool intended to assist interagency working

> *The Common Assessment Framework, the principles and the ideas great, because it's to identify families before they get into crisis, and put resources in and support to move things forward for them so they go back into universal services [ ] and it's very bureaucratic, takes a lot of time, form filling in, and it has to go to a panel and if the panel decide they are not getting it then you've been through all of that you know. I think you set families to fail because you're saying this is the process we have to go through and then you have to go back to them and say well actually you're not a priority this month, someone else is getting it, and it's just doesn't sit.*

There was discussion about the process being easier when it was less formal, when they could just pick up a phone and explain what was needed. From the health visitor perspective the formalisation of the process and putting in an extra layer of 'expert' decision making to justify allocation of scarce resources has acted against the interests of clients and this is another area which would benefit from some collaborative inter-professional work. Much of the health visitor activity is based on *coordinating*, *signposting* and *referring on* rather than what might be termed collaborative work i.e. work where different professional groups come together to share understanding of the issues and collectively develop new solutions that might involve new ways of working across organisations.

Recommendations
The original study made a range of recommendations to the Trust based on the experiences of health visitors. Two of the key areas highlighted here relate to:
1) A time frame that enables systemic learning i.e. interaction between practitioner learning about new ways of working and shaping of broader strategies.
2) Concrete areas for multi-professional work and service improvement identified

e.g. improving documentation and processes related to Common Assessment Framework; assessing, amending and developing tools for workload analysis; work on inter professional communication in relation to vulnerable children and families.

A further area for development work, based on the previous discussion, would be to set up a structure of researcher/practitioner meetings, using the Change Laboratory methodology, where practitioners have the opportunity to work on some on the internal tension they have identified in their role.

Conclusion

This paper started off with an academic partnership and assumptions related to the more dominant discourses of knowledge to action. It outlined three different but overlapping discourses of knowledge. Analysis of the 'voices' of health visitors, the tensions within their roles and the policy context suggested that policy, management , regulation and commissioning were aligned predominantly to a 'linear' discourse that constructed knowledge as a product whereas the actual practice of health visitors was much more aligned to an 'interpretive' discourse where knowledge was constructed as a process. The argument was made that Cultural Historical Activity Theory (CHAT), as a conceptual framework, could potentially bridge the different discourses and integrate them. There are other frameworks for synthesising 'different ways of knowing' (Senge 1993, Nonaka 1994) but CHAT incorporates an emphasis on the historical and highlights the importance of working with evolving internal 'contradictions' in practice to trigger expansive learning and transformational organizational change through the dialectical method of 'ascending from the abstract to the concrete'. (Engeström 1999). It also offers specific tools such as the Change Laboratory to engage researchers and practitioners in this process and these are included in the recommendations. From a CHAT perspective internal contradictions are present in local activity systems because they are located in broader socio-economic formations so the framework offers scope to look at broader configurations of power and how these impact on more local activity systems. A detailed analysis of power relations is beyond the scope of this paper but the current dominance of a linear and hierarchical model of knowledge transfer is likely to overshadow and silence voices from practice and inhibit rather than promote a transformational model of knowledge exchange.

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