“I am a Health Visitor now”- An Investigation of Student Health Visitors’ perceptions of their Professional Identity

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Contents

List of figures and tables

Abstract.

In many health care professions professional identity is considered to be important because it aids recruitment and retention and improves quality of care. Professional identity in nursing has been examined in depth in relation to students joining the profession but it has not been considered in detail in relation to those who change roles in nursing. Professional identity in health visiting is significant because health visiting has a complex history from independent practice to a specialist branch of nursing. Health visitors are qualified nurses who complete a year-long post-qualification course and this thesis explores whether these preparation and transition programmes have a role in their professional identity development. Therefore, this study aims to examine professional identity in an under-researched professional group and to identify implications for educationalists involved in the professional preparation of HVs.

This study involved a narrative inquiry wherein five student health visitors took part in three unstructured interviews during their year-long Specialist Community Public Health Nursing course. Participants told their stories about their career choices and their perceptions of their professional identity. Using the Wengerian notion of Communities of Practice as a theoretical framework and an analytical lens, the resulting interviews were analysed using a two-stage approach: a thematic analysis focussing on the content of the interviews and dialogic analysis to increase the depth of analysis

The findings suggested that there were three overarching categories that impacted on the participants' perceptions of their professional identity: their previous experience; their personal qualities (both pre-and post-participation in the course) and their conception of the health visitor's role.

This study thus adds to what is known about student health visitor professional identity and confirms comparable research findings in relation to other groups of health care professionals. It confirms a view of identity development as a process dependent on expectations, shared understanding of their role and was influenced by practitioners prior experience. These findings are important for: individuals who

are considering undertaking a Health Visitor programme; for policy makers; for organisations that influence health visiting; for Higher Education Institutions who deliver programmes; for Commissioners of Education for health visiting and for employers who wish to retain student health visitors and improve quality of care .

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Glossary

CETHV - Council for the Education and Training of Health Visitors

CNN – Community Nursery Nurse

CoP – Community of Practice

CPT – Community Practice Teacher

CSN – Community Staff Nurse

DH – Department of Health

EBP - Evidence-Based Practice

EU - European Union

GP – General Practitioner

HCP – Healthy Child Programme

HEI – Higher Education Institution

HV – Health Visitor

HVIP – Health Visitor Implementation Plan

IPW – Interprofessional Working

iHV– Institute of Health Visiting

LA – Local Authority

LPP – Legitimate Peripheral Participation

LSA – Ladies Sanitary Association

MoH – Medical Officer for Health

NHS – National Health Service

NI – Narrative Inquiry

NLFN – National League for Nursing

NMC – Nursing and Midwifery Council

PHE – Public Health England

PHN – Public Health Nurse

PI - Professional Identity

RSH – Royal Society for the Promotion of Health

RSI – Royal Sanitary Institute

SMW – Sanitary Mission Women

SCPHN – Specialist Community Public Health Nurse

UKCC – United Kingdom Central Council for Nursing and Midwifery

UKPHA – United Kingdom Public Health Association

UKSC – United Kingdom Standing Conference

WBL – Work Based Learning

Chapter One: Introduction

Health Visitors (HVs) are qualified nurses and midwives who have additional public health training; they work in the community supporting individuals and families, promoting health, assessing needs and reducing inequalities in health. The history of health visiting spans over 150 years and shows a pattern whereby HVs have been linked to several professions including social work and aspects of education before becoming principally aligned with nursing (Baldwin 2012). Initially a voluntary service, health visiting became formalised as a statutory service in 1929 and HVs now play a crucial role in the modern NHS workforce. The multifaceted history has, to some extent, influenced the still-fluctuating nature of the HV's role in the modern NHS workforce and is partially responsible for an oft reported lack of clarity about HVs 'professional identity'. Thus, this study aspires to examine professional identity in an under-researched professional group and identify implications for educationalists involved in the professional preparation of HVs.

This chapter sets the context for this study, explaining why the topic of HV professional identity is of significance to me, to students and to health visiting as a profession. It then explores the historical development of the profession and the implications of this for professional identity as well as outlining the contemporary role of the HV focusing on the situation in England. The emphasis is on England because the profession has evolved differently since devolution in Scotland, Northern Ireland and Wales, influenced by distinctive government policies. Furthermore, this study was carried out in England. The penultimate section of this chapter describes the contemporary and ongoing changes that continue to influence HV regulation, training and education and the impact these have on the continuous state of flux. The final section outlines the structure of the remainder of the thesis.

Significance of topic: for myself, students and from the literature

I qualified as a nurse in 1987 then trained as a midwife in 1988 and I qualified as a HV in 1990. Health visiting combined all the knowledge and experience I had gained in my professional career and I felt that it offered a different approach to being a

healthcare professional. As I ended my HV training, I felt that my conception of professional identity had changed and that I now saw myself predominantly as a HV rather than a nurse or midwife. This autobiographical experience provided my first prompting that professional identity is an issue that warrants further investigation.

Confirmatory experiences were accrued in my ten years' experience working as a HV and in my teaching of HVs in several guises for the last 20 years both on professional preparation courses and as part of their continuing professional development. During this time, I have worked with a wide range of HVs and students; often when we talked about our professional roles, we would debate whether we were most accurately categorised as nurses or midwives or whether 'Health Visitor' represented a substantive identity. Opinion was divided but overwhelmingly we saw ourselves as HVs first, then nurses or midwives; in some cases, the perception was of a HV as a variety of specialist nurse and for others nursing or midwifery were viewed as a separate profession. Such anecdotal reflections indicated the fluidity of the professional role and these ongoing discussions indicated that my own ambivalence regarding HV professional identity is mirrored by both established practitioners and new entrants to the profession, thus professional identity is an issue worthy of further consideration.

Furthermore, perusal of the extant literature regarding HV professional identity (see Chapter Two) confirms that the role ambiguity detected in my own practice experiences is mirrored more widely and merits further exploration, particularly by those like myself who are involved in the professional preparation of Health Visitors. While there is limited literature on student HV professional identity, research focussing on Public Health Nurse (PHN) students by Hjalmhult (2009) in Norway indicates that developing professional identity is a process that requires support. Additionally, Machin et al (2012) in their study of qualified HVs and their developing professional identity in England note that identity is affected by changes in role indicating there is flux in HV professional identity. Dahl and Clancy (2015) support this and suggest that a cohesive identity is challenged by changes in policy. These issues are investigated further in the literature review in Chapter Two.

In my own professional practice, I have always experienced health visiting, both in practice and education, as qualitatively different from nursing, although some of the skills and knowledge are transferable. My interest in professional identity is from the perspective of a HV educationalist seeking to understand how professional identity develops and the degree to which it influences the support required during health visiting educational programmes and shapes them as professionals. Therefore, this thesis explores the perceptions of student HVs in relation to their professional identity as they progress through their training since this is of significance for both their individual professional development and the profession overall.

Having established the importance of professional identity for myself, students and colleagues and noted its significance in the literature it is necessary, in order to explore the question posed, to explore the concept of professional identity. This is the subject of the next chapter. Prior to this, an overview of health visiting and its historical development is presented.

HVs in the UK are registered nurses or midwives who have completed a year-long post-qualification programme in a Higher Education Institution (HEI) (NMC 2004). On completion they become a Specialist Community Public Health Nurse (SCPHN) (NMC 2004). Their role is to facilitate early child development through offering a universal preventative service aimed at preschool children and their families. They promote optimum child development, improve wellbeing; prevent disease and address inequalities through home visiting. They are expert, autonomous practitioners who are family centred and aspire to empower clients (Cowley and Frost 2010, Cowley et al 2013, Cowley et al 2018a).Their role is often misunderstood by both the public and fellow professionals. The focus on children and families has been a signature feature of health visiting practice in England and the reasons for this are outlined in the following sections.

The history of health visiting is complex and helps to elucidate why professional identity is often unclear for HVs. When health visiting began in the 1860s it was designated as a profession with no links to nursing yet its subsequent history and development shows many points of intersection and overlap with other professions. This remains significant when trying to understand HV professional identity and how

the contemporary role has developed (Baldwin 2012). Therefore, in the following section HV history is charted through division into four parts: rationale for development; voluntary to a statutory service; role clarification and employment; and the call to action for health visiting.

The rationale for the origination of health visiting was influenced by the work of sanitary inspectors and voluntary philanthropic visitors (Craig 2010). Voluntary home visiting developed as a result of both the social and political climate in the nineteenth century. Home visitors were introduced in response to concerns about high infant mortality and the cramped unsanitary living conditions of individual families (Adams 2012). When, after the Anglo-Boer War, 1899–1902, the Inter-Departmental Committee on the Physical Deterioration of the Poor was instituted, it reported that the deteriorating health of the poor was linked to poor mothering (Brooks and Rafferty 2010), with the result that home visiting became part of a more collectivist approach to the development of a national child welfare system (Dingwall 1977, Craig and Smith 1998).

Health visiting evolved from the volunteer home visitors to be a statutory service, however, its origins as we recognise them today are credited to the Ladies Sanitary Association (LSA) in Manchester (Baldwin 2012). Similar organisations did exist in other parts of the country but the history in Manchester chronicles the incremental development of the role (Heggie 2011). Lady visitors attended the homes of working-class women to give advice and through this to achieve sanitary and health reform. The visitors followed in the steps of the City Mission by distributing tracts focussing on abstinence from alcohol and avoiding sleeping in crowded rooms (Heggie 2011). The visitors worked alongside male sanitary inspectors, but their focus was on the home life of the families whereas the sanitary inspectors focussed on buildings and working with landlords (Heggie 2011). The lady visitors were volunteers and had limited training from the male sanitary inspectors; they purchased the tracts they distributed to the working-class families (Heggie 2011). The lady visitors differed from the district nurses from the Sick Poor Institute who also visited the poor because the district nurse's role was to carry out care whereas the lady visitors were there to offer advice (Heggie 2011).

The middle-class lady visitors were often poorly received and from 1867 they were gradually replaced by Sanitary Mission Women (SMW) who were working-class women paid by the LSA (Heggie 2011). In 1891 the payment of the SMW was taken over by the corporations in Manchester and Salford and the name of the role changed to ‘Health Visitor’ but the organisation remained with the LSA (Heggie 2011). However, in her seminal work on the history of health visiting, Davies (1988) suggests that there was debate about whether the HV’s role was of equal status to sanitary inspectors or whether they should be considered ‘mother’s friend’ at a lower level than sanitary inspectors (Davies 1988:55), Historically this is an early example of what would become a characteristic and enduring lack of clarity about the role of HVs.

During this period the HVs began to work with the Medical Officers for Health (MoH) and the LSA had less influence, the relationship with the MoH continued until the 1970s (Craig and Smith 1998). The HVs reported on the sanitary conditions in the homes to the MoH, who reported to the corporations (Kelsey 2000). In 1907 the entire organisation of the health visiting system was subsumed by the two corporations in Manchester and Salford and the focus changed from general advice to child and maternal welfare and reports went directly to the MoH (Heggie 2011). By 1917 other councils had followed suit and employed women to visit other women in their homes to advise on infant feeding and home hygiene; their focus, although individual, was also about improving the health of populations (Kelsey 2000).

Health visiting developed as a state sponsored service following the Notification of Births Act of 1907 and the subsequent extension to the Act’s provision in 1915. The latter made notification compulsory and made it easier to offer timely advice and support to new mothers (Wilkie 1980, Cowley et al 2018a). Health visiting became a statutory service in 1929 following the Local Government Act and HVs were employed by local government working with the MoH in child health clinics and family homes giving advice and support. Their role primarily focussed on maternal and child health, but they were also involved in TB visiting (Adams 2012). Health visiting has remained a consistent part of the British welfare state since 1929 (Peckover 2011).

Role clarification remained an issue; despite being a statutory service from 1929, change was ongoing which led to confusion among other professionals about HVs' responsibilities and their professional allegiances (Kelsey 2000). Following the inception of the NHS in 1948 which included the health visiting service, HVs continued to work alongside the MoH and to be employed by Local Authorities (LA) yet their role had limited involvement in public health, their focus was on caring for the family and involvement in infection control and school health services (Kelsey 2000). Tension between the community approach and the family focus of their public health role led to much debate between HVs as a profession and other professional groups, especially in relation to caring for children (Hoskins 2009). This sense that the roles and responsibilities of the HV were contested and variously distributed between home-based and institution-based care served to further the ambiguity around HV professional identity.

One illustrative debate in this period concerned the role-difference between HVs and social workers. Historically their relationship had been fraught (Craig 2010). Both were discharging similar roles caring for deprived children and both were employed by the LA, but social workers had higher status (Craig 2010). Jameson (1956) sought to clarify their different roles, suggesting that HVs were generalists and were there to find cases who required support whereas social workers were there to work the cases (Malone 2000). However, the confusion remained, particularly in relation to child protection (Malone 2000). Jameson (1956) suggested that HVs should be general family visitors (Kelsey 2001).

In 1974 following an NHS reorganisation, HVs employment moved to the NHS rather than the LA and HVs became accountable to hospital nurses at divisional level (Craig 2010). Thus, HVs worked with other community nurses and General Practitioners (GPs) rather than with social workers and the MoH. The reorganisation meant that HVs were attached to GP practices and assigned to the GP's patients resulting in a further increased focus on individual health care rather than a population-wide remit (Craig and Smith 1998). Furthermore, in the early 1990s, during GP fundholding, HVs were expected to meet targets specified by GPs even though they were employed by NHS Community Trusts but HV services were commissioned by Primary Care Groups (Craig and Smith 1998). However, as policy

changed so did the role of the HV reverting to emphasis on public health in the 1990s supported by the then government (DH 1999). Despite this change in role, HVs remained attached to GP practices. Following the Health and Social Care Act (2012) HV services were commissioned by Clinical Commissioning Groups. Alongside the change in commissioning of services there was a change of employer for a minority of HVs due to commissioning being separated from provision as part of the Transforming Community Services government programme. This programme enabled providers such as social enterprises and private providers to employ HVs as well as the NHS (Whittaker et al 2013). Regardless of their employer HVs continued to work with caseloads of children and families attached to GP surgeries. Since 2015, following implementation of the Health and Social Care Act (2012) HV employment has remained consistent but the commissioning of services has moved to the LAs where HVs deliver the Healthy Child Programme (HCP) which is explored in more detail below. Suffice to say during these frequent reorganisations the role of the HV has changed leading to less focus on home visiting and more on skill mix and leading teams. This fast-changing pattern of affiliation, separation, and sometimes re-affiliation to different areas of the NHS infrastructure and organisation will have played its own considerable part in impacting upon HV perceptions of their professional identity, leaving a legacy for contemporary holders of the role (Luker et al 2012).

We come now to the most recent of the historical milestones in the development of the HV profession. In 2011 the UK coalition government instigated a ‘Call to Action’ - Health Visitor Implementation Plan (HVIP) to increase HV numbers in England by 4200 in a four-year period (DH 2011a). This led to the highest number of full-time equivalent HVs in recent history (Datagov 2015). This increase in numbers reflected the recognition of the value of support during pregnancy and the first three years of life in improving the health outcomes of children and enabled HVs to increase the support they offered (Cowley et al 2015). However, when commissioning for health visiting services changed from the NHS to LA, the funding was not fully ring-fenced and numbers of HVs decreased. In 2017 it was suggested that any gain from the HVIP has been offset (Bryar et al 2017, Cowley et al 2018b). There has also been a loss of visibility of health visiting leading to fragmentation of services for families (Institute of Health Visiting (iHV) 2018). These recent oscillations in the resourcing

and recruitment to Health Visiting provide the contemporary context for HV professional identity development.

It would appear from the preceding discussion that of all professional groups in the contemporary NHS, the HV's role is perhaps particularly contingent upon the policy context and imperatives of the government of the day. Current policy focus is on ensuring every child gets the best start in life though health promotion and disease prevention (Public Health England (PHE) 2014). As part of this HVs oversee the 'Healthy Child Programme' (HCP) DH 2009 ,DH 2011a, PHE 2015).The combination of mandated visits at different levels depending on need and focus on specific topics is known as the '4,5 6 model of health visiting' and is illustrated below (Department of Health and Social Care and PHE 2018).

(Public Health England 2018)

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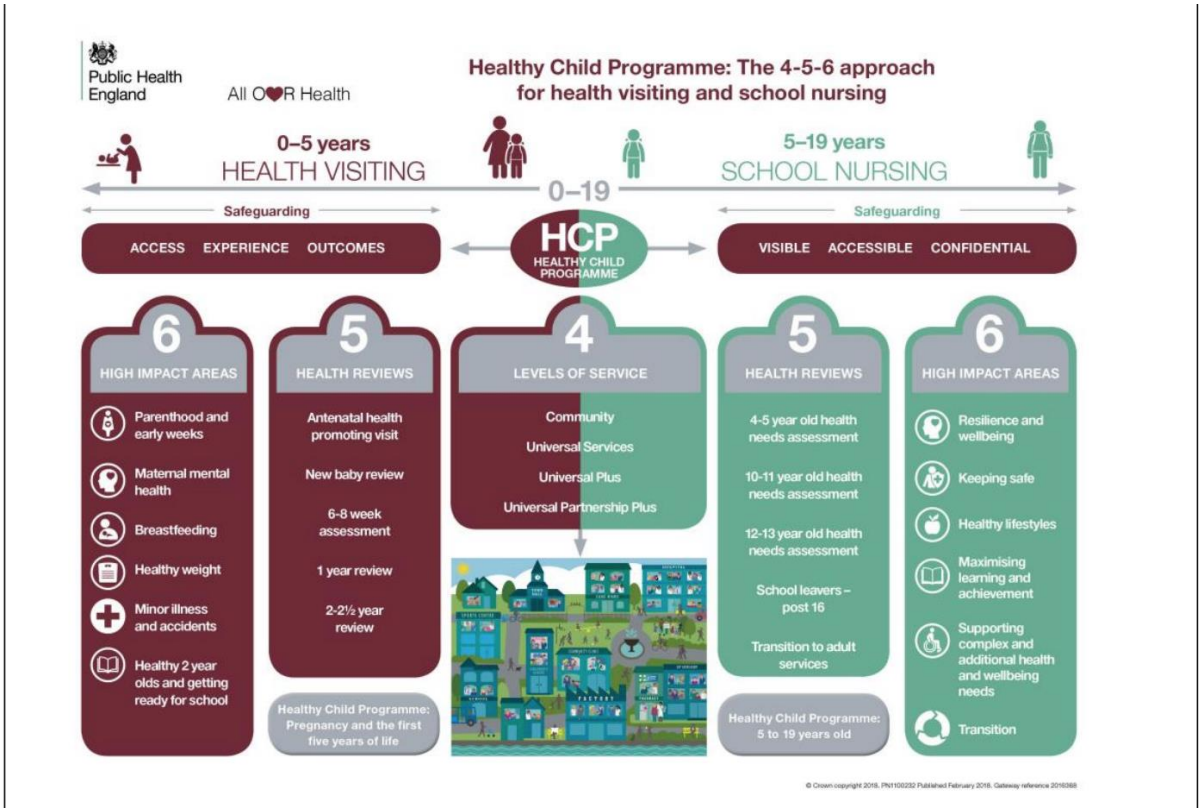

Figure 1 Healthy Child Programme 4-5-6 Model of Health Visiting and School Nursing

The number of visits increase in relation to need in line with Marmot's (2010) proportionate universalism (DH 2011a, Cowley et al 2015, Institute of Health Equity 2020). This is a place-based approach working with both families and communities. HVs are leaders and deliverers of the HCP; part of their role is to liaise with colleagues and signpost families to sources of support rather than carrying out all care themselves. This is a whole-systems approach to prevention (PHE 2018). However, the use of whole-systems approaches to prevention is sometimes criticised for being prescriptive and limiting professional autonomy (Appleton and Cowley 2004, Condon 2011, Cowley et al 2015, Scott 2019). Currently the iHV is calling for a review of the number of contacts and the levels of provision (iHV 2019a).

Since devolution the degree of universality has varied across the four nations of the United Kingdom (Cowley et al 2018a). The situation is that in Scotland eleven mandated visits are required in the first five years (Scottish Government 2015) , while Wales and Northern Ireland offer between 8 and 10 (Department of Health Social Services and Public Safety, 2010; Welsh Government, 2016). Research in England indicates that increasing the number of visits improves outcomes (Local Government Association 2019).

Concurrent with these administrative differences in the conducting of HV roles, debates about the HV role have taken place within the profession. Cowley who is a noted commentator on contemporary health visiting, has steered these debates as part of several different authorial teams. Cowley with her colleagues identified that the key issues for health visiting were defining successful health visiting and explaining practice. Cowley et al (2013,2015) moreover suggested that 'orientation to practice' was fundamental for successful health visiting; this comprises understanding the need to focus on salutogenesis (health-creation),being aware of person-centredness (human valuing) and recognising the role of an individual's situation (human ecology) (Cowley et al 2015:473). Furthermore, Cowley et al (2015:474) go on to suggest that the 'orientation to practice' is operationalised through 'a service journey' where relationships are built using good communication skills during regular home visits and by instigating a continuous needs assessment. Through this service journey the essence of health visiting is developed, working

together to address any issues that arise and supporting the client to feel able to approach the HVs in times of need (Cowley et al 2015). Moreover, Cowley et al (2018a) and Cowley et al (2018b) expand on the previous research and indicate that successful health visiting includes the principles of universality, continuity and coordination, autonomy and professional knowledge. These principles help with recognising and meeting needs within the universal offer. Whittaker et al (2017) highlight similar principles that relationships, continuity, professional knowledge and autonomy are essential for successful health visiting. Both Cowley et al (2018a) and Whittaker et al (2017) have built on the original principles outlined below:

- The search for health needs
- The stimulation of an awareness of health needs
- The influence on polices affecting health
- The facilitation of health-enhancing activities

(Council for the Education and Training of Health Visitors (CETHV) 1977) cited in Kendall and Merritt 2021:256)

These principles have been used as a way of explaining and guiding health visiting practice, highlighting the public health role as well as supporting individuals, thus they are a way of describing the knowledge base and processes of health visiting (Cowley and Rudgely 2009). The principles were introduced initially in 1972, reviewed again in 1992 and 2006, and remain appropriate. It is suggested that the principles are the bedrock of health visiting, both informing practice and academic discussion (Malone 2000). More recently application of the principles has been affected by the decrease in funding for health visiting leading to an increased focus on addressing challenging situations such as safeguarding and child poverty (iHV 2019a, Scott 2019).

Health Visitor Education and Regulation

If the preceding discussion has indicated how shifts in policy and administration may well have impacted on contemporary HV professional identity, these have arguably been matched by the correspondingly ad hoc arrangements for HV education and regulation over the last 150 years which have also impacted on professional identity.

Broadly speaking I have divided the development of HV education into four distinct phases: initiation, formalisation, regulation and specialisation.

The initiation phase was late nineteenth century to the Second World War when there was lack of clarity about the requirements to be a HV. In the late nineteenth century women who acted as HVs had no specific qualifications and they were not regulated. Illustrative examples can be drawn from cities such as Manchester where the focus initially was on women of similar status to those they visited (Davies 1988).

The first health visiting course was instigated by Florence Nightingale and her nephew in 1882. It consisted of 16 lectures for non-nurses by the MoH followed by discussions with the MoH. Nightingale is cited as stating that health visiting was totally different from nursing the sick and therefore required different training (Wilkie 1980). In the early twentieth century qualifications required by HVs varied across the country; in Manchester in 1907 qualification as a nurse was required (Dingwall 1977). In London in 1909 HV appointments were officially sanctioned by the Local Government Board but applicants had to be medically qualified or be a nurse or midwife or have experience as an unqualified HV and have a further qualification as either a sanitary inspector or a recognised HV certificate (Dingwall 1977, Kelsey 2000). In 1916 it was recommended that HVs should have at least two of the following: nurse training; sanitary inspector's certificate or a certificate from the central midwives' board. In 1918 it was agreed that HV posts would only be funded if the HV had a recognised qualification, but the nature of the required qualification was unclear (Dingwall 1977). A circular in 1919 from the Ministry of Health and Board for Education set the requirement that HV training had to take place in universities and separate arrangements had to be made for the practical aspects (Wilkie 1980). The specified course was two years in length but shortened to one year for those already qualified as a nurse or were graduates (Adams 2012). Kelsey (2000) suggests that this was one of the key moments in the development of the relationship between nursing and health visiting as the preference was to train those who were already qualified as nurses due to the lesser cost of training for one year and the difficulties that some non-nurses had in gaining employment after the programme. Previous training as a nurse was viewed as important because it brought personal attributes with it but knowledge of sick children is not always

relevant to working with healthy populations (Wilkie 1980). In 1925 a midwifery certificate was required as a prerequisite for HV training and the duration of the course was reduced to six months. However, later commentators suggested that this prerequisite limited the scope of health visiting to maternal and child health and it would have been better to focus on improving maternity services (Clarke 1973 cited in Wilkie 1980).

In 1925 the Royal Sanitary Institute (RSI) which later became the Royal Society for the Promotion of Health (RSH) was approved by the Ministry of Health as the national examining body for health visiting. The curriculum was standardised and the qualifying examination for HVs was set through a training and examination committee comprising representatives from the training institutions and the RSI (Wilkie 1980). Thus by 1925 there was an established regulatory system, generally agreed curriculum and training for HVs even though the training was diverse (Kelsey 2000). Nevertheless, during the next twenty years debate continued about the appropriate mode of training and whether nurse training should be a prerequisite, linking very much to the debates about the HV role (Brooks and Rafferty 2010).

The formalisation phase was the Second World War to the early 1960s, linked to the development of the NHS. Established in 1945, another body influenced HV training, the United Kingdom Standing Conference for Health Visitor Education (UKSC) working alongside the RSI and MoH. The UKSC was a voluntary organisation with representatives from all the training organisations which influenced the final examinations and recruitment of HV students. From the UKSC eight members were selected to sit on the examination committee for the RSI. The UKSC also considered recruitment of HV students and their training but it did not have a legal regulatory function rather it acted as a pressure group on the RSI and the Ministry of Health (Wilkie 1980). As we shall see from data reported later in this study, the involvement of so many stakeholders in HV training will likely also have impacted on role development and role-holder professional identity.

In this period there was a proliferation of different HV preparation programmes varying in length from six months to two years (Kelsey 2000). None of the courses had a specification of the division between theory and practice. Courses were

generally run by LAs who utilised their local area for the practical component and their own staff for the theory, mainly the MoH which led to a medical bias (Wilkie 1980). In 1943 an attempt was made to instigate a separate register for HVs. This was unsuccessful partly because of the insistence of the MoH to appoint only HVs who had nurse training (Kelsey 2000).

During the late 1940s and early 1950s there was much debate about the length of the HV preparation programmes as there had been many policy changes that needed to be included with the advent of the welfare state (Kelsey 2000), thus the preparation programmes extended again to a year but the two-year preparation continued as well until the early 1950s. Davies (1988) suggested this led to discrepancies in practice and confusion about the role. However, Dingwall (1977) suggests that the different routes were due to the improvement in the health of the population in the inter-war years resulting in less need for a national service and less emphasis on population health.

Following the extension of the standard preparation programmes to a year, debates continued about the requirements for nursing experience and registration and the differences between HVs and social workers. Commissioned by the Ministry of Health in response to these concerns, the Jameson report of 1956 discussed HV training as well as practice. Differentiation from social work was highlighted due to HVs' nursing background. However, entry to HV training remained open to non-nurses until 1962 (Robinson 1982).

The Jameson Report led to the Health Visiting and Social Work (Training) Act 1962 which established the Council for the Training of Health Visitors (CTHV) and the Council for Training in Social Work (CTSW) instigating the third phase regulation. In 1970 the title was changed to the Council for the Education and Training for Health Visitors (CETHV) and in 1975 the Social Work and HV organisations separated. Prior to this the two councils had worked informally together, particularly in recognition of the different roles of social workers and HVs following on from Jameson's (1956) recommendations (Wilkie 1980). For reasons that Wilkie (1980) finds to be unclear, the new regulatory body for HVs was separate to the regulatory body for nurses.

Prior to 1962 HV training varied both in form and content. There were 29 institutions that trained HVs, some based in LAs and some in technical colleges and the curriculum varied depending on who was organising the training (Wilkie 1980). The CETHV began by standardising the curriculum and venue, programmes were to be taught in educational establishments not by the employing authority, facilitating multi-professional learning and working. The length of the course was also standardised to a calendar year along with support in practice from specially trained HVs known as field work teachers (Kelsey 2001). Commencing in 1965, the new approved programme was offered at certificate level and required candidates to be on the general register for nurses for the first time (Wilkie 1980). It is suggested that the implications of this change in the relationship between nursing and health visiting were not at first recognised (Wilkie1980). However, this was the first time that health visiting was acknowledged as a post-registration course for nurses. Despite this it was presented in a different way to other post-registration programmes, apart from district nursing programmes, with delivery in an education institute, not in a hospital, likely widening the perception gap between nursing and health visiting (Wilkie 1980). In statute health visiting was not linked to nursing, but the tacit assumption of such a link was widely made even though the CETHV was the regulatory body for health visiting and was separate from nursing. Many HVs belonged to the Health Visitors Association (HVA) where the links to nursing were considered tenuous and in the HVA manifesto health visiting was regarded as a separate profession linked to nursing and social work but separate from both (HVA 1970).

The CETHV curriculum remained in place until the demise of the CETHV in 1982. Health visiting then became part of the nursing registry body, United Kingdom Central Council (UKCC) but retained a separate register until 2003. There were three parts of the nursing register: nursing, midwifery and health visiting. HV was recognised in statute as a separate profession and HVs had to be recorded on the third part of the UKCC register, as a legal requirement (UKCC 1998). Prior to the closure of the health visiting register decisions about what should be included in HV programmes were made by HVs because if a group has a title protected by law it is up to that group to define what is required for qualification (Cowley and Pearson 2002). However, the removal of health visiting from statute meant that decisions

about HV education were then made by nurses and midwives (Cowley and Pearson 2002). Indeed, Cowley and Pearson (2002) suggest that this change meant health visiting as a profession was reduced in its legitimacy to a branch of nursing. This has caused ongoing debate since the closure of the register (Cowley and Bidmead 2009, Hoskins 2009).

In 1994 after the demise of the CETHV a new HV training was introduced as part of specialist practice; specialisation is the fourth phase of education. This programme reduced the length of the programme to a minimum of 32 weeks and with no requirement for support in practice from a specialist teacher (UKCC 1994,Cowley and Frost 2010). A minimum of one third and a maximum of two thirds of the programme were required to be taught alongside other community nurses such as district nurses and community children's nurses. Some universities offered longer programmes as there was disquiet about the preparedness of the students for practice on completion of such a relatively short programme. Reviews of the programme followed, and changes were introduced and agreed by the Nursing and Midwifery Council (NMC) following its inception in 2002.Changes were made to the HV training to increase the emphasis on public health and well-being and the links to the principles of health visiting. Further changes were made when the new NMC register was established in 2004 and the standards for SCPHN were introduced as discussed below (Cowley and Frost 2010).

Following the Nursing and Midwifery Order (2001) health visiting was removed from statute and was no longer a protected title with its own register. Instead a new voluntary third part of the register was introduced by the NMC which recognises the qualification but does not accord authority to practise and is not recognised in statute like the nursing and midwifery qualifications in the other two parts of the register. For the first time in its history, health visiting was no longer a protected recognised profession (Hoskins 2009). Health visiting was absorbed into the more generic register Specialist Community Public Health Nurse (SCPHN) and it was suggested that this change impacted on recruitment due to lack of clarity about the role (United Kingdom Public Health Association (UKPHA) 2007). Health visiting was then viewed as a post-registration nursing qualification rather than a qualification in its own right (Cowley et al 2009).

Current programmes for HV education in the UK are governed by the Standards for Proficiency for SCPHN (NMC 2004). This standard is currently under review (NMC 2020a) and recommendations for a national curriculum have been made by the iHV (2019b) stipulating the skills, knowledge and personal attributes that should be developed by students during the course. Programmes are taught at a minimum of degree level and are 52 weeks long; 45 of those weeks must be programmed and there must be clear progression points. The programme must be 50% theory and 50% practice and there must be a ten-week consolidation period at the end of the programme in practice. Students should be supported in both theory and practice by appropriately qualified teachers).For a long period students had to be supported in practice by Community Practice Teachers (CPTs) but in 2018 the NMC removed this stipulation (NMC 2018). The programme must be led by a SCPHN practitioner (NMC 2004) and curriculum must facilitate the student to understand their role in practice and to understand public health. The curriculum and the competencies that the student must achieve are divided into four areas that reflect the aforementioned principles of health visiting (NMC 2004). Since 2011 government policy has also influenced educational programmes (DH 2011b) with an increased emphasis on relationships. Where possible, SCPHN students - who can be School Nurses; Occupational Health Nurses; Public Health Nurses; Family Health Nurses or HVs - should have shared learning. Students should be assessed in theory and practice, but the assessment must include an examination. Throughout the programme students are supernumerary when in practice (NMC 2004).

There has been extensive debate over the last ten years about whether HV preparation programmes are long enough and have a specific enough focus to prepare HVs for practice (Cowley et al 2009, Cowley and Bidmead 2009, Malone et al 2016). All HV students are registered nurses or midwives but the three years of Pre-Registration Nurse Education, depending on when it was completed, could focus on pathology and care of the sick whereas only one year focuses on child development; family relationships and the other skills needed to be a competent HV (Cowley and Bidmead 2009). There is concern that Pre-registration programmes vary; students can enter HV training from the adult nursing field, children's nursing, midwifery or mental health nursing (NMC 2004). Therefore, students enter training

with different levels of expertise. For example a children's nurse will know a great deal about child development but little about childbirth; an adult nurse will know about illnesses but may know very little about child development or family relationships; a midwife will know a great deal about breastfeeding but may know very little about overall child development (Malone at al 2016). Recent changes to the Pre-registration nurse curriculum as a result of new standards introduced by the NMC in 2019 (NMC 2019) should have addressed these differences. Since the removal of health visiting from statute there has been much debate about the value of direct entry health visiting removing the need to complete nurse or midwifery training first instead having a three-year or four-year programme in a comparable manner to direct entry midwifery (Cowley and Bidmead 2009). This is one solution to addressing the length of the programme as students could complete one year that addressed issues that were relevant from nurse education and three years focussing on HV-specific issues (Cowley and Bidmead 2009, Malone et al 2016). While this would require legislative changes, it is an approach that was supported by Willis (2015) in his review of Nurse Education. Another Willis-endorsed option is that students could address the areas where they lack knowledge by undertaking modules prior to their HV training (Malone et al 2016). Alternatively, at qualification, HVs could enter formal training posts which ensure that they develop all the skills and knowledge they require for their role (Malone et al 2016).

HV education has always been predicated on most students being sponsored by a Local Health Trust or other employers commissioned by the LA for example Virgin Care and being employed whilst undertaking the programme however currently there are possible changes to this with no clear direction for the future (Bryar et al 2017). There is also a possibility of a categorical change in approach with apprenticeships as the way forward (iHV 2019c).

We have thus seen how HV education over the last 150 years has changed from being linked to sanitary inspectors and carried out by voluntary organisations and then LAs with no links to nursing to now being a branch of nursing. There were no formal requirements for nursing registration prior to completing a health visiting qualification until 1962 although it had been considered desirable. Currently HVs are required to be a registered nurse or midwife and then to complete a health visiting

qualification. Over 50 years after the instigation of a nursing qualification there is again debate about whether direct entry health visiting would better meet the needs of practitioners and clients alike (Cowley et al 2009, Cowley and Bidmead 2009, Malone et al 2016).

These constantly shifting educational and policy contexts go some way to explain why HV professional identity might well be perceived by role-holders as contested or undefined. Health visiting as a profession is often regarded as difficult to understand. This lack of clarity has often been linked to HVs being seen as ‘a jack of all trades’ (Hunt 1972:18). Significantly the lack of clarity about roles in other professions related to child development has led to discussions about the impact this could have on professional identity (McGillivray 2008) but this has not yet been fully explored in relation to health visiting.

Accordingly, the present study sets out, in seven chapters, to explore perceptions of professional identity amongst a contemporary cohort of student health visitors in England. Chapter 3 expounds the study methodology and seeks to justify the adoption of narrative inquiry as the research approach. The findings are divided into two chapters: Chapter 4 presents thematic analysis of two participants' interviews while Chapter 5 conducts dialogic analysis of the remaining three participants' interviews. The penultimate chapter is a discussion of the findings and relates them to literature on professional identity. The final chapter indicates the conclusions and implications from the study. All of this is prefaced with a substantive literature review on professional identity in order to elucidate why HV professional identity is an area that warrants further exploration. This is the subject of the next chapter.

Chapter Two: Literature Review

Introduction

This chapter begins by briefly exploring the concept of identity and how it relates to professional identity (PI) and how PI is defined, before focussing on identity development in the nursing profession and the particular role that education and practice appear to play in facilitating PI. This is followed by a discussion on transition and role change and the potential impact these may have on PI. The penultimate section focuses on the PI of HVs, exploring how PI develops and the impact of previous experience as a nurse or midwife. Finally, what is known about student HV PI is examined to set the context for this study.

Identity

Identity is a complex concept with plentiful evidence that it is, at least in part, culturally constituted and variegated and thus it is not amenable to a simple definition (Lawler 2014). Exploring identity per se is beyond the scope of this review. Different disciplinary perspectives generate different accounts of identity but perhaps most instructive for our purposes is Lawler's (2014) sociological approach which predicates that identity has three elements: how individuals are similar to each other; how they differ and how they identify with other individuals. According to this sociological account, identity is a process rather than a definable entity (Muir and Wetherall 2010).

Identity has different features, for example the individual's self-concept or how others view them or the roles they fulfil; all of these are different aspects of identity and are equally important (Lawler 2014). This pluralistic view is shared by Baldwin (2008) who asserts that identity is a multi-faceted part of an individual's life, which is difficult to clearly explain or define.

Of course, identity can equally be examined via a philosophical, or psychological approach (Lawler 2014). From the former identity focuses on what makes an individual unique and how identity is maintained throughout life, despite significant changes (Solberger 2013).This approach seems less relevant to this review as the emphasis is on what makes an individual distinctive rather how they view themselves

and how they engage with others. In contrast psychological theories (Baxter 2011) emphasise how individual perceptions are relevant (Baldwin 2008). One of the most influential psychological theories was that of Erikson (1956) who focuses on an individual's identity developing through achieving developmental stages as part of their lifespan. Other influential theories include Tajfel (1982) who takes a social psychological approach concentrating on the impact of groups on identity. He stresses that identity links to identifiable social attributes and this approach has been used in relation to occupations (Iwasaki et al 2018) and choice of profession may link to core attributes of identity (Kroger and Marcia 2011).

Within psychology there are several contrasting approaches to identity including the debate about the difference between self-concept and identity. Johnson (et al 2012) conducted an integrative literature review exploring the relationship between nursing PI and self-concept to determine whether a PI pathway could be identified that would influence PI throughout nurses careers. Their analysis suggested that self-concept combines self-confidence, self-awareness and self-worth but excludes self-esteem as this is more about emotional evaluation as opposed to knowledge of self. They further argue that self-concept and identity are two separate constructs, but both need to be understood as they are intertwined (Johnson et al 2012). However, in much of the literature the terms are used interchangeably even within the same paper as highlighted by Ten Hoeve et al (2014) in their review of notions of identity among a professional group. The preceding discussion reinforces that understanding identity is complex, yet the emergent distinction between identity and self-concept is instructive; in this literature review the focus is on identity as opposed to self-concept.

The sociological approach to identity has centred around defined categories such as gender, race, social class and age groups (Baldwin 2008). This view recognises that individuals socially construct their identities but from pre-signified and culturally shared attitudes, behaviours and patterns; but the focus is on society rather than the individual. Lawler (2014) suggests that many of the psychological theories can simultaneously embrace a sociological perspective, for example the focus on constructing identity through narratives. Sociological approaches emphasise the collective view of identity, not the impact the individual has on their own identity - a

view that has more in common with Tajfel (1982) than Erikson (1956). Nevertheless, Muir and Wetherall (2010) assert that identity is always formed by our own actions and through our interaction with others, arguing that both psychological and sociological approaches to understanding identity are required. This combined approach is particularly appropriate when thinking about PI as outlined below.

Professional Identity

Before thinking about the phenomenon of PI it is essential to explore briefly what it means to be a professional. Newsome and Langley (2014) suggest that there are four constituent characteristics of a profession: education, self-determination, status, and discipline. Furthermore, it is suggested by Andrew (2012) that having an identified body of knowledge is also key for PI formation. Yam (2004) suggests the following components as specific to nursing: theoretical knowledge; specialist expertise; commitment to serve; autonomy; an ethical code and professional accreditation and a combined personal and PI. However, in a review of the literature pertaining to public sector professionals, Baxter (2011) suggested that there are five slightly different key elements that need to be included in order to be considered as a professional: having a professional body; a code of ethics; continuing accreditation; operational standards and a sense of being part of the profession or a PI. These criteria differ slightly from those predicated by Yam (2004) who includes serving others which may not always be relevant. Baxter (2011) is more inclusive than Newsome and Langley (2014) and emphasises the importance of PI being essential for being a professional. Noble et al (2014) concur with this view. Baxter's (2011) focus excludes health care and yet, these criteria appear apposite for this study having greater currency than Yam (2004) and being more comprehensive than Newsome and Langley (2014). These studies suggest that the task of defining 'a professional' and 'professional identity' are related but ultimately separate endeavours. However, Crigger and Godfrey (2014) suggest that professionalism is another aspect of PI which relates to understanding and internalising professional values. In contrast Wiles (2013) suggests identity and professionalism are separate, but indicates PI has two components: the identity of the professional group or 'brand' and that of the individual within the group. In this study the focus will be on both as opposed to professionalism, but it recognises that they are related.

Awareness of these competing definitions of ‘professional’ and PI is essential for this study as is understanding how PI differs from ‘occupational identity’. Occupational identity is a conscious awareness of oneself as a worker and links to our perceptions and views of ourselves in a given role. It is influenced by significant others and can influence career choices (Skorikov and Vondracek 2011). Occupational identity links to who one is and who one wishes to become and is intrinsically related to an individual’s self-concept and developmental tasks (Thomas et al 2017) rather than the profession as a group which is the focus in PI. Therefore, in this study the focus is on PI rather than occupational identity.

The next section identifies why PI is important in a range of professions and the impact it can have on outcomes. Baxter (2011) in her literature review of PI in the public sector suggests that a disjointed PI leads to low motivation of staff, less effective roles, more attrition and ultimately less public confidence. In medicine Monrouxe (2010) suggests PI affects professional cohesiveness and effectiveness PI can also impact on retention to a profession. Conversely, where the PI of a specific profession is ill defined, fewer applicants seek to enter that profession (Grainger and Bolan 2006, Baldwin 2008). All these reasons indicate that understanding and recognising a profession’s identity is important for that profession’s future.

Like individual identity, PI would appear to be a combination of an individual’s qualities and a social discourse that influences and impinges on the individual (Dahl et al 2014). It is based on characteristics that link an individual to one group whilst differentiating members from another (Dahl and Clancy 2015). These characteristics are based on biological, psychological and social processes (Erikson 1956). Baxter (2011) following her review of the public sector PI literature, supports the combination approach suggesting that PI can be viewed as a trajectory melding the personal and the professional, a view to some extent anticipated by Muir and Wetherall (2010) who argue that distinguishing between personal and PI is arbitrary as identity is always about ourselves and where we are.

Moreover, Peel (2005) suggests that individuals can inhabit more than one PI, giving the example of a teacher who may see themselves as a teacher and a researcher and further suggests in order to arrogate both identities to them self, there must be interaction between personal and professional identities. Monrouxe (2010) supports this view and suggests that it is through relationships that identities are synergised. PI is forged through sharing a common history and engaging with a common language, practices and traditions (Andrew et al 2014). Baldwin (2008) suggests that PI links very much to professional socialisation, explaining that an individual will become part of a professional group by adapting to and accepting the way things are done in organisations. It is through socialisation that individuals learn the knowledge, skills and values of the profession, helping to form a cohesive group identity. Professional socialisation can be viewed as a dynamic proactive process rather than reactive and is influenced by experience as well as by education (Howkins and Ewens 1999, Monrouxe 2010).

However, King and Ross (2004) suggest that identity is not fixed by being part of a group, rather it is an ongoing process that develops with every social encounter and that identity links closely to an individual's role. They go on to state that identity is constrained by the history and social expectations of the profession, suggesting identity links closely to the values of the profession. Furthermore, they indicate that two professionals in the same profession may have a very different view of PI, but key constructs will remain part of their PI (King and Ross 2004). Again, this highlights the complexity of both identity and PI.

Professional Identity in Nursing

The focus of this study is the professional identity of health visiting students. That this is an under-researched area is illustrated by the markedly low number of results concerned when one conducts a search of CINHAL within the date parameters 1990-2019 using the key terms 'professional identity' and 'student health visitors' or 'student public health nurses' or student primary health visitor'. Such a search retrieved only two studies that related to the key focus of this study. The search was repeated in Pubmed and this produced 29 studies the two identified from CINHAL and 27 others which after reading their abstracts were discarded as

irrelevant. Further searches were conducted and extended by removing 'students' as a term in CINAHL and Pubmed and instead using the keywords-'professional identity' and 'health visiting' or 'Health Visitors' or 'primary health visitor' or 'home visiting' or 'community health nursing'. Searches within the date parameters 1990-2019 produced 39 articles in total; abstracts were read and 14 of the studies were found to be relevant. Another search using the key terms 'Professional identity' and 'health visiting' or 'Health Visitors' or 'Public Health Nurse' found 19 articles, 8 of which were relevant, but these were all replicas of articles from the first search. Inclusion criteria were that the studies should be written in English and explicitly link to the PI of health visitors or Public Health Nurses (PHN) . Very few of the studies relate to the UK but there are some studies exploring the PI of PHN in other countries.

PI in nursing is often contested, possibly due to an outdated view of the nurse as a "jack of all trades" with no specific skills (Hurley 2009:385). However, nursing does meet Baxter's (2011) five key elements and has arguably undergone considerable professional formation and development over the last three decades. Interestingly, Andrew (2012) suggests nursing does not have recourse to a specific body of knowledge because nursing is still influenced by medicine. However, I dispute this and suggest that the developments in nursing research and education during the last thirty years illustrate that nursing does have a very specific body of knowledge that influences practice. Another key issue for consideration in relation to being a professional is that of Autonomy. Eraut (1994) in his seminal work on developing professional competence asserts that autonomy is part of accountability but for professionals in the public sector it is often challenging due to the dual level of autonomy that is required. Nurses have an autonomous professional body that defines competence and is generally effective in maintaining standards. However, nurses themselves need to have autonomy to deliver services taking into account the needs of patients, best evidence and their professional judgment. This level of autonomy is often tested by policy and procedures and without this it is difficult to be a professional. Furthermore, another difficulty with regarding nursing as a profession is the dispute about the key concepts of nursing - while there was arguably a longstanding consensus that the one agreed central component or guiding principle was the notion of providing care, even this is now contested and in some cases

devalued due to diversification in the nurse's actual roles with more emphasis on leadership and performativity and less on actual care (Scholes 2008, Scott 2008). In a study conducted among student nurses by Cowin and Johnson (2011) caring was not seen as a predominant quality by the nurses but Browne et al (2018) in a study involving Australian student nurses contest this assertion stating caring is seen as an essential quality. Moreover, the UK Nursing and Midwifery standards comprise seven key components, five of which are linked specifically to caring (NMC 2019) which suggests caring is deemed integral by its professional body. The lack of agreement as to the professional roles and responsibilities of the nurse makes it more difficult for PI to be maintained due to different roles and social expectations and practices (King and Ross 2004, Andrew 2014).

Therefore, from a nursing perspective, defining PI is a complex endeavour with any proffered definition likely to be provisional and tentative. Nevertheless, a helpful definition is:

> professional identity is conceptualized as having a direct linkage to everyday nursing practice. Professional identity refers to a nurse's conception of what it means to be and act as a nurse; that is, it represents her/his philosophy of nursing. (Fagermoen 1997: 435).

While this definition is of value in relating identity to nursing practice, its focus is solely individual, neglecting the question of how far socialisation might also impact on identity factors. Wilson et al (2013) supply this missing dimension in focusing on the role of socialisation and characterising PI as the combination of personal factors '...social relationships and organizational and institutional structures...' (Wilson et al 2013:370). A combination of the two definitions is supported by a recent integrative review (Rasmussen et al 2018) where it is suggested that PI is composed of three elements: self - who you are; role - what you do and context - where you do it; echoing Lawler's (2014) earlier assertions. Rasmussen et al (2018) indicate that alignment of the three elements leads to a durable PI, misalignment can lead to stress and frustration. This definition, in illustrating the complex nature of PI, most closely reflects the assumptions of the present study and is favoured as the working definition of the concept in the chapters that follow.

However, there is good reason to advocate for the wider recognition and understanding of nurse PI since there is increasing evidence that a cohesive and developed sense of PI improves how nurses feel about themselves and correlates with improved patient care in terms of performativity, interaction and the care environment. It is also suggested that a cohesive PI connects to improved retention and job satisfaction (Grainger and Bolan 2006, Johnson et al 2012, Ashby et al 2013, Larson et al 2013, Arreciado Marañón and Isla Pera 2015, Traynor and Buss 2016, Rasmussen et al 2018, Clements et al 2016).

The evidence supporting these assertions is taken from a range of individual studies and integrative literature reviews. The studies are either qualitative studies with small numbers of participants or surveys. However, since the concept of professional identity is very personal a preponderance of qualitative studies is to be expected and appropriate. The evidence is strengthened by the agreement between the studies and with the integrative reviews. Examples are expanded upon below.

It is proposed that PI is important because it supports the ideals of a profession and in the case of healthcare professionals it is suggested it leads to quality care (Hensel 2013). Horton et al (2007) explored quality of care and the value of nursing in an integrative literature review of 32 studies from across the globe. They concluded that understanding the value of nursing would lead to a cohesive workforce which they thought would impact on patient care but this finding was not definitive. Although this is now a relatively old review it is used by Johnson et al (2012) to support a similar point. The relationship between understanding nursing and quality patient care was emphasised by Bjorkstom et al (2008) who conducted a longitudinal study of 163 student nurses using a validated questionnaire over a 3-5 year period to measure the student's view of their professional self, thereby linking to their professional identify. Results from this study indicated that the participants rated themselves highly in relation to their self-concept and PI as a nurse. They thought these were important for good performance as a nurse including quality patient care. However, the study was limited by only 67 of the 163 participants completing all three questionnaires over the study period and by the links to patient care not being objective.

In a slightly more recent study Hensel (2013) states PI promotes the ideals of the profession and links to quality care. She carried out a mixed method study with 36 student nurses in North America. The study explored the students' attitudes towards nursing by measuring their ideas against predetermined criteria. The majority of the students demonstrated intent to provide quality care and this connected to their understanding of their PI but this does not demonstrate that they would carry out high quality care. It did however demonstrate that their understanding of what it means to be a nurse and their PI influenced how they behaved. In an earlier study Hensel (2011) administered a questionnaire about health and lifestyle to over 300 qualified mid-career nurses at three hospitals in the Midwest of North America and found that those who had a healthy lifestyle and positive view of themselves as a nurse thought they provided better patient care again suggesting that quality of care is influenced by nurses attitudes and expectations. However, there were 450 potential participants and only 132 nurses responded to the questionnaire, which could indicate bias and the results showed the nurses thought they provided better care; there were no external arbiters of this. Rasmussen et al (2018) conducted an integrative literature review focussing on the perceptions of nurses about their PI. This review had a reproducible search strategy and clear inclusion criteria and it supports Hensel's (2011) findings asserting that how individuals view themselves impacts on their PI which impacts on how they behave.

Moreover, it is suggested that a cohesive PI supports student nurse retention, with a strong commitment to the profession increasing the likelihood of remaining in nursing (Clements et al 2016). These findings are from a survey of students across 17 UK HEIs (171 students) supported by semi structured interviews with 9 students. The focus in this study was on their perceptions of their educational experience and their commitment to nursing. The results suggested that commitment to nursing was important for success alongside developing their professional identity. They felt clinical placements were key for this and positive experience in the clinical area helped them to consolidate what it means to be a nurse and to feel positive about nursing and this increased their desire to stay in the profession. However, the study recognised that sometimes negative practice experiences had a damaging impact on both how they felt about themselves and nursing. This was a small study but the use of a survey together with the semi structured interviews enhances its credibility.

Furthermore, it is supported by the results of Arreciado Marañón and Isla Pera's (2015) qualitative ethnographic study. This took place over a four month period using participant observation with 23 student nurses in a public hospital in Spain. They found that student nurses developed their understanding of professional reality through clinical placements. This helped the students to understand their role, supported identity development and increased their commitment to nursing. Although this was a small study with a short period of observation the findings aligned with those of Clements et al (2016).

Retention of qualified nurses has also been shown to be influenced by their PI. Cowin et al (2008) carried out a cross sectional study of 528 nurses in Australia to assess links between Self-concept, job satisfaction and retention. The nurses completed two postal questionnaires over an eight-month period. This study found that there was an identified link between positive self-concept and intention to remain in nursing and suggested professional development to increase the individual's positive image of nursing was important. However, the study did not explicitly mention PI and was limited by the response rate of the participants for the second study which was only 332. The findings were expanded upon in a large cross-sectional study of 2,012 qualified nurses in Turkey (Sabanciogullari and Dogan 2015). Data were gathered by three questionnaires, two of which were validated by previous research, to assess the relationship between job satisfaction, intention to leave and PI. The results found a strong correlation between job satisfaction, intention to leave nursing and PI. The authors concluded that those with a strong sense of PI were committed to the nursing profession and that this positively affected their job satisfaction. They found that, in order to retain nurses in their role, PI needed to be fostered, suggesting that professional development programmes can help with this, thus highlighting the role of the employing organisation in PI. However, generalisability of this study was limited by the population being only 2.8% of the nursing population in Turkey and by the questions on intention to leave not being part of a validated questionnaire. The authors suggested that qualitative studies might be more effective in determining individuals' views of their situation. Again Rasmussen et al (2018) supports these findings suggesting that a cohesive PI needs nurse to feel positive about themselves and their role and for organisations to support them in this endeavour.

Furthermore, Johnson et al (2012) suggest that the key consideration in PI development is that it is built over time and links to interpersonal relationships. Johnson et al (2012) go on to suggest that there is a recognised pathway for PI formation: starting prior to joining educational programmes; ongoing through education and clinical experience; and continuing throughout an individual's career. Johnson et al (2012) further suggest that the pathway links to individual values. Moreover, Clements et al (2016) suggest personal and professional values meld as PI is established.

Baxter (2011) concurs that there is a process but suggests that there are five stages that individuals undertake before attaining full PI. She suggests developing PI begins before entering the profession as individuals consider the social view of the chosen profession. The next stage is being selected for professional training and then completing it, followed by learning in post-registration placements and finally undertaking continuous professional development. It is only at this point that the arrogation of PI to an individual is deemed to be complete. These stages are moreover informed by the formal curriculum which is the advertised curriculum, the informal curriculum or life experience and the hidden curriculum for example the political context and hidden assumptions of the profession (Baxter 2011). Importantly, identity builds over time, and there can be multiple professional identities, but PI may not be the most prevalent aspect of individual identity, however individual and PI are linked (Baxter 2011, Johnson et al 2012).

Role of Education

Exploring how professional education informs PI is an important step towards understanding PI overall (National League for Nursing (NLFN) 2010, Baxter 2011, Johnson et al 2012). In a range of different professions PI is considered to be the core focus of professional education: Monrouxe (2010) in medicine; Noble et al (2014) in pharmacy; Wiles (2013) in social work; Beauchamp and Thomas (2009) in teacher education. Shahidi et al (2014) likewise view PI development as one of the main functions of nursing education. Crigger and Godfrey (2014) concur and moreover suggest that discussion of PI should be explicit in the nursing curriculum.

Both Johnson et al (2012) and Arreciado Marañón and Isla Pera (2015) suggest from their respective analysis of studies and own research that it is during initial education that identity starts to develop, however, Sims (2011) suggests that identity is also influenced by what happened prior to commencing education and is linked to experience and exposure. Baldwin (2008) asserts that it is through socialisation, training and introduction to conceptual frameworks that individuals develop the characteristics of the profession and these link to identity. In nursing, professional education takes place in both HEIs and in practice. However, it must not be forgotten that nursing students hold their own values and beliefs before they enter a programme and some of these may be unrealistic and may clash with values through the programme (Sims 2011, Johnson et al 2012, Browne et al 2018). In the USA, the NLFN's (2010) view that developing a clear PI is an important part of being a nurse, finds reflection as an explicit component of all nursing curricula (Hensel 2013). In the UK the NMC (2015: 10) indicates that "supporting students' and 'colleagues' learning to help them develop their professional competence and confidence" is also a vital part of nurse education.

Since UK nurse education takes place in HEIs, it is imperative to understand the role of HEIs in the development of PI. In their review of twenty studies across a range of professions Trede et al (2012) conclude that HEIs help individuals to learn what their professional roles are, how workplaces operate and begin the process of professional socialisation. The review authors sought to answer the question of what PI is, finding that agreed definitions were scarce but establishing agreement that identity included a variety of notions including: technical skills; professional knowledge; professional judgment; critical reasoning; understanding of responsibilities; reflection and an awareness of professional values. In similar terms to those presented by Johnson et al (2012), PI was seen as 'a way of being and a lens to evaluate, learn and make sense of practice'. (Trede et al 2012:374). The study further reported that PI appeared to develop through individual reflection and through transformational learning following experience, suggesting that PI is formulated by internal and external factors, and it is not something that is assigned (Trede et al 2012). Negative experiences were seen as an essential part of development, in helping students to develop their own view (Trede et al 2012). Socialisation in the workplace was also seen as a crucial factor in developing identity

and helped with reconciling personal and professional values. Universities help with this through making the links between theory and practice and supporting transformative learning which facilitates the development of PI (Trede et al 2012). Assessment was also viewed as essential to help students develop social, critical, personal and professional aspects of PI. Bramming (2007) argues that universities' main role is to maintain standards through assessment but acknowledges that the development of identity through transformative learning and engagement with the process is additionally fundamental.

Trede et al (2012) further suggested that PI formation is complex because it requires students to be part of both a higher education setting and a practice setting. Learning in both settings needs to be transformative and to help students become self-aware. However, the review authors intimate that developing PI is an individual learning process and it requires students to engage with troublesome knowledge (Clouder 2005) where they are undergoing a transformational process and developing their knowledge so that it becomes trouble free; this process influences PI. Importantly Trede et al (2012) stress that there are no specific or obvious principles for developing PI that are generic; development is profession specific, but they conclude that one of the main issues is the poor articulation of exactly what PI entails.

Education can be seen as being key in developing PI as knowledge develops and students have opportunities to learn from role models (Johnson et al 2012). As stated previously, having a cohesive PI helps with retention and recruitment; universities could help with this by focussing on developing PI explicitly and curricula could identify differences between professions and enable students to socialise within their profession (Monrouxe 2010). Explicit programmes to develop nurse PI have been incorporated into some initial nurse education in the United States (Crigger and Godfrey 2014); similar notions are addressed in some medical curricula in the UK (Monrouxe 2010).

Professional Identity in Practice

Development of PI also takes place in practice placements as illustrated by an Australian study of 159 student nurses. Here, Walker et al (2014) found that being

part of a group of nurses in placement promoted identity formation. Five key elements were found to influence identity formation: positive role models, leading to an understanding of what it is to be a nurse; belonging and being accepted as part of the team; peer support; critical thinking skills and increasing confidence particularly in relation to developing non-judgmental attitudes (Walker et al 2014). Identity formation was found to be a process with the students keen to align themselves with colleagues and support was critical for identity to develop and the essential role of socialisation was highlighted, supporting the findings of Johnson et al (2012) who suggested creating communities of practice in placements enables students to learn. Wiles (2013) concurs, suggesting that being in practice enables the normative development of PI through the formation of a community of practice. Grainger and Bolan (2006) highlight that negative experiences in practice can lead to dissonance in identity, especially if the experience in practice does not fulfil expectations, however, positive experiences, especially when supported by positive relationships, cement PI. Furthermore, a small study in the UK found that peer support helped overall with developing confidence and knowledge leading to a feeling of belonging and enhanced PI (Green 2018).

However, Walker et al's (2014) study was limited by collecting data via an online questionnaire and by being carried out in one area of Australia but identifying these five aspects of identity means that students can be made aware of the process and supported more openly. Similarly, Green's (2018) study was confined to one area of the UK and focussed on learning disability nurses but the results appear relevant to a range of nurses.

The suggestion in the preceding discussion that PI is fluid rather than static and is influenced by education and practice, is further supported by Hurley (2009) who carried out a qualitative study focussing on how mental health nurses developed PI. Interviewing a purposive sample of 24 participants, Hurley (2009) found that the mental health nurses in the sample did not have a fixed identity rather they manifested several core constructions of identity that were affected by context and practice. The focus of this study was experience rather than education, but it helps with understanding of the complexity of PI in nursing. The comprehension of how PI develops has been further increased by research on different aspects of identity and

examining how other factors appear to influence it. For example, evidence suggests that PI can be challenged by change (Hurley 2009). In their research on the impact of interprofessional collaboration on PI King and Ross (2004) found that sustained change was one of the factors that affected identity and made different professionals adhere to their established identity and increased resistance to change and collaboration. Their results were based on evaluating two case studies of change in Health Trusts in Northern England. The authors concluded that recognising the importance of PI and working with different identities could significantly improve collaboration between professionals. However, as it only focussed on two case studies the application of this research is arguably limited. Further research has identified that PI is especially important in careers that have boundaries that change due to organisational factors: this is often the case in nursing as there are frequent changes in role (Slay and Smith 2011).

It has been demonstrated in this section that PI is a complex and diverse concept which would appear to be influenced by the individual's socialisation in practice and education and by transitions. The latter forms the substantive focus of the next section.

Role Transition and Professional Identity

One element of PI is one's formally constituted role. Thus, before considering the specific PI of HVs it is crucial to explore the literature around role transitions since these appear to have significant links to PI development. Successful role transition is viewed as essential in developing PI. Johnson et al (2012) highlight that graduation as a nurse is only part of developing identity; transition to practise is equally key and Johnson et al (2012) suggest that this is often not recognised leading to frustration and attrition in newly qualified nurses.

Role transition has been explored in detail in the nursing literature including in seminal works by Kramer (1974:4) where the term 'reality shock' was coined. This term has been used to indicate change involving an element of cognitive dissonance such as the disparity between the idealised world of schools of nursing and the reality of working on the wards as a newly qualified staff nurse. Further work by

Duchscher (2009:1105) found that newly qualified nurses experienced physical, intellectual, emotional and sociocultural/developmental challenges and she termed this ‘transition shock’. Over the years many interventions have been adopted to try and navigate this significant transition, ranging from formal programmes to the use of mentors and preceptors (Levett-Jones and Fitzgerald 2005). Transition is the way individuals respond to change over time (Kralik 2006). Part of a successful transition is building a sense of PI and feeling valued (Maxwell et al 2018).

Transitions can be positive and may have an end in sight, but the individual concerned must adapt (Hughes-Morris and Roberts 2017). However, Spoelstra and Robbins (2010) indicate that transition is a difficult process and having realistic expectations can ameliorate some of the challenges. Chick and Meleis (1986) outline four stages of transition: initial recognition of movement or change, a sense of disconnectedness linked to disruption, then a change in individuals’ perceptions of the situation and finally changes in patterns of behaviour. Further work by Duchscher (2012) explored the importance of transitions for nurses, suggesting that changes in role are similar to other life transitions and that transitions are a process and can be significant in supporting successful adjustment to new situations. However, during the process there is often distress and irritability and anxiety as well as a feeling of achievement at the end. Chick and Meleis (1986) go on to assert that although similarities can be found in transitions, they are not experienced in the same way by everyone but there are commonalities of entry, passage and exit. Links have been made between transition in educational terms and Benner’s (1984) accepted journey from novice to expert.

Much of the literature on transition from one role to another in nursing focuses on the transition from being a student to being a qualified nurse (Arrowsmith et al 2016). This literature highlights that change is stressful and anxiety provoking, further supporting earlier research which suggests that this change leads some students to leave the profession (Phillips et al 2013). In their research with newly qualified nurses starting work in community practice Maxwell et al (2018) highlighted the importance of developing confidence, being supported and feeling part of a team in developing PI. Deppoliti’s (2008) study of newly qualified nurses in hospitals in the

first three years offered the confirmatory findings that relationships are key to successful transitions.

The significance of the transition from working in acute hospitals to working in primary health care is explored by Ashley et al (2016) in an integrative literature review of eight studies examining the transition for a range of primary health care nurses. None of the study populations included HVs but their findings are significant. They found that there were a number of barriers and enablers to successful transition, including a reported lack of knowledge of primary care nursing from the undergraduate curriculum as well as the nurses' high expectations of themselves to be able to adapt to the new role due to their existing skills and relevant knowledge. Enablers included formal educational preparation for the new roles and support from peers. Initially the participants in all the studies examined reported that they were stressed by the change due to lack of confidence and familiarity with their role, but over time they reported that they were empowered by the change in role (Zurmehly 2007). Ashley et al (2016) concluded that the role transition for nurses moving from acute to primary care was like the experience of newly-graduated nurses taking their first post and was an important area for future research. Research by Andrew et al (2009) studied the transition from clinical nurse to nurse academic and highlighted that participants initially mourned their clinical role and felt deskilled. However, Andrew et al (2009) asserts that over time they accepted their dual identity and were able to recognise and utilise their transferable skills. Like Johnson et al (2012) the study by Andrew et al (2009) suggests communities of practice facilitated the change. Baldwin et al (2017) suggest that transition is a process of reconciling PI, balancing two professional identities and becoming an academic.

In a combined literature review of both quantitative and qualitative studies, Arrowsmith et al (2016) considered role transitions for both novice and experienced nurses. The review identified that for both groups transition was stressful and followed a similar pattern but that the experienced nurses appeared to cope better with transitions than the novices suggesting that transition was mediated by previous experience. Sullivan-Bentz et al (2010) carried out a study with 23 newly-qualified primary care nurses in Canada, following them through their first year in post after completion of a one-year post-qualifying course. For them the change in role was

also stressful but it followed a process outlined by Brown and Olshansky (1997) of four phases: laying the foundation; launching themselves; meeting the challenge and broadening perspectives. By the end of the first year they were confident practitioners seeking new challenges. However, five factors appeared to affect the transition: transition itself, context, policy, relationships, and education. Mentorship was key to a successful transition; organisational preparedness and support were also essential ensuring job descriptions were in place and supported by relevant policy (Sullivan-Bentz et al 2010). Another important factor was that other healthcare professionals needed to understand the role. In this study it was not always clear what the nurses were expected to do particularly in relation to working with physicians which made the transition complex and stressful. It was suggested that educational preparation needed to take account of transition by offering theoretical explanations and longer placements.

Hughes-Morris and Roberts (2017) reviewed the literature on transitions and role-changes before carrying out a study with students commencing a SCPHN programme to become HVs and School Nurses. The focus of the study was the impact on the individual of returning to student status after a period as a qualified nurse. From the literature Hughes-Morris and Roberts (2017) reported two key areas for consideration in transition, firstly the emotional effects of the student role, reported as lack of self-worth and decrease in self-esteem during the change but ending with a feeling of accomplishment. The second area of concern is the reported feeling of lack of value placed on their existing knowledge and skills by those with whom they were working. From their research Hughes-Morris and Roberts (2017) identified that students often felt uncomfortable at being watched and sometimes resented the fact that their previous experience was not recognised by colleagues and clients. They felt devalued if they were introduced as a student and found that they could cope better if they were introduced as a nurse who was undertaking further study. This finding could link to their PI although it is difficult to explore this point further as it was not the substantive focus of this study. Lack of autonomy was also an issue for many of the participants who reported that they felt frustrated by being unable to make decisions. Additionally, they identified that the change of role was challenging and left them feeling vulnerable. Furthermore, the students reported that the change in environment was an issue for some of them, changing from the

hospital setting to the community and entering client's homes for the first time was difficult for many of the participants. Interestingly this was not mentioned as an issue in Ashley et al's (2016) study.

Role transition is a difficult process; Benner (1984) suggests that change in clinical setting does have an impact on ability however, adapting to new roles involves a balance between role loss and role expansion (Holt 2008). Role transition is aided by having realistic expectations and is supported by specific programmes that can aid professional development as well as having an impact on PI. These considerations are particularly important during the transition from nursing student to Registered Nurse but also when nurses change areas of practice (Cleary et al 2009). Furthermore, Cleary et al (2009) suggest that educational programmes should be offered that support reflective practice, career development and attainment of professional goals to aid transition and change in role. For some of the participants in Hughes-Morris and Roberts' (2017) study these issues had not been fully addressed as the participants had not thought about the impact that completing the SCPHN programme and being a student would have on them as an individual.

Darvill et al (2014) conducted a study with newly qualified children's nurses who on qualification worked in the community with children. The study identified that the students went through three phases of transition: shadowing, the visits, and emerging identity.

Shadowing involved working closely with a preceptor and beginning to separate from their identity as a student nurse. If this period was successful, the students reported they were protected from clinical situations that were beyond their capabilities, but some students felt they were observed too closely and that their previous experience was not necessarily recognised echoing the findings of Hughes-Morris and Roberts (2017).

Visiting clients independently was seen as a key step by the students; timing for this was generally negotiated by the student and preceptor. When it was an agreed timeline it was found to be very positive and aided transition but if there was no agreement it was reported as adding to the students' stress and delayed the

transition process. This may link to the findings of Hughes-Morris and Roberts' (2017) study and the anxiety of visiting alone. Students reported feeling supported if they went from simple to complex visits linking to Benner's (1984) notion of development from novice to expert. They also need to adjust to the feeling of being on their own, away from the large institution of the hospital which involves a reassigning of power with clients.

Emerging Identity was the third phase of the transition; this related very much to working alone in the client's home which appeared to increase confidence and helped them to identify with being a community nurse. Meleis et al (2000) suggest that it is part of a successful transition for an individual to compare the current situation with the previous one as this helps with developing PI. For many participants this final phase involved them having to adapt to the rest of the team, learning about the team rules and hierarchy and their place within it (Darvill et al 2014). It seemed to take 12-14 months for the new graduates to feel they were experienced, and this was an important factor in both their transition and developing PI. Being able to relate their experiences to other team members was viewed as an integral part of developing their identity. The final element was being allocated their own caseload which helped them to feel they were community nurses. Overall, it appears that transitions and roles are closely linked to PI. Darvill et al (2014) indicate that a successful transition helps with the formation of PI. Successful transition includes support from an identified preceptor and team enabling key milestones to be completed supported by opportunities to make decisions about when milestones are achieved. Barriers to transition include lack of recognition of previous experience and unnecessary observation (Darvill et al 2014).

As the preceding discussion illustrates, development of PI is an ongoing process which changes throughout a nurse's career. Transition is a significant part of this and as suggested by Yuval-Davis (2006) resides in notions of being and becoming. Research has focused on understanding how PI develops for newly qualified nurses and identifying what happens at times of transition in order to be able to support nurses through change. However, less effort has been expended to understand what happens when qualified nurses change roles and the impact that this can have on their PI, but the studies that have been carried out in relation to change of role have

raised interesting points and need to be considered when moving forward to explore the PI of HVs.

Health Visitor's Professional Identity

As already explained research on the PI of HVs is scarce. However, there is some research on PI of PHN in other countries. Research on PI has established that recognition of the professional role by other professionals is key to developing a cohesive PI meaning that other professionals need to understand the role in order for an individual's PI to develop into a cohesive whole and influence their work (Adams 2013). Dahl and Clancy (2015) suggest that a unified PI can improve the quality of nursing work and is particularly important in public health nursing because of the changing context. They indicate that continuous changes threaten cohesive identity. Therefore, the focus of their Norwegian study was to understand PI through stories from practise during a time of change. They concluded that PHNs in Norway have an uncertain PI because the policy expectation is that their role focuses on primary prevention and health promotion and this is what they are educated for as generalists who can support families and refer them on. However, due to role constraints and an emphasis on following protocols their day-to-day work is concentrated on individual problem solving and secondary prevention, of which they have limited specialist knowledge. This contrasts with other public health professionals and their PI.

Similar debates have arisen in America where there is a long history of discussion regarding PHN, the nature of their role and the impact this has on their PI (Canales and Drevdahl 2014). It is suggested that there is an increasing need to train nurses who specialise in indirect care and take a population approach. However, the length of the ongoing debate has led to concerns being expressed that the different view of identity between the individuals and the employing organisations have resulted in losing the PI of PHN. Furthermore, the unresolved debate has led to a reduction in the number of institutions offering specific training for PHN (Canales and Drevdahl 2014).

In Japan PHNs are also post-registered nurses and have a separate licence to practise as distinct from general nurses. Recent research by Iwasaki et al (2018) suggested that the many changes that had taken place in the Japanese health care system and the impact that these have had on the role and scope of practice of PHNs had also impacted on their PI. They suggested that their PI had become unstable and that this was a significant issue because identity affects nursing practise. The changes in their role meant that PHNs were no longer responsible for an identified community but instead they worked either with specific age ranges or had an administrative role working with social services. These changes in role appear to have altered their identity. The researcher conducted single interviews with 24 PHNs who, when asked to reflect on their identity, reported being unsure about their identity and role. As there was only one interview each, this may have been a limitation of the study as there was possible recall bias.

In the UK HVs are registered nurses or midwives with additional post-qualification education (NMC 2004). The role shares some similarities with the roles of other PHNs worldwide, especially those in Norway. The history of health visiting and their current role has been rehearsed in the previous chapter, which showed that numerous changes within the role have arguably led to confusion about health visiting identity (Cowley 2007, Cowley et al 2015). A recent report by the iHV (2019:30) suggests that having 'A strong sense of professional identity is required...' to ensure HVs fulfil their role. As being a nurse or midwife is a prerequisite for becoming a HV, this previous identity may also have an impact on HV PI (Machin et al 2012).

UK research on HV PI is sparse; there is one study by Machin et al (2012) which focuses specifically on HV PI and, like the aforementioned study by Dahl and Clancy (2015), links to the HVs' role in a changing political and policy context. This was a grounded theory study aiming to produce a theory about role stability and included 17 participants from two separate trusts. This was a small study which took place during a time of change and this may have impacted on the number of participants who agreed to contribute. The focus on developing a theory about role stability may also have impacted on the amount of information elicited connected to HV perceptions about their PI. The key finding from this study was that role identity is

“influenced, through a self-referent feedback process, by: other health visitors; inter-professional colleagues; and local and national policies” (Machin et al 2012:1529). Furthermore, the study identified four key interrelated themes in relation to HV PI and these findings concur with those of Dahl and Clancy’s (2015) in Norway where the role of PHN is similar to that of HVs, in that this category of staff have a post-registration qualification and focus on children and families.

The first of the four themes, professional role in action, established that the HV role in the UK overlaps with other professionals in the team due to undertaking similar activities and having comparable knowledge. Furthermore, the participants' role identity was reinforced by feedback from other HVs. The second theme was professional role identity which emphasised that agreement was required as to what the role consists of and that understanding of the role was influenced by self-referential feedback from the HVs they worked with. In this study the consensus was that the role included: autonomy, home visiting and a universal service. However, there was also dispute among the participants about their public health role; child screening and the relationship to nursing. The latter caused debate among the participants with one reporting they ‘don’t necessarily want to be grouped as nurses, they want to be grouped as Health Visitors’ (Machin et al 2012:1532) whereas others felt that their links with nursing were a positive asset. This indicates that collective identity cannot be assumed.

The third theme, interprofessional working, suggested their role identity is influenced by other professionals, for example working with both GP’s and with others in public health. One participant stated that the essence of the role had been lost and it was difficult to articulate the unique nature of the role of HVs. The final theme was local micro systems for practise; the study established that the HVs had varying roles in the different trusts. Other important factors that influenced their view of the role and added to the lack of consensus about role identity of HVs were changes in national policy and the change in title from HV to SCPHN (NMC 2004).

Overall, the study suggested that lack of role consensus led to identity fragmentation and that differing expectations of the role impacted on individuals and affected the profession because there were no clear standards or role. These inconsistencies

made it difficult to work interprofessionally and the change of title may have caused interprofessional conflict further exacerbated by the variety of roles across the UK. Machin et al (2012) suggested that the identity confusion, if not addressed, would increase low morale at a time when strategies were being implemented to increase the numbers of HVs across the UK. These findings are relevant to the question posed in this study; however, the data was collected between 2002 and 2008 and the situation could have changed in the intervening years. Furthermore, it only compared the situation in two trusts but the theory that was generated does resonate with the historical situation in health visiting.

Another pertinent recent study is Whittaker et al's (2017) appreciative inquiry of the values of 22 qualified HVs and 17 students across two geographically diverse Health Care Trusts to ascertain the factors that affected recruitment and retention of HVs. The participants expressed an overall desire to make a difference, through prevention, to the children and families they worked with. Four identified themes underpinned this: the privilege of connecting with families at key points in their lives in their homes; working with others in the community; using existing knowledge, skills and experience as well as building on these to develop specialist knowledge and skills; and using professional autonomy to respond appropriately and flexibly to needs. This study emphasises the professional values of HVs and links to the 'orientation to practice' (Cowley et al 2015:474) which were outlined in the introduction. Although it is not explicitly about PI it is salient here because it indicates the core values of HVs and their relationship to PI. The core values are 'health creation, person-centredness and human ecology' (Whittaker et al 2017:355). Furthermore, the study also established that HVs and students wanted to work for an employer who shared their professional values.

Thus far in this chapter the focus has been on nurses. However, since 2004 direct entry midwives have been able to complete the SCPHN programme and become HVs (NMC 2004). Prior to 2004 only qualified nurses could access the then health visiting course. Jay et al 's (2016) research suggests that there has been an increase in the number of direct entry midwives becoming HVs. This has implications for the midwifery profession but also has implications for the midwives' views of themselves

and their PI. This is another under researched area with only one study examining this specifically (Jay, et al 2016).

However, there are several studies that explore midwives' professional identities. One such study by Hildingsson et al (2016) examined the role of midwives in Sweden, Australia and New Zealand and reported that midwives felt their PI had changed. This was particularly the case with the Australian respondents who felt they were no longer able to offer women-centred care and they felt their autonomy had been challenged. However, it is unclear whether these midwives were direct entrants or nurses as both are possible in Australia. In Sweden midwives are nurses first and in New Zealand they are direct entrants only. Research with a group of experienced midwives in Sweden suggested that the PI of midwives had been challenged by increases in technology and by the changing roles of other professionals as well as parents being better educated and more aware (Larsson et al 2009).

The only specific study of UK midwives who later qualified as HVs is by Jay et al (2016) who studied 23 direct entry midwives in the south of England. They found that many of the participants decided to become HVs because they felt burnout in midwifery and felt there were more opportunities to care for clients holistically and be more autonomous as HVs. The study reported that after completing their programme, half of the respondents viewed themselves as HVs rather than midwives and thus appeared to have shifted their dominant PI (Jay et al 2016). This was a unique study and indicated that the number of direct entry UK midwives becoming health visitors is increasing thus it is important to be aware of the issues.

Studies focussing on HV PI are rare, as are those that consider the PI of HV students and how or whether they change. This lack of data on the issue forms a principal rationale for this study. However, one aforementioned study was carried out in Norway (Hjalmhult 2009). In Norway PHN’s undergo a similar training to the UK, they are post registered nurses with at least one year’s experience of clinical practice who undertake a one-year course that combines university study with clinical practice working with a supervisor. This grounded theory study combined interviews and clinical journals. The results indicated that the students struggled with their PI,

initially feeling they had lost their identity as nurses and finding it hard to balance their new role with their previous one as a qualified nurse. The aim of this study was to develop a theory about how the PHN conquered operational space and worked to resolve their concerns. This focus meant that there was minimal emphasis on the student's perceptions. However the findings as explained below do relate to my current study.

Hjalmhult (2009) proposed that the students went through three phases during their training: *positioning,* where initial identity was misplaced and they were unsure what was expected of them, therefore they avoided participation due to being uncertain of their role; *involving*, where they took an active role but were constantly afraid of being monitored and assessed and getting something wrong; and finally *integratin*g to realise their potential and find a new PI. The students reported that they found the course exhausting and it was challenging both personally and professionally. However, by the end of their training they had recognised their potential as PHNs. These phases resonate with those proposed by Darvill et al (2014) in relation to nurses' changing role to work in the community.

Previous research in Ireland (Begley 2007) illustrated similar problems for post-registration students becoming children's nurses. The focus in this study is on role confusion rather than PI but Hjalmhult (2009) indicates that the two are linked. Begley (2007) highlights that the position of children's nurses is similar to that of post registration midwifery students in Ireland who perceived that years of previous experience as a nurse was often disregarded leading to stress and feelings of not being valued alongside a lack of status. This could be similar to health visiting students. In Begley's (2007) study, students reported that they coped by supporting each other, recognising the valuable role of social and emotional support. However, these students lamented the lack of support from some of the ward staff and unlike the PHN students in Hjalmhult's (2009) study they did not have an allocated mentor which they felt would have been valuable. Research in the UK stresses that CPTs have a significant impact on the developing PI of student HVs both through socialisation and support (Adams 2013).

Conclusions

This chapter has investigated the concept of identity and explained how PI differs from an individual's identity overall. The PI of nurses has been explored and the reasons why this is important for the profession has been articulated. The links between role transitions and PI have been examined with reference to pertinent literature. The PI of HVs as a group has been discussed and the relevant literature on the PI of student HVs has been critiqued. By doing this the context for the current study is provided and a gap in knowledge identified specifically the experiences of HVs navigating the development of their PI during their period of enrolment on a HV course. The following chapter outlines the methodology adopted in the present study's attempt to address this gap in knowledge.

Chapter Three: Methodology and Method

The purpose of this chapter is to explain the decisions made in relation to this study, justifying both the use of theory and the practical choices in the research. The chapter begins with a brief discussion of the conceptual framework including the use of Communities of Practice (CoP) as an educational theory and theoretical framework, followed by an explanation of the choice of topic, and a succinct justification for undertaking the research in the qualitative tradition. This is followed by consideration of the methodological approach, which is Narrative Inquiry (NI): this is explained and the rationale for the choice with reference to its comparative advantages over the other possible qualitative approaches of ethnography and phenomenology. Narrative inquiry was chosen as the methodology following a review of the literature and consideration of the question. Narrative inquiry was well placed to capture the process-based nature of evolving professional identity, recognising the role of experience in individual self-concepts and as such it seemed to be the most effective way of addressing the question posed. The philosophical assumptions underpinning narrative inquiry are interrogated by stating the ontological and epistemological position of narrative inquiry before moving onto an outline of the study design including genre of narrative inquiry, participant selection, question-design and researcher relationship with participants and trustworthiness. The rationale is provided for the study's multiple methods of data collection (field texts; interviews; reflections, field notes and autobiography) and an account provided of the different types of analysis available in narrative inquiry, the particular analytical two stage approach taken including the use of CoP as an analytical lens, and the ethical considerations which bear upon the study.

Methodology

Conceptual Framework

A conceptual framework acts as a guide to qualitative research and addresses a wide range of issues, which are inherent in the research. Ravitich and Mittenfelner Carl (2016) indicate that the framework combines the key aspects of the study

design and presents a rationale for why the study is required. This takes place throughout the present study but is of significance in this chapter where the research question, use of formal theory, methodology, methods and goals of the research are discussed.

Theoretical Framework-Communities of Practice

Theory is part of the conceptual framework. In Chapter Two we saw how Johnson et al (2012), Wiles (2013) and Andrew et al (2009) all report that the notion of Communities of Practice (CoP) can prove valuable in helping to understand how PI develops an assumption shared by this thesis and explained later in this section . CoP (Lave and Wenger 1991, Wenger 1998) is an established social participative learning theory that postulates that learning takes place in the workplace through interaction and forms part of authentic practice. It was introduced in the 1980s and challenged the view that learning was an individual pursuit, instead stating that participating in and developing relationships within the group fosters learning and knowledge development (Lave and Wenger 1991, Andrew et al 2009, Ranmuthugala et al 2011, Sayer 2014). In brief, situated learning grew out of dissatisfaction with the focus on learning as the individual transfer of knowledge from the expert to the novice (Woods et al 2016). Situated learning moved towards a reflexive approach to learning linking particularly to ways of knowing and professional identity (Woods et aal 2016). Learning in CoPs is transformative and focuses on the relationship between those with minimal experience ‘newcomers’ and those who were more experienced ‘oldtimers’ (Lave and Wenger 1991, Philip 2019). It is based on the key notion of Legitimate Peripheral Participation (LPP) which is the process of newcomers becoming old timers, highlighting that individuals begin at the periphery doing basic tasks and then develop their knowledge and expertise to become experts and part of the CoP and participate in it fully.

The theory was originally applied to explain knowledge exchange in management and business situations but has more recently been used in healthcare focusing on student education (Andrew 2009, Li 2009, Morley 2016, Molesworth 2017). The key

premise is that individuals begin in the periphery of a group and through experience and participation become established members of the CoP and as a result of this develop both their knowledge and identity through gradual understanding of roles and responsibilities (Wenger 1998).

Definitions of CoP have developed over time; Lave and Wenger (1981) and Wenger (1988) have used differing definitions which has provoked criticism from Fuller et al (2005) of lack of consistency. The definition utilised in my thesis is from Wenger's later work (Wenger et al 2002) which has a managerial rather than an educational focus. However, it clearly explains the concept and elucidates how CoP is viewed in this thesis:

> Communities of practice are groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis. (Wenger et al 2002 :4)

The variety of reasons for using CoPs and their purpose as well as effectiveness are debated (Ranmuthugala et al 2011). However, it is clear that CoPs do have three areas in common: they intend to facilitate learning; exchange information; and improve practice (Ranmuthugala et al 2011). CoPs were initially defined as having three key elements: joint enterprise; mutual engagement; and shared repertoire which were all interconnected (Wenger 1998). In nursing education, Morley (2016) suggested that joint enterprise is when groups work together to create local ownership of knowledge which enables mutual engagement and participative learning which leads to a shared repertoire. Morley's (2016) explanation chimes with how CoPs are viewed in this thesis.

The term CoP is used loosely in the healthcare literature referring to those who have geography or an area of interest in common (Woods et al 2016). In this thesis the focus is on those who have the experience of being a HV student in common and the three key elements alongside LPP are applied as a lens to understand the participants' journey. Wenger (1998) suggested that individuals join communities of learning, which should be identifiable, to increase their sense of belonging and develop their professional identity. Andrew et al (2009) suggested that CoP are an

excellent way of transmitting tacit knowledge and can help individuals develop their professional identity through social participation. Wenger (1998) highlighted that CoP can be long or short lived and formal or informal but they thrive through the commitment of their members and they can complement formal training programmes The purpose of a CoP is to support individuals in developing both new knowledge and the formation and maintenance of their professional identity.

There are a number of examples of where CoPs have been used successfully. Andrew et al (2009) found that a CoP worked well with new nursing academics and suggested they are a way of overcoming the theory/practice gap in nursing (Andrew et al 2014). Furthermore, Andrew et al (2014) argue that CoPs are an effective way of developing nursing as a profession by integrating academics and clinicians. Additionally, Johnson et al (2012) suggested that using Wenger's (1998) model would increase cooperation between students and clinical staff to create a positive learning environment that fosters learning and helps generate professional identity. CoP has been used in nurse education to consider how students become nurses, Molesworth (2017) demonstrated how using CoP as a framework could reduce feelings of being on the periphery or being marginalised in first placements. Furthermore, CoPs have been used to explore other aspects of nurse education. Philip et al (2019) used CoP as a lens to consider how the communication learning needs of overseas nurses in Australia could be addressed. These nurses were already qualified and a CoP was used to explore their transition through the use of legitimate peripheral participation. These examples are pertinent to illustrate how effective CoPs can be.

However CoP as a theory does have limitations. Wiles (2013) argued that one of the limitations is that the theory does not take account of the power differentials within a group, implying that CoPs are always positive is naïve. Power is briefly considered by Lave and Wenger (1991) in relation to LPP. They suggest joining a CoP can be empowering or disempowering and that newcomers can be a threat to old timers and existing members of a group may not always be supportive of new members and may not be willing to share new knowledge. This is not explored fully and CoPs are seen as stable. In relation to my study this could be an issue as there is a clear difference in power between the participants and the teams they work with, this is

exacerbated by the participants needing to be assessed as competent. Wenger (1998) does not address this. Moreover, another limitation of CoPs is that the literature does not appear to take account of the range of ways of working in organisations where one team may carry out their role in different ways to the accepted pattern or policy. This links to power and could be problematic for the participants in this study as they need to be assessed and pass their competencies.

Furthermore, Fuller et al (2005) criticise Lave and Wenger's (1991) notion of LPP for not taking account of newcomers who already have expertise in a different area and the impact this has on their participation. Again this could be an issue for the participants in my study as they are already qualified nurses and midwives. Philip et al (2019) found that not recognising existing experience could cause difficulties and might lead to marginalisation of the new members of the CoP rather than enabling them to be supported. Philip et al (2019) suggested that one of the key factors for success was clear communication with mentors and recognition of the experience of all parties and focusing on relationships These findings concur with Li et al (2009) who reviewed the evolution of CoPs and suggested the focus should be on developing supportive relationships as part of a CoP. The participants in my study had a relationship with their CPT and a mentor too. It is important that this relationship is supportive and meets the needs of all parties. Philip et al (2019) also suggested that newcomers moved back and forth in relation to participation depending on their level of confidence. This is not acknowledged by Lave and Wenger (1991) or Wenger (1998).

Terry et al (2020) in a systematic review of the literature relating to the use of CoPs in student nurse education suggested that marginalisation, alienation and frustration due to lack of understanding of their role were the key barriers to success in a CoP. For the participants in my study the latter could be an issue because of their change in role, meaning that they may not be clear what is expected of them leading to frustration which could impact on their learning.

On balance despite the criticisms of CoP I decided that it would be beneficial as a theoretical framework because of the links to identity as explained in the next section and because of the focus in CoPs on learning through socialisation.

Identity and Communities of Practice

Participating in a CoP results in shared learning and this learning also impacts on identity which Wenger (1998) proposes is both social and individual. Wenger's (1998) view of identity corresponds with my interpretation of identity that it is socially constructed but it also varies according to individual characteristics. Wenger (1998) recognised the complex nature of identity and he illustrates this via his social ecological model of identity, which I have chosen to use as an analytic lens. Wenger (1998) suggested that within a CoP identity is formed through participation and reification and that it is being a member of the community which influences identity recognising that both participation and non- participation are important factors in identity development. Wenger (1998) proposed that identity formation is an ongoing process that follows a flexible pathway focussing on becoming rather than being; identity develops through recognising who one identifies with. Wenger's views of identity are not specifically about PI, but he suggests: 'Identity is the lived experience of participation in specific communities' (1998:151).

Wenger (1998) indicates that participation and non-participation are a dichotomy in relation to forming identity and that both are of equal importance as they help to determine who is being identified with at both an individual and organisational level. Furthermore, he explains that identity is a result of competence within the CoP by which he means being able to practise within the CoP, suggesting that roles and responsibilities within the CoP will affect identity. However, Wenger (1998) indicates that an individual can belong to a few CoPs therefore identity is multifaceted. Nevertheless, belonging to more than one CoP can be challenging and may lead to conflict and possible changes in identity. Wenger highlighted that identity is complex and includes understanding of who we are and who we are not: 'coherent identity is of necessity a mixture of being in and out' (1998:165).

Wenger's social ecological model of identity formation goes beyond practising in a specific CoP (1998: passim). It includes three 'modes of belonging': engagement including active involvement in the CoP and recognition of wider history and negotiation of meanings; imagination comprising envisaging links between different elements of the CoP as well as images of the world and ourselves and alignment which focuses on recognising the broader structure and connecting with it to become part of a bigger picture. Alongside these three characteristics are two strands which influence identity formation: identification and negotiability.

Identification combines engagement, imagination and alignment along with participation and non-participation to influence becoming a member of a community (Wenger 1998). Negotiability is also required in identity construction; this is the ability to take responsibility for meanings (ideas, artefacts, policies and knowledge) within a social situation and to influence these meanings. Negotiability is also affected by participation and non-participation, which leads to 'ownership of meanings' either related to ideas or practice (Wenger 1998 passim). 'Ownership of meanings' is the degree that individuals affect or alter meanings and is influenced by their immediate community. The meanings are shared and have an impact on the local community whereas 'economies of meanings' are the organisation-wide sanctioned view of meanings which can be influenced by negotiation (Wenger 1998 passim). Therefore, identity is affected at two levels: individual understanding and interpretation of meanings and the organisation's understanding and interpretation (Wenger 1998). Meanings can change and individuals will interpret these based on their situation and their interpretation; this will in turn impact on identity. The final element of the model is structure. Wenger (1998) suggests that in order to develop identity, practice does not take place in a vacuum rather that structure influences identity either as a result of it emerging from practice or due to it being designed by an institution, therefore structure influences all aspects of identity and is not a separate element . In both cases it can and will influence identity. Interactions of the elements of the model are represented in Figure 2.

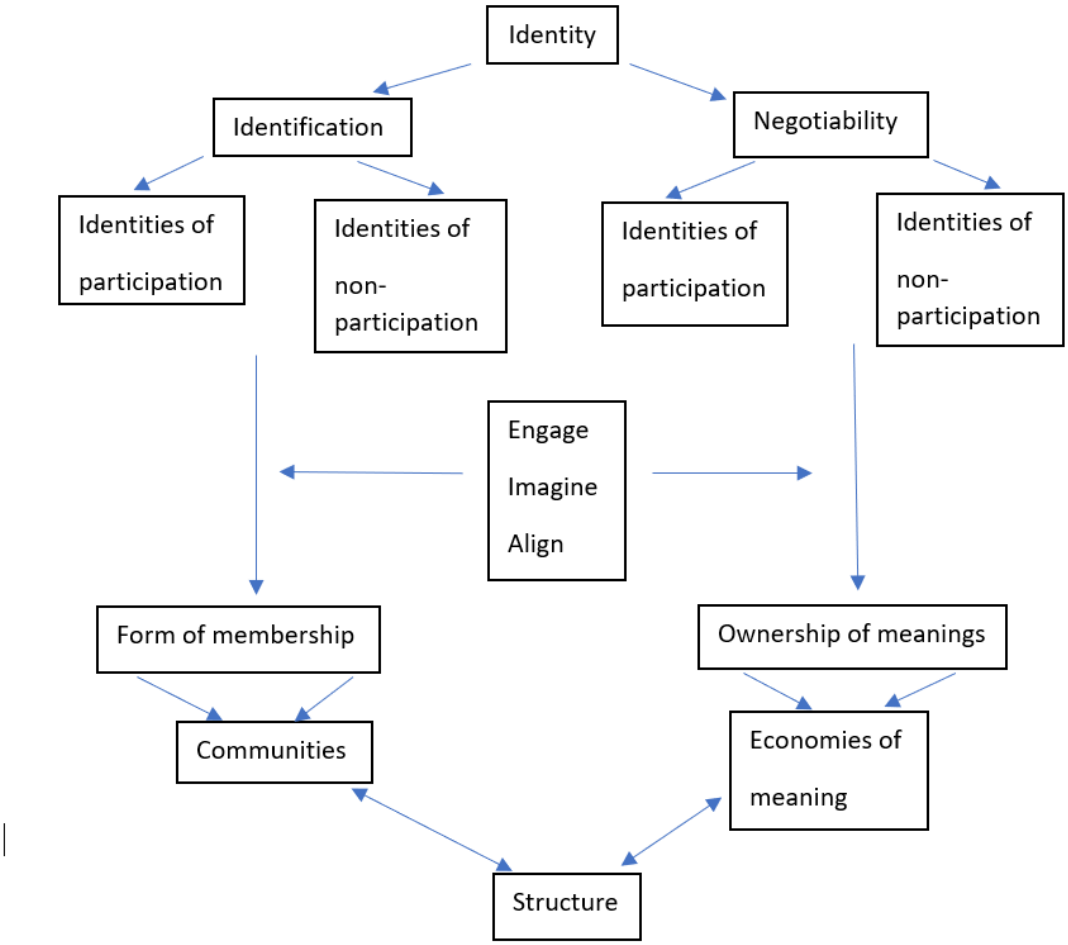

Figure 2 Social Ecology of identity - adapted from Wenger (1998)

This model is used as part of the thematic analysis to examine how the identity of two of the participants develops.

Research topic

The focus of this study was to explore student HVs' perceptions of their PI and the degree to which this was demonstrably influenced by their experience on a Higher Education SCPHN or HV course, exploring whether, in this instance, education can be said to have a discernible influence on identity. The research question was 'How do student health visitors perceive their professional identity?' The rationale for my

choice has been explained in Chapter One but in essence it was provoked by my experience as a student HV and by discussing the topic with colleagues and students. As a result of this and reviewing literature I realised that very little is known about the impact of PI on this professional group. This led me to explore the issue in order to be able to offer appropriate support to student HV's.

Qualitative or Quantitative Research

The debate about the respective merits of quantitative and qualitative research has to some extent been resolved in recent years and has been subsumed by the discussion regarding different paradigms (Crotty 1998). However, selecting the most appropriate approach is key for the success of any research project (Robson 2002). Crotty (1998) advises that when undertaking social research that focuses on social reality and social understandings, differentiating between the two approaches causes confusion and he suggests that it is only at the level of method that the distinction is relevant. However, other authors dispute this and indicate that distinguishing between the two approaches leads to greater clarity in research design (Cohen et al 2011). In contrast, Kelly (2018) suggests that viewing the different paradigms as a continuum rather than extremes aids understanding, a view supported by the recent increase in mixed methods research. In this study a qualitative approach has been utilised and the rationale for this is explained below.

Qualitative research focuses on phenomena in their natural setting and uses words to describe and explore issues, before interpreting them to facilitate understanding rather than using numbers to predict an outcome (Kim 2016). Another way of expressing this is that qualitative research is: 'inductive, emerging and shaped by the researcher's experience' (Creswell 2007:19).

Theoretical Perspective-Interpretivism

The theoretical perspective identifies 'how we know what we know' (Crotty 1998:8). There are a range of theoretical perspectives such as positivism, interpretivism and critical realism (Gray 2014). It is essential that the epistemology, theoretical perspective, methodology and method form a cohesive whole to ensure the research is sound and produces viable outcomes (Crotty 1998). Interpretivism aims to

broaden understanding of an issue or area with emphasis on understanding the individual perspective (Rasmussen 2016). Interpretivism is often closely linked to constructivism. There is ongoing ambiguity about the difference between them but they both favour qualitative interpretive methods (Crotty 1998). However, Gray (2011) suggests that interpretivism is the paradigm and constructivism is the theoretical perspective, Kelly et al (2018) dispute this view and purport both should be regarded as paradigms. In this study interpretivism was the paradigm rather than constructivism due to the focus on individual views and the understanding of the participants' experiences. Constructivism is more concerned with culture (Crotty, 1998). Epistemology and ontology are considered later in the chapter but the role of interpretivism is explored below.

Crotty (1998) indicated that different ways of viewing the world lead to different ways of researching the world so it is important to explore the assumptions underlying this perspective. Interpretivism advocates that the researcher shares the same frame of reference as the participants and is not objective (Cohen et al 2011). This is particularly important in this research project, as I had similar experiences to the participants due to my own experience of HV training. However, the experience being explored will be from the perspective of the participants and will be viewed as unique rather than being expected to be generalisable to other situations (Cohen et al 2011). The participants' experience was researched in their natural setting emphasising that each individual constructs their own reality rather than it being imposed on them (Byrne 2015, Gray 2014). Crotty (1998:67) summarises interpretivism as 'culturally derived and historically situated interpretations of the social life world'.

Choice of Methodological Approach

The recognition that qualitative research enables a deep understanding of social issues influenced its utilisation in this study. Notions of PI, and the exploration of perceptions and attitudes towards the influence of an educational intervention call for a qualitative approach which will be receptive to individual experiences and sufficiently nuanced to reflect qualitative variations in participants' views. Furthermore, the selected approach needed to be able to take account of the role of

my experience and be able to accommodate autobiography. The alignment of the research with the qualitative tradition was thus clear; what remained to be established was the particular qualitative methodology that was best placed to elicit this data and these distinctions. Therefore, a variety of qualitative approaches were considered and evaluated on philosophical and practical grounds: ethnography, phenomenology and NI.

Ethnography

Ethnography is used to study aspects of everyday life through spending time with participants in their environment. The focus is on behaviour, beliefs or language that are shared within a specific group examining how these are developed (Creswell 2013). Ethnography has been used previously to successfully explore PI. For example, Aagaard et al (2017) used ethnography to explore the PI of nurse anaesthetists in Denmark. The study concluded that these nurses' PI was complex and influenced by the views of other professionals as well as by the nurses' individual characteristics. Ethnography was appropriate in this instance because of the controlled technological environment of the operating theatre and depth was achieved through interviews. However, observing student HVs may not have been appropriate due to many of their interactions being in client's homes and Aagaard et al's (2017) study had a longer time frame for data collection than was feasible for this current study. Therefore, I decided against this approach.

Phenomenology

Phenomenology is both a research method and a philosophy (Flood 2010). Because of this it is essential to stipulate exactly how it could be used. A Heideggerian approach was considered to be apposite as interpretation of identity is key and the focus could be on the lived experience of the student HVs, trying to understand the essence of their experience (Creswell 2013). The idea of becoming is especially relevant to understanding their PI integrating knowing, acting and being (Dall'Alba 2009). However, phenomenology focuses on the phenomenon (professional identity) as it is rather than how it evolves (Lindsay 2006). In relation to student HV PI this approach may not have facilitated longitudinal exploration over the year-long course as the current study is very much focused on development.

Despite the suggested challenges of using phenomenology in this current study there are prior examples in the nursing literature of when this approach was used successfully. One such example is Standing's (2009) successful use of a Heideggerian approach over a longitudinal period. The focus in this study was on student nurses' experience of decision-making during their course. They were interviewed four times over a four-year period to explore their experience of decision making, alongside the interviews they kept a reflective diary and carried out critical incident analysis. This study utilised a larger cohort of students than would be feasible in my study and half of the participants left the study over the four-year period. Although phenomenology would have been an apt approach to exploring the topic of student HV PI it would have been complex and the small cohort of student HVs that were available would not have allowed for a high rate of attrition. Phenomenology would have permitted exploration of individual perspectives regarding identity and would not have focussed on producing generalisable results but there may have less focus on experience.

Narrative Inquiry

Narrative inquiry is a relatively recent addition to qualitative research. It emerged in the early 1990s and aims to assist in understanding varied phenomena from individual experience to social structure through the telling of stories (Kim 2016). However, although this is the basic premise it differs from other qualitative research genres in that it does not specify defined methods (Andrews, et al 2013); it is fluid rather than a set of procedures (Clandinin 2013). This causes difficulties in that there are numerous approaches within the genre and there is not always agreement about how it should be utilized (Andrews, et al 2013). However, Clandinin and Connelly (2000) highlight that narrative inquiry allows for the phenomenon (in my case, PI) to be seen as it evolves over time and that the focus is on understanding through utilising the Dewayan notion of experience (Clandidnin and Rosiek 2006). As the experience of student HVs is key in this study narrative inquiry seems thus to be an appropriate approach.

Narrative inquiry has been used in a cognate field – narrative inquiry was applied in a study that examined the professional resilience of Occupational Therapists (OTs) (Ashby et al 2013). The study took place with nine participants over a year. The participants were interviewed twice and it was established that an important factor in developing and sustaining resilience was PI. This was illustrated through individual stories of their experience over time. However, the findings indicate that the OTs' identity was often challenged because other professional groups did not understand their role. This study supports the choice of narrative inquiry being pertinent for exploring student HV identity, as the situation is comparable due to the role of HVs often being misunderstood.

Narrative Inquiry-Application

It is significant that Clandinin and Connelly (2002) highlight the role of narrative inquiry in helping to understand identity development through storytelling. However, it is important to note that encouraging storytelling can influence what participants say and encourage them to seek meaning and progress through their accounts; this could be considered as a limitation of this approach but as the focus is on striving to understand individual perceptions and experience it could also be an advantage (Kim 2016).

Telling stories is how we express who we are and what we know; storytelling allows individuals to broaden their experience and understand the experience of others (Kim 2016). Storytelling is used in a variety of professional contexts (Kim 2016). In this study stories are used to understand an educational experience. Clandinin and Connelly (1998) suggest that using stories enables individuals to organise their experiences and thus make meaning. Using narrative inquiry to understand the PI of the student HVs was reasoned to be the best choice of qualitative approach, as it would allow in-depth exploration of the topic area focussing on the student HV's experience.

Narrative Inquiry- Philosophical Underpinnings

Understanding of the philosophical and theoretical underpinnings of research helps researchers to answer their proposed questions in more depth (Kim 2016). However, novice researchers often consider theory to be a hindrance rather than a support. Ravitich and Mittenfelner Carl (2016) indicate that researchers should be clear about what theories underpin their work and that this is a significant part of the conceptual framework. Theory is only useful if it helps and is characterised by Kim (2016) to be a box of tools. Theory is a resource and can be used to help understand the phenomenon in question, explain what has happened and offer solutions (Rasmussen 2016). It can also be engaged with to help to develop the researcher's conceptual framework (Ravitich and Mittenfelner Carl 2016). Theory can be used to problematise an issue that is of concern to a researcher, as in the philosophy of education, and thus challenge preconceptions (Rasmussen 2016). Theory is used throughout this study to understand the phenomena of PI.

Furthermore, as researchers try to link theory to practice, they often engage with philosophy through engaging with paradigms, exploring ontology, epistemology and methodology. Crotty (1998) as outlined earlier proposes that only epistemology and methodology are significant in qualitative research. However, Creswell (2013) argues that ontology is a key facet of the conceptual framework of qualitative research as it concerns the nature of being. In relation to this study all three aspects will be considered.

Epistemology

The meaning of epistemology is contested; it is defined by Cohen et al (2011) as how we know about reality, whereas Gray (2014) suggests that epistemology focuses on what it means to know and can help with decisions about what is legitimate knowledge. Crotty (1998) is very specific in his definition of epistemology; he suggests it is the theory of knowledge and it is linked closely to the theoretical perspective and the methodology. A clear understanding of the chosen epistemology is essential because it enables the researcher to clarify the research design and what will work including the kind of evidence that is being acquired and where evidence will come from as well how it will be analysed (Gray 2014). For this study

the theory of knowledge subscribed to is that knowledge is socially constructed from stories (Byrne 2015). However, as a social entity, such knowledge is in turn influenced by the relationship between the researcher and participants. It is therefore co-constructed. There is no one reality; it is multifaceted, and it is influenced by time and place (Clandinin and Connelly 2000).

Ontology

Crotty (1998) asserts that ontology sits alongside epistemology. He defines ontology as the study of being and suggests that researchers sometimes confuse it with epistemology and use it inappropriately. He purports that it is more effective to focus on the epistemology and theoretical perspective. Other authors disagree; Cohen et al (2011) suggest that ontology comes first and epistemology follows and then methodological considerations can be addressed. The ontology of this study is based on Clandinin and Murphy's (2009) discussion of ontology in NI whereby the ontology is experiential and relational. Both the epistemology and ontology of this study utilise experience as the key construct and the study does not focus on presenting a true account of experience rather recognising that reality is 'relational temporal and continuous' (Clandinin and Murphy 2009:599). The ontology recognises that becoming is influenced by examining experiences and developing relationships and that these are continuous (Clandinin 2013).

For this study, this means that the attention was placed on developing a relationship with the participants during the time they undertook their HV course. The research will aim to understand their experience and with them develop new knowledge, which will change during the process of completing the programme. Clandinin (2013) stresses that NI is always relational, continuous and social in nature and it follows from this there are no single census points for measurement. However, in this instance, the extrinsic reference point of the HV course provides the time frame for the enquiry and for reaching at least provisional judgements regarding the influence of an educational experience on the development of PI.

Narrative Inquiry-Methodology

As a methodology, narrative inquiry is at the same time similar and different to other qualitative research approaches. As mentioned earlier, this is partly due to the variety of approaches within the genre but also because narrative inquiry is both the phenomenon and the methodology (Clandinin and Connelly 2000). It is a methodology that utilises relationships to understand experience but at the same time experience is being studied (Clandinin 2013). To facilitate this, narrative inquiry begins with the researcher's autobiographical story and considers how this links to the research question in this case, How do student health visitors perceive their professional identity? For me the link between autobiography and the research question is a key reason for choosing narrative inquiry as I have had the experience of undertaking a HV course on completion of which I felt that my PI had undergone substantive change, which I could confidently attribute to the programme as an educational intervention, largely independent of other variables. Clandinin (2013) asserts that as inquirers we are part of the story and our experience impacts on the story; we are part of the phenomenon that we are studying.

Definitions of narrative inquiry as a methodology vary but for the purpose of this study the definition that is being used is:

> Narrative inquiry is a way of understanding experience. It is collaboration between the researcher and participants, over time, in a place or a series of places and in social interaction with milieus. An inquirer enters this matrix in the midst and progresses in the same spirit (Clandinin and Connelly 2000 p20).

To use narrative inquiry as a methodology, Connelly and Clandinin (2006) suggest that the researcher needs to think narratively which involves being aware that NI takes place within a lifespace so inquirers need to be aware of everything that takes place in that lifespace, as this is where the lived experience occurs. Clandinin (2013) expands on the idea of thinking narratively and suggests that there are four key terms in NI linked to stories: living - everyone lives their own stories; telling - we all tell stories of our lives; retelling - this is when narrative inquirers come alongside individuals; and reliving – which grows out of exploration of the individual stories as the retelling changes the story, highlighting that stories are not fixed entities. Narrative inquiry can begin with telling stories through interviews or through 'coming alongside' individuals and participating in their lives (Clandinin 2013). Telling stories

is the more popular approach in narrative inquiry and is what will be adopted in this study, but it is important to recognise that part of thinking narratively is recognising that phenomena change throughout the study period.

Narrative inquirers need to embrace three commonplaces simultaneously and it is these that, in part, distinguish narrative inquiry from other methodologies (Connelly and Clandinin 2006, Clandinin and Huber 2010, Clandinin 2013). Commonplaces are interrelated elements that link to analysis and act as 'checkpoints' in narrative inquiry in relation to the inquirer and the respondent (Connelly and Clandinin 2006: 479). The first consideration is temporality. It is important to acknowledge that events are in temporal transition and that participants engaged in the process of NI will be reflecting on the past, discussing the present and exploring the future (Clandinin et al 2007). Sociality is also essential, recognising that the inquiry explores an individual's situation including their feelings, hopes and ambitions as well as the social situation including the conditions under which the experience is taking place and neither one is more important than the other (Kim 2016). Furthermore, the relationship between the inquirer and the participant is an important component of sociality (Clandinin et al 2007). Finally, place is an important consideration; NI occurs in a place and this has an impact on the inquiry, as experience does not take place in isolation because, as Clandinin (2013) indicates, all inquiries take place somewhere whether it be a country, region or an institution.

For this study, temporality was considered by asking the participants to talk about their experience during their health visiting course, but they were also asked to reflect on why they decided to take the programme and what they hoped to achieve in the future. Sociality is addressed through discussion of how they felt and the circumstances that surround their decisions to become a HV. My relationship with the participants is reflected on as part of this study through my reflective accounts and field notes. Finally, place is considered in relation to the university where their programme took place alongside their role in their employing organisation. These three areas will be explored throughout the interviews and I have discussed my experiences of them too through my reflections.

Method-Narrative Research Design

Narrative Inquiry Genres

Although the methodology of narrative inquiry is clear, Salmon and Riessman (2013) suggest, that, surprisingly, not enough narrative inquirers stipulate which genre or form of NI they are using. Kim (2016) also notes this omission but accepts that a researcher can legitimately be a narrative inquirer and not identify the specific genre in which the enquiry is pursued. However, Kim (2016) recommends that the inquirer identifies the genre or explains why none of the genres are relevant as identifying the form of the inquiry impacts on the data that is collected and highlights how NI differs from other qualitative research. Kim (2016) suggests there are three distinct genres: autobiographical inquiry including autobiography and auto ethnography; arts-based NI including literary-based and visual inquiry and biographical NI including Bildungsroman (a personal identity development story), oral history, life story and life history. All three have different purposes and Kim (2016) suggests it is acceptable to combine genres to address a proposed question. Furthermore, it is important to remember that participants might instinctively adopt one or more of the genres when recounting their thoughts.

In this study I have decided to combine autobiography and biography. Autobiography is not just a chronological account of an individual's life but also rather an exposition of inner thoughts and feelings in relation to situations that occur. Kim (2016) states that it can be a narrative discussion of identity, which explains how a life evolved. This is an important facet of this narrative inquiry as I have experienced the transition of PI from being a nurse and midwife to being a HV and have included my autobiography as data.

From the participants I wanted to reify their identity through the story of how they decided to become a HV and the experiences they had whilst undertaking the programme; the resulting accounts will likely align with the genre of biography but may not necessarily fit into any of Kim's (2016) categories of biography.

Question Development

Designing an effective research question is an essential part of the methodology as it acts as a guide for the study by identifying the gap that is going to be explored (Gray 2014). However, qualitative research questions are not definitive but rather evolve over time and may change throughout the study especially during analysis (Kim 2016). Qualitative research questions need to be focussed as they are examining the perspective of a small group of individuals in a particular situation. Kim (2016) suggests that in NI the question should always be mindful of context and should emphasise the story about what event and in which context. Clandinin and Connelly (2000) suggest that rather than working with questions, narrative inquirers should propose puzzles to be solved. The research question or puzzle for this study focuses on PI and whether or not it changes as a result of undertaking the health visiting programme leading therefore to the question - How do student health visitors perceive their professional identity? However, this assumes that the participants have a notion of their PI which may not be the case. The reason why I consider PI to be important is a combination of its personal and professional significance for me as an individual and as educator of HVs, and theoretical interest in the personal and social influences on the development of identity. It might also be of practical significance as it could impact on how the HV preparation course is delivered, especially as there are ongoing changes to HV education and it could lead to new knowledge about the importance of PI for role cohesion. The proposed research thus meets the tripartite justification for NI as expressed by Clandinin et al (2007): personally as explained earlier; practically in its potential to influence HV education and socially in its recognition of contemporaneous changes in the role and education of HVs.

The initial question was identified earlier in this chapter; alongside this there will be consideration of whether completing a HV programme influences PI in any way; although it may not be possible to differentiate between the impact of the course and other variables.

Sample and Participant Identification

As this study focused on student HVs' perceptions of their PI the sample is purposive. In qualitative research the function of the sample is to provide detailed

accounts of the phenomena under study (Ravitch and Mittenfelner Carl 2016). The appositeness of the term sample is sometimes contested as it is arguably reminiscent of quantitative research and evocative of this as the normative tradition, however purposive sampling can take many different formats. Clandinin and Connelly (2000) caution that the sample population must have the experience in order to be able to share their stories, therefore a purposive sample is the essential way of obtaining participants if the experience is relatively easily defined.

To qualify for inclusion in this study each participant needed to be either a qualified nurse or midwife who is undertaking a health visiting course. All of the student cohort who were starting the programme in a University in the South East of England were invited to participate in the study. There are over 40 validated HV courses in the UK, (NMC 2016) they all comply with the NMC standards (NMC 2004) however there are variations in delivery, but the content is similar. The full-time programme takes one year, and the students were invited to participate in three individual interviews during the year-long course. The students were invited in person by me. I attended one of their initial study days and gave them information about the study and left them an information sheet and invitation letter (Appendices A and B). I asked those who expressed an interest for their email address. I then contacted them and arranged to meet with them and obtain informed consent (Appendix C). Confidentiality and data storage ensuring that this complied with University policy (Oxford Brookes University 2017) and GDPR were also discussed, and the participants were asked if quotations from their interviews could be used in the final work with their names changed. This is significant in NI because samples are small and individuals might be recognised. Clandinin and Connelly (2000) suggest that the co-construction of the data can mitigate against participant concerns; Josselson (2007) recommends that attempts should be made to prevent recognition but agrees that sometimes it is inevitable and suggests that having an ethical attitude and respecting participants can prevent issues arising. Ethics is a consideration in design of narrative inquiries and is considered in more depth later in the chapter.

Sample size varies in qualitative research and different authors argue about the ideal number of participants. Beitin (2012) suggests 6-12 participants whereas Kvale (1996) suggests 15 or more. In NI sample sizes are often small; Clandinin and

Connelly (2000) suggest that two or three participants is an acceptable number and that it is not the number that is important rather the relevance of the participants and their experience.

There were 14 HV students on the course; they were divided into two cohorts, starting in September 2017 and January 2018. All 14 students were invited to participate and although 8 expressed an interest initially; only 5 responded to the emails I sent to arrange a meeting. The 5 who agreed to meet all signed the consent form and were keen to be involved.

Relationship with the Participants

NI requires the inquirer to develop a relationship with the participants (Clandinin and Connelly 2000) as the experience of both is essential to the inquiry. A starting premise of the approach is that it is not possible for the inquirer to distance themselves from the inquiry or to be objective and indeed, both researcher and participant should learn from being part of the inquiry (Pinnegar and Daynes 2007). Clandinin (2013) expands this notion explaining that in this approach, participants and researchers both become storytellers and develop a dynamic relationship leading to collaborative stories. These stories are the field texts or data that are used in the study; thus, it is important to remember that they cannot ever be objective (Clandinin and Connelly 2000). NI encourages participants to become co-researchers (Kim 2016) which supports the overall integrity of the research. I embraced this by sharing my experiences with the participants and developing a relationship with them over the year.

Trustworthiness in this study is maintained through detailed justifications of every stage of the study design, the rationale for the choice of methodology, selection of participants, the collection and analysis of the data are all explored in depth. Furthermore, as mentioned earlier data was stored in accordance with university policy and GDPR and will be destroyed after 10 years. Reflexivity is an essential component in NI (Mahoney 2007), as are notions of verisimilitude; authenticity and plausibility which are advocated by Clandinin and Connelly (2000) as ways of maintaining trustworthiness.

I needed to be able to explain my decisions throughout the study and keeping a regular research journal formed a key part of this using Brookfield's (2017) critical incident questions. These questions were initially devised to encourage reflexivity following teaching episodes. The questions were adapted to focus on the study. In addition, after each interview I reflected on the interview and my perceptions of it using the critical incident questions. These reflections are incorporated as part of the analysis.

Data Collection

While there are competing definitions of the nature and function of narratives (Polkinghorne 1988, Squire et al 2014, Kim 2016), the principal definition influencing this study is that the terms 'narrative' and 'story' are used interchangeably and they are intertwined. Narrative means to tell and to know and it is found everywhere and helps with understanding however when it is organised temporally in a sequence it becomes a story. 'Narratives constitute stories, and stories rely on narrative' (Kim 2016:9). Stories have a beginning, middle and end and are full descriptions of a lived event that are open to interpretation.

Further debate centres on whether narratives are 'big' or 'small' stories (Bamberg 2006). 'Big' stories are generally used in auto-biographical or biographical interviews and recount events and experiences in the past. By contrast 'small' stories occur in day-to-day conversations and focus on current events. As a result, these tend to be less in-depth but can be just as valuable for understanding different perspectives (Kim 2016). In this study the focus is on 'big' stories, which are about events and experiences (Bamberg 2006) and are particularly helpful in understanding identity (Phoenix 2013).

The focus in the present study is on the 'big' stories, which are concerned with experience. The students were asked to share their stories about why they have become student HVs and their experiences leading up to and over the year-long course.

Earlier applications of NI gathered data or field texts in a number of ways including observation; collection of artefacts; reflective journals; field notes; autobiographies and interviews (Clandinin and Connelly 2000). More recently other methods have been considered such as visual media (Riessman 2008) and social media (Squire et al 2014). However, in this study four methods are utilised: interviews, field notes, autobiography, and reflections.

Clandinin and Connelly (2000) use the term 'field text' for any data that is collected in the process of conducting NI; they use this term to emphasise that all data is subject to interpretation reporting that the term data is often used to imply objective facts which is not the case in NI so they avoid its use. However, in this study although acknowledging Clandinin and Connelly's (2000) intentions in avoiding the term 'data' it is used interchangeably with field texts as other authors do use the former term. Interviews, autobiography, reflections and field notes are all field texts or data. Clandinin and Connelly (2000) stress that as inquirers we are not able to record all the data that is available. Accordingly, there is always an element of selection and interpretation in whatever is recorded. Field texts, when they are analysed and linked to theory, become research texts and inform the finished thesis (Clandinin and Connelly 2000).

Interviews

In qualitative research, interviews are a common method of obtaining data (Holloway 2010). Of the different forms of interview available in the qualitative tradition, NI tends to favour open-ended interviews (Kim 2016).

The purpose of narrative interviews is to understand the world from the individual's point of view; Clandinin and Connelly (2000) suggest that the way the interviewer interacts with the participants' impacts on the way the relationship is formed and the responses that are given. Kvale (1996) advises that trust and respect are essential components of an interview and that these can be developed through using a number of interviews; often the first interview is led by expectations of what the interviewee thinks the interviewer might want to hear and subsequent interviews are generally more in-depth (Grinyer and Thomas 2012). However, Kim (2016) argues

that there is a danger of developing a relationship, which is too in-depth, and can lead to bias but Clandinin and Connelly (2000) emphasise that NI is relationship-based so a balance needs to be achieved. The balance can be facilitated by the researcher sharing their experiences and showing genuine caring interest as well as treating the respondents with dignity (Kim 2016). Sharing experiences was an integral part of this study and helped in the development of a relationship.

Open-ended interviews have no set agenda; they begin with a general topic to focus the interview and the researcher should listen without leading, allowing the participant to tell their story (Kim 2016). However, this needs to be tempered with developing relationships that encourage conversation; thus, the use of active listening and probing with relevant questions are key skills. Sometimes stories that do not appear relevant are presented but it is important not to judge as they may be important from an analytical point of view (Clandinin and Connelly 2000, Riessman 2013).

In this study the interviews were carried out as a conversation beginning with a two-sentence format (Kim 2016) firstly explaining the issue and then asking the question. This approach allows the interviewer to involve the participants from the beginning, ensures attention and helps with the development of a relationship and encourages the participant to talk and tell their story (Kim 2016). However, some questions required follow up to expand in the points made. The interviews were conversations and were overall relaxed. My clinical experience of encouraging people to talk using active listening helped me in this as did the participants' enthusiasm. The example questions in Figure 3 demonstrate the two sentence format and some follow up questions that were used to probe participants' answers.

Figure 3 Example Questions

First Interview beginning of the course Opening questions to establish the participant's background : **Question to Helen:** I have explained a little bit about the background of the study to you and the focus is on your professional identity. What I would like you to do is to explain to me how you decided to become a health visitor?

Question to Anna:

I've said to you already this study is about student health visitor's professional identity. What I'd really like to know, is what made you decide to be a health visitor?

Later in the interview Anna said she did not like to be called a nurse so I asked her a probing question :

Being called a public health nurse is difficult for you?

Question to Sophie:

This study is about professional identity it is a conversation, it's not a formal interview or anything. What I'd like to know is why you decided to be a health visitor? How come you're here?

Second interview – **half way through the course**. Examples of starting questions

Question to Caroline:

What I'd like you to tell me about this time, is how you feel about it all now. What do you feel your identity is now?

Later in the interview Helen was discussing her experience of safeguarding and I asked her a probing question :

How do you think that links to your identity as a health visitor?

Question to Kath:

So last time we talked about your professional identity as a nurse and why you wanted to be a health visitor and that was kind of what we focused on. This time it would be really interesting to think about your identity now, who you think you are?

Later in the interview Kath was talking about the role of reflection and I asked her:

Can you think of any examples of things you've reflected on, any visits?

Interview Three- starting question after participants had just qualified as a HV

Question to Helen:

We talked the first time we met about why you decided to be a health visitor and how you felt about that. Then last time we talked about how you were feeling, half way through the course. So now, how do you feel about being a health visitor?

She talked about her experience in her new job I went on to ask her:

Do you feel that you've taken the course and you are a health visitor?

Question to Anna

I've just been looking through your previous interview, you talked at the beginning about how excited you were about being a health visitor. Then last time I think you were a bit, not sure. So how are you feeling now?

Later in the interview Anna reported that she found people were willing to open up to her and I wanted to know more about this so I asked her:

What kind of things have people opened up to you about?

Participants were interviewed on three separate occasions during their period of enrolment on their course (between 2017 and 2019).On average the interviews lasted 50-60 minutes. Clandinin and Connelly (2000) stress that when and where the interviews take place can influence the outcome of the interview. Most of the first interviews in this study took place in the University but one took place in the GP surgery where the participant worked. The second interviews were undertaken in the same places. The final interviews all happened in the participants' workplace, apart from one, which took place in a coffee shop. The participants chose the time and place of the interviews and their comfort and convenience was paramount. One of the key considerations for this study was encouraging the participants to invest in the study for the whole year, the informal nature of the interviews facilitated this as did flexibility regarding timing and encouraging the participants to reflect on their experiences. Between interviews I sent the participants the transcripts and asked them for their opinions, none of them suggested any amendments but they were

always pleased to hear from me and responded quickly, thus maintaining our relationship.

Reflection and Field Notes

From the perspective of Clandinin and Connelly (2000), reflective journals are suggested as an effective way of researchers recording their experience and adding to field texts. They are also useful for justifying research decisions (Clandinin 2013).

Bearing these points in mind, reflection and reflexivity have been incorporated into this study. In line with Clandinin and Connelly's (2000) suggestions that using field notes and reflective journals can provide balance when it comes to data analysis, I completed field notes and a reflective journal throughout the study, as a source of data supplementary to the audio recordings. The reflections were utilised as part of the analysis, therefore becoming a research text.

Autobiography

A further source of field text adopted in the study espoused by Clandinin and Connelly (2000:100) was the completion of a short reflective autobiography to allow positioning "in the midst"; it is important as a narrative beginning and helps to justify the research puzzle (Clandinin 2013). Autobiography links to the three-dimensional space, helping us to consider temporality; sociality and place (Clandinin and Connelly 2000). Furthermore, Clandinin and Connelly (2000) note that every autobiography is by rights interpretative but could be reconstructed as any other story; it can be fictitious as well as based on fact. Autobiography encourages us to look backwards and forwards, helping us to see why we feel as we do about ourselves and about the research puzzle, as well as helping to understand the participants (Clandinin 2013).

At the beginning of this study I completed an autobiographical account of how I became a HV including how I felt about my experiences and the situations where the experiences took place. This was helpful for clarification and situating myself within the research puzzle aiding me to consider what had happened and the situation now. Initially the autobiography was field text, but it became research text when it was

utilised in the analysis. Narrative inquiry recognises the role of co-construction of data by acknowledging the experience of both the researcher and participants. However, it is important that the researcher's experience does not dominate the data. I was aware that this could happen and used reflexivity as part of my regular reflections to address any issues

Analysis

Analysis of the data in narrative inquiry can appear overwhelming on account of the volume of data but as Kim (2016) suggests, analysis is an important transitional step in research. Analysis is the process of converting data from field text to research texts which Clandinin and Connelly (2000) propose is a key stage in narrative inquiry. In order to do this effectively, researchers need to be open-minded, utilising free association by aiming to question the legitimacy of what we know in order to develop new ideas (Kim 2016). However, analytic decisions begin as soon as the data is collected, for example decisions are made about who transcribes the interviews and what is included in them such as disfluencies and vernacular language (Riessman 2008). It is through being open-minded and curious that aims, and ends, are worked out and new ideas are explored (Kim 2016).

Data analysis in narrative inquiry is influenced by the broader principles of data analysis in qualitative research. Therefore, this section will start by briefly exploring qualitative data analysis before moving onto the specifics of data analysis in narrative inquiry.

Data analysis varies according to the methodological approach but there are shared features for all qualitative data analysis. Gray (2014) outlines these simply. Analysis begins with familiarisation with the data; this should be iterative. Once the researcher is familiar with the data the next stage is careful reading of the data, which leads to the initial development of codes that classify the data. The codes are reviewed and revised until an appropriate number is identified. From the codes, theories and explanations are generated to answer the questions posed.

Another way of considering analysis is to view it in three parts: reduction of data which aims to identify the phenomena of interest; reorganisation of data which is when codes are compared to create themes, in a recursive manner which links to preliminary findings; and representation of data which is when researchers develop arguments based on the data and previous theory (Roulston 2014).

The above summary of analysis highlights that data analysis is complex. Data analysis is theoretical and it always involves interpretation. Combining analysis, which is objective, with interpretation that is subjective and working together, requires the researcher to be structured in their approach whilst also being flexible (Kim 2016, Ravitch and Mittenfelner Carl 2016).

Data Analysis in Narrative Inquiry

Data analysis in narrative inquiry follows a similar process to those outlined above. However, narrative research is interpretive at all stages including even what we choose to study. Chase (2011) suggests that as part of analysis the researcher needs to justify interpretations. Narrative inquiry aims to understand human experience through stories and as a result understand the phenomenon that is being studied which in this case is PI (Kim 2016). Polkinghorne (1988) stresses that the study of narrative meaning is a fundamental part of analysis; it is a cognitive process, but researchers need to make explicit what the cognitive processes are that have produced the meaning. Kim (2016:190) reiterates this by characterising the process of analysis as a “meaning finding act”. Analysis is difficult in narrative inquiry because the meaning may not be palpable, and it is influenced by how the storyteller presents ideas and stories as they are always context sensitive (Polkinghorne 1988). Therefore, in narrative inquiry analysis is hermeneutic; remembrance, imagination and perception influence meaning and it is difficult to investigate (Polkinghorne1988).

Data analysis in narrative inquiry takes several different formats. One of the first decisions that influence the approach is whether the analysis will take the form of analysis of narratives where each interview is examined as an entity and content is the focus or narrative analysis where the interview is analysed for structure and plot (Polkinghorne 1988). This initial decision about which approach is used influences

the entire analysis. Narrative inquirers can use this division to help with other choices about how the analysis will be conducted (Kim 2016). This study uses analysis of narratives.

Analysis of narrative or paradigmatic analysis is searching for common categories and characteristics (Polkinghorne 1988). The aim is to fit the individual details into a larger pattern and from this general concepts and categories are identified which are then generalised into themes or noticeable concepts in the data (Polkinghorne 1988). These concepts or categories can then be linked to previous theory or, as in grounded theory, be inductive (Polkinghorne 1988) but one of the key differences is that analysis keeps the stories intact and does not look for themes across the stories by breaking the stories down (Riessman 2008). Clandinin and Connelly (2000) advocate paradigmatic analysis, searching for themes and relationships between the themes, thereby uncovering commonalities, across stories leading to knowledge and understanding of a set of stories. The focus of the analysis is the content of the stories (Polkinghorne 1988). In this study the content of the stories is biographical focussing on events and enabling consideration of identity.

The analysis for this study utilises analysis of narratives to explore the individual stories as they are described then searches for commonalities across the different types of data: interviews; field notes; autobiography and reflections. The reason for my choice is that PI is about the individual as well as the professional group and looking for patterns across both will help with understanding of the key issues. As Clandinin and Connelly (2000) state, NI examines both the personal and social through the focus on experience. By examining stories of individuals, it is likely that social stories will also emerge leading to a greater understanding of PI. Individuals cannot be understood in isolation; the social situation is also important and looking at the two together develops a greater depth of understanding (Clandinin and Connelly 2000). Fidelity to the stories of the individual will help with understanding and Kim (2016) suggests this is paramount in any narrative analysis and is supported by use of vernacular language so that the audience is engaged.

Analytical Approaches

Riessman (2008) suggests that there are four main styles of qualitative data analysis: thematic - focussing on the content; structural - concentrating on the way the narrative is organised; dialogic - which highlights the creation of the narrative through interaction and visual - which emphasises analysis of images. Elements of the four can be combined to produce a coherent analysis. In this study two approaches, thematic and dialogic, are used.

Thematic analysis is exclusively about the content. Riessman (2008) clarifies that in this approach the focus is on the told - what the informants report about the events. It does not consider the telling or how they explained their stories. The investigator identifies the themes based on what is said or linked to prior theory to aid interpretation; in this study CoP is used as a prior theory. This approach requires methodical analysis whereby each story is examined as a whole, and the sequence of the story is preserved. Content is the focus, but time and place are also considered, linking to Connelly and Clandinin's (2006) three commonplaces of NI. Squire et al (2014) suggests that thematic analysis is most effective if themes are tested against theory and then reviewed in a classic hermeneutic approach. Josselson (2011) highlights that narrative researchers sometimes use analytic tools that were developed for other qualitative methodologies, but it is the focus on the entirety of a situation that distinguishes narrative analysis from other approaches. Focusing on experience in the analysis clearly links to Clandinin and Connelly's (2000) view of narrative inquiry as being primarily about individual experience.

Dialogic analysis is broader in its approach than thematic analysis. It focuses on who the story is being told to and when it is being told and why. Emphasis is placed on the social construction of a story, what the context is and how it was co-produced. The area of interest is how social reality is constructed through social interaction suggesting that individuals talk to each other and as a result perform narratives (Riessman 2008). This approach focuses on supporting interpretation of the data and recognises that the researcher, setting and circumstances all have significant influence on what is said.

Thematic and dialogic analysis are combined. Blending these two approaches enables understanding of what is being said and how and why it is being said, which will, in turn, help with understanding of context. This is because identity is a very individual construct, but it is also a social one and context will be both implicit and explicit in the individual stories. Furthermore, combining these two approaches adds to the rigour of the analysis.

The five participants, who are all given pseudonyms, are each initially viewed as a case study and their interviews are analysed for themes using Braun and Clarke's (2006) six-stage framework. This analysis is further reinforced by utilisation of Wenger's (1998) CoP as a lens to understand identity development. This theory was chosen in preference over Bourdieu's notions of field and habitus where the focus is on social structures. By contrast, CoP is a well-established model for examining engagement and interactions within a group and considering individual development. Only two participants' interviews were analysed using CoP theory due to the prolix nature of this analysis. Its application was a way of deriving additional theoretical insights rather than the key focus of the analysis. All five participants interviews were analysed using thematic analysis and data saturation was reached Analysis was shared with my supervisor. The rationale for the analysis of two participants' interviews using this theory is expanded on in earlier in this chapter

Following data saturation the three remaining participants' interviews were analysed using dialogic analysis aiming to: aid understanding; add context and depth to the analysis and explain how and why. Further aspects of using dialogic analysis are discussed in Chapter Five. Esin et al (2014) suggest that dialogic analysis is a constructivist approach to analysis allowing consideration of interaction history dialogue and institutions. This supports co-construction of the dialogue, which is also an important feature of narrative interviewing and analysis.

Chase (2011), in a review of the progress narrative inquiry has made as a field, stipulates that focussing too much on the individual can distort interpretation. Narratives are at best when they are both personal and social. Thomas (2010) emphasises that researchers should explicitly state how analysis is carried out. She

advocates a systematic approach that considers content form and context. Using the above approaches will achieve this.

Analytic decisions are part of the methodology and begin as soon as the data is collected. However, they are also part of the ethical stance of the study. Practicalities are discussed below and then the theory of ethics is investigated later in the chapter. In this study some of the interviews were transcribed by the researcher, while a professional transcriber transcribed the remainder. It was agreed that colloquial language would be included but dysfluencies such as ‘um’ and ‘ah’ would be removed to aid the flow of the interviews. The researcher checked all the transcriptions for accuracy by listening to the recordings whilst reading the transcripts.

Ethics

The ethical principles influentially outlined by Beauchamp and Childress (2013) are often used as guidelines to ensure that research is designed and carried out in an ethical way. Whilst observing the principles of beneficence, non-maleficence, justice and autonomy this study has also utilised ethical guidance from institutional review boards and national guidelines. This focus on procedures and principles is designed to protect participants but they may not address all the ethical issues that arise (Kim 2016). In NI there is a need to concentrate on the ethical issues that occur throughout the study especially linked to the relational nature of the inquiry (Clandinin and Connelly 2000).

Ethical issues include being transparent about why the research is important personally and professionally. This has been discussed above. It is also important to ensure that the relationship with participants is fully explored and that their welfare is paramount (British Educational Research Association (BERA) 2018). This is achieved by ensuring that participants felt the interviews took place within a safe space and helping them to feel connected to what they are doing and helping them to see that what they are doing will make a difference (Munro Hendry 2007).

In NI ethics requires good judgment in each situation that arises and should not be rule-based. Kim (2016 p104) suggests the emphasis should be on *phronesis* 'doing the right thing at the right time in the right place in the right way'. This is achieved by thinking about the specifics of the situation through reflection and reflexivity, not just focussing on the facts but the impact of the research including the researcher's actions. Reflexivity is often included as a way of addressing rigour but should go beyond this to include all ethical issues; it should go beyond obtaining ethical permissions and focus on supporting the participants and producing transparent research. Josselson (2007:538) concurs with this approach suggesting that in NI the researcher needs to have an "ethical attitude" throughout collection analysis and dissemination of the research data. Researchers need to be fully aware of the sensitive nature of their relationship with the participants. Furthermore, the researcher should acknowledge that the participant is sharing aspects of their life with the researcher and ensure the participant is conversant with what will happen to the information that is shared. Clandinin and Connelly (2000:177) summarise these ideas and suggest that in order to remain ethical throughout NI the researcher must take 'relational responsibility' for the duration of the inquiry.

Due to my role as both an employee and a student it was essential that I remained constantly attentive to ethical principles and ensured that the participants were protected from any harm. I was aware that even though the focus was on developing an equal relationship with the participants, there was a power imbalance due to my experience as a lecturer and as a HV. I assured the participants that I had no influence on their progress as a student and I would only consult with their course leader if any areas of unsafe practice were identified as part of the interviews. I explained I would be obliged to do this an NMC registrant.

When I started this study, my role was Principal Lecturer responsible for the community nursing programmes at a post-1992 university. My role meant that I was unable to recruit study participants from my own institution's HV programme as ethically this might challenge the students' autonomy, as they could feel coerced. Josselson (2007) indicates that it is imperative in NI that researchers and participants do not have a dual relationship. I thus sought permission from a neighbouring HEI to approach their students and this was agreed. Informed consent

is also a key consideration and as explained above, as part of the recruitment, it was made explicit through the information sheet and discussion with the study participants, individually, what they were agreeing to participate in. Clandinin and Connelly (2000) highlight that the relational nature of NI means that autonomy and informed consent are less of an issue because the research is collaborative. However, I acknowledge that it can never be a truly collaborative relationship due to the difference in power and status between myself and the participants. BERA (2018) highlights the significance of participants being aware they are able to withdraw at any time even though the research is collaborative. These issues were clearly addressed in order to seek permission from the university research ethics committee and this was duly granted (Appendix D).

Beneficence and non-maleficence were also considered in framing this research. It was made clear to the students that completing this study may not benefit them as individuals, but it might be of benefit to the profession due to increased understanding of PI. Doing no harm was considered both in relation to the topics of the interviews and any connections that might arise due to the participants personal history therefore the interviews were confidential, and that support was offered if any unexpected issues arose. From the beginning the students were encouraged to be honest and reflect on their experiences and the impact that they might have had. However, they were also made aware that interviews were recorded and would be transcribed by myself or a professional transcriber and quotations, with their permission, would be used in the final thesis.

Chapter Summary

Having explained the conceptual framework, choice of topic, and justification for the research approach, the methodological approach, in narrative inquiry, has been explained and comparison with alternatives undertaken. Subsequently the philosophical assumptions underpinning narrative inquiry have been outlined including, participant selection, question design and researcher relationship with participants and trustworthiness. Data collection methods and the study's approach to analysis have been outlined along with the key ethical considerations impinging on

the study. In the next chapter the findings are explained and analysed using a thematic approach.

Chapter Four: Findings-Thematic Analysis

Introduction

This chapter presents findings and concomitant analysis in line with the conventions of NI. Clandinin and Connelly (2000) highlight that researchers seeking a series of steps for analysis will be disappointed in NI because analysis is a process that requires constant negotiation. Analysis in this study accordingly took place on two levels, as explained previously. Riessman (2008) in her seminal work on narrative analysis advocates using a variety of methods of analysis to enable the researcher to know and interpret the phenomenon, in this case PI, in different ways therefore producing unique insights into the situation. Furthermore, Riessman (2008) suggests that combining analytic methods allows the researcher to be innovative. Thematic and dialogic analysis are two of these approaches and to facilitate their application in this study Findings and Analysis are distributed over two chapters. The present chapter explores the thematic analysis of two participants' interviews the data from the thematic analysis for the other three participants is in Appendix F and the next chapter focuses on their interviews analysed by dialogic analysis.

Initially a thematic analysis was carried out on all the interviews. Andrews et al (2013) suggest that this is the simplest method of analysis and interpretation. The thematic analysis allowed me to ‘flirt’ with the data as advocated by Kim (2016), getting to know the participants and their stories in more detail and depth as well as remaining open minded and willing to experiment through being curious and accepting surprises. Braun and Clarke (2006) suggest that thematic analysis can be used as a foundational technique for qualitative analysis because it provides researchers with essential skills and is flexible. Being clear about how analysis was carried out is essential for evaluating its effectiveness particularly being aware of the assumptions that inform the analysis (Braun and Clarke 2006). It is highlighted by Braun and Clarke (2006) that themes do not emerge- rather they are actively identified by the researcher which is particularly important in this study as I have the same professional background as the participants and this may have influenced

what they have shared with me and how I have interpreted their ideas. This risk was addressed by me acknowledging it and by me developing an open honest relationship with the participants.

Braun and Clarke (2006) suggest that before analysis begins the researcher must make several pertinent decisions, which will affect the analysis. One of the first decisions is what counts as a theme, either ideas that occur frequently or on a consistent basis. For this study, the thematic analysis was initially intra-participant to capture what was important to the individual, so salience was less important than recurrence. Additionally, the type of data should be clarified: whether the researcher was looking for semantic data where description and interpretation are the focus or latent data where underlying assumptions are of interest. A distinction should also be made between taking a realist approach to the data focusing on the individual view or a constructionist approach examining the social situation that has led to the issue. Finally, consideration should be given whether it was a deductive theoretical approach linking to a predetermined coding framework and a specific question or inductive linking to the data itself and the question arising from the coding (Braun and Clarke 2006).

In this study the analytic focus was primarily semantic with an interest in the social constructions and based on deduction linked to what was already known about the issues. Analysis initially took place by searching for themes within the body of text formed by each participant's successive interviews following Braun and Clarke's (2006) six- phase framework. The first phase was familiarisation with the data through listening to the recordings and reading the transcripts per corpus several times. The initial coding took place through reading each participant's interview as a whole and identifying issues of interest. The codes were then grouped together as themes, developing a map of themes for each person examples are presented later in this chapter and in Appendix F. The fifth stage was that the themes were defined and named and in the final stage extracts that illustrated the themes were identified and the meaning explored to create an analytic narrative. For two of the participants, Kath and Caroline, the thematic analysis was strengthened by applying Wenger's (1998) framework for identity development, due to the prolix nature of this analysis and it being a lens to add value rather than an analytical tool it was agreed with my

supervisors that using it for two participants would be appropriate. These two participants were chosen for elucidation in the light of this theory based on three criteria:

- the distance travelled during the year exploring their personal trajectory
- their reported understanding of the threshold concept of health visiting
- their demonstration of meeting the components of being a professional.

The two selected participants (Kath and Caroline) demonstrated these criteria in more detail than the other three participants.

Utilising theory to help structure the analysis in this study increases the depth of the analysis and avoids the analysis being overly descriptive (Wolford 2001). As explained in Chapter Three Wenger's (1998) Social Ecology of Identity is used as an analytical lens in this thesis to increase the depth of analysis.

Polkinghorne (1995) suggests that in analysis of narratives, ideas can be developed from themes and categories across the database of stories, so it becomes across-participants or inter-participant paradigmatic analysis. Clandinin and Connelly (2000) agree that this is a consistent approach, but caution should be utilised, avoiding inter- participant generalisations until the intra-participant stories are established, building categories from the individual themes rather than reducing the ideas to themes. In this study the themes are initially identified per person as suggested by Riessman (2008), then relationships between themes and across participants are outlined to produce key categories as advised by Clandinin and Connelly (2000). One of the disadvantages of looking across participants is that the uniqueness of the stories could be lost (Kim 2016) but having two levels of analysis reduces the chances of this as distinctive stories are highlighted through the second level dialogic analysis.

The thematic analysis of Helen, Sophie and Anna's interviews are not reported in this chapter but the codes and themes are in Appendix F. Undertaking the thematic analysis was an important part of understanding their stories. The thematic analysis informed the identification of the excerpts from the three participants' interviews that were then analysed dialogically. At the end of this chapter the overall categories for all five participants are presented.

Participant 1: Kath

At the time of the study Kath was in her early 50s. She qualified as an adult nurse in the late 1980s and worked as an adult nurse for two years. She then completed another course to become a paediatric nurse, a post-registration qualification. She worked as a paediatric nurse for over five years and then took a career break and worked as a child minder for twelve years while her own children required her care, returning to nursing through a 'Return to Practice' course four years ago and then working as a paediatric nurse again. The SCPHN programme was completed between September 2017 and September 2018 at degree level. Kath had not studied at degree level before and only had minimal experience of working in the community; both her adult and paediatric nursing experience had been gained in hospitals. Kath participated in three interviews: November 2017; April 2018 and November 2018, each lasted approximately an hour.

Initial coding of Kath's three interviews (K1-3) identified 24 codes, which were grouped into four themes. The themes were: being a nurse; becoming a HV; personal qualities and learning. These are illustrated below.

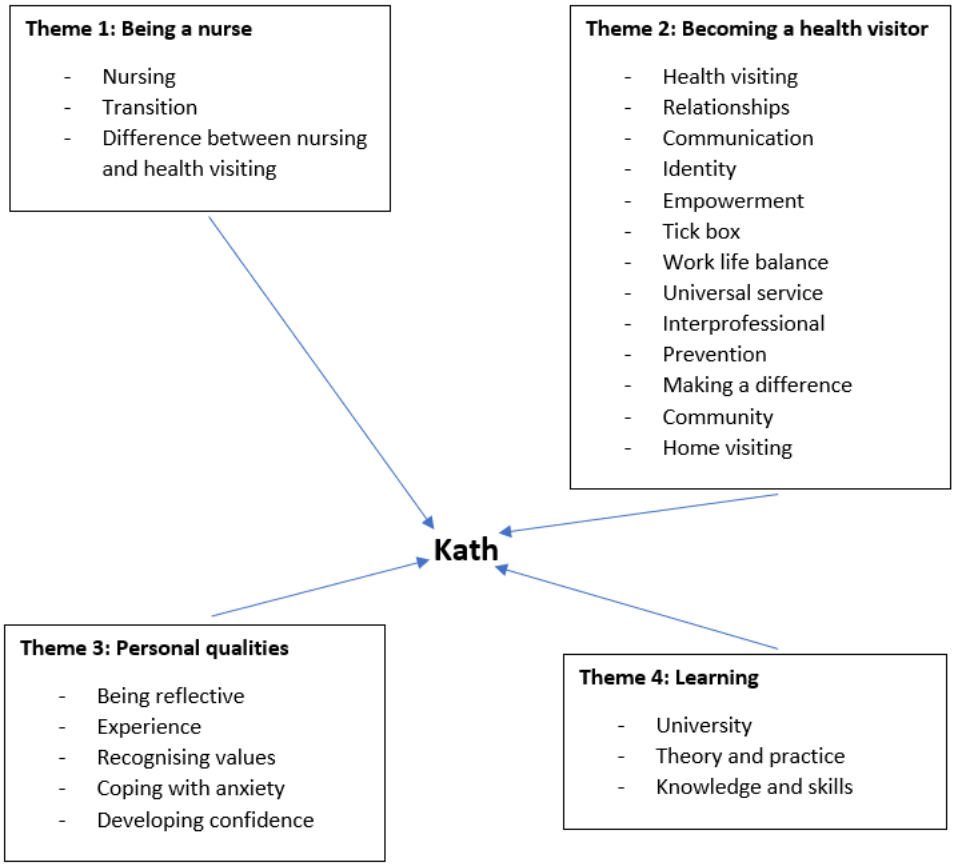

Figure 4 Kath

Theme One: Being a nurse

This theme focussed on Kath's identity as a nurse, particularly as a paediatric nurse, therefore mentions of nursing in her interviews were assumed to refer to paediatric nursing. During our conversations she made very little reference to her experience as an adult nurse; this could mean that Kath no longer considers herself part of this CoP or that Kath's primary affiliation is not with adult nursing (Wenger 1998). Kath reported that being a paediatric nurse was important to her and that having trained and worked as such helped her initially in her new role: *"it is quite a comfort*". Furthermore, she suggested that being a nurse meant she would be able to react appropriately in a situation when a child was ill. She suggested that being a nurse made it easier to gain access to people's homes and that through utilising her nursing knowledge she could gain the trust of the clients. She explained her CPT introduced her as a children's nurse who was doing extra training to be a HV. Following on from this introduction the mother asked Kath about her child's skin blemish and seemed interested in her opinion.

Kath thought that being a nurse was: *"a good way of getting people on board*". Indicating that this could help with negotiation of her new role. She also felt being a nurse prepared you for the different situations that might be encountered in client's homes. Home visiting is a separate code and is discussed in theme three.

Kath initially reported that she felt like a paediatric nurse and her identity was influenced by her participation, engagement and alignment with nursing (Wenger 1998). Furthermore, her identity was affected by her nursing knowledge, which is illuminated by Wenger's (1998) premise of negotiability.

The second code transition was mentioned briefly but did seem to be a significant factor for Kath. She reported halfway through the course (K2) that nursing was *"in her"* but that it felt very distant. She went onto say that supporting people rather than doing things for them as a HV was difficult for her and she felt that this was a: "*nursey transitioning thing"*. Wenger (1998) indicates that changing identities between CoPs can be challenging which is what Kath appears to be demonstrating here.

The final code in this theme was the difference between nursing and health visiting. Kath mentioned this in all the interviews, more than once and it seemed to be something she had given a great deal of thought to. She started out by highlighting that there was a lot less doing in health visiting than nursing and that the role of a HV was far less prescriptive. She also indicated that health visiting was very different from being on a ward because you were in someone's house making the situation: "*A weird in between thing, on a ward you're in uniform and and you're tasked, ... then you're a friend going round for coffee".* Kath mentioned this at least twice in her interviews, stating that HVs must behave almost like friends but were there in a professional capacity, which could be challenging and required good communication skills that are discussed in theme three. Kath recognised after six weeks on the course: "*I've noticed a difference... The way your attitude has to be quite different... you're going into someone's house".*

However, she went on to say that health visiting and nursing were very different, such as there was often nothing physical to see for what had been done and that generally you were visiting at a happy time of people's lives whereas*: "normally in hospital you are seeing people at their most heightened stress".* Furthermore, in hospital patients must conform to the hospital policies, procedures and culture but in health visiting she felt it was the other way around. Again, this is explored further in relation to home visiting and being a HV in theme two.

Kath talked about her PI; she thought she would stay with health visiting and that she was still in flux but she was becoming a HV: *"It's a bit like I'm dipping my toes in lots of different things but I haven't gone for a swim yet"*. Wenger (1998) supports the idea that an individual's identity changes and that it is something you become rather than are. Additionally, this statement could indicate the level of commitment Kath has to health visiting.

Reflection is part of theme four, but Kath used reflection as another way of explaining the difference between nursing and health visiting reporting that in nursing you reflect and use reflective practice but in health visiting: "*much more so... you reflect all the time".*

Through these excerpts from Kath's interviews her experiences can tenably be described in terms of some of the elements of Wenger's (1998) framework. Kath stated that she was in transition and her use of knowledge was changing which supports Wenger's (1998) principle of negotiability as she developed her 'ownership of meanings'. She also indicateed her engagement and imagination through participation and considering how her practice and knowledge connect. Kath was also showing her changing idea of who she is and who she is not (Wenger 1998).

Theme Two: Becoming a HV

Twelve codes contributed to this theme. However, some of the codes are linked together and therefore are discussed together.

Health visiting was the first code and was primarily concerned with how Kath views health visiting. She discussed this in all the interviews developing her ideas throughout the course. In K1 Kath began by admitting she had very little experience of health visiting but from her reading she hoped it would allow her to combine her current skills and knowledge. She reported that she thought she would like it as a job, but she was wary because of her limited experience.

She recognised how broad the role was with people asking so many things and very few of them linking to the care of infants and children. She outlined the difference between health visiting and nursing which links to theme one: "*quite hard to quantify what you do … you can't say oh look your wound's better".*

In K2 she talked about her developing knowledge and skills and reported that she now had time to revisit some of her initial ideas about health visiting. She explained that she had been undertaking a few visits with her mentor after having visited alone and now could see different things. Health visiting was not about giving information and asking questions but more about developing relationships and empowering people and being able to communicate; these codes are discussed further later *"she did the visit. And it was interesting... You hadn't noticed the way she was".*

Over the course of K1-3 Kath developed her view of what it is to be a HV: "*The more you find out the more you realise there is to go...I think it is worth it".* From Wenger's (1998) perspective this is both engagement and imagination leading to identification, ultimately helping Kath with her identity development. Kath went on to talk about how important she felt the service was and how it was validated by some of the complex situations she had been involved in. She expanded on the importance of having a universal service: *"you don't know what people need... you're almost discriminating people aren't you by not offering?"* This statement links to one of the principles of health visiting discussed in Chapter One - the search for health needs (CETHV 1977), focussing on prevention by identifying areas of need.

Kath's exploration of the difference between nursing and health visiting was considered in the previous theme but one of the areas that she reported was key to health visiting was being able to communicate and develop relationships. Although

these were initially two separate themes they were often linked in the interviews. Kath reported that as a nurse working on the wards for over five years, she had developed relationships with clients, but these were often superficial. She would ask them how they were: "*that minute - did you sleep? ...you don't get into their life experiences".* However, as a student HV her communication and relationship-building skills had improved, enabling her to offer support. She reflected that she wished she had spoken more to HVs when she was discharging patients from the hospital so patients could be supported, she indicated that the lack of liaison was due to her lack of understanding of the role and now she realised: "*more than I ever thought it would be as a role... completely different to what I thought"*. This revelation could have been a threat to Kath's identity as a nurse, but she seemed to view this as a positive change linking to her developing identity as a HV.

Kath reported she was much more aware of the bigger picture recognising the impact of wider factors on individual lives and linking this to how they were now: *"I spend my whole time walking round town looking at people ...oh I wonder if they had a bad childhood*". This wider perspective illustrates Wenger's (1998) concept of imagination indicating her ability to look at how elements link together and the impact this had on her identity.

She explained how as a student HV she had been able to build relationships with clients and even in challenging circumstances for example when a mother ignored her advice about feeding her infant goat's milk, she used her communication skills to delve into the situation, reflecting: "*So there was just like all these layers*...". The mother revealed she had no family support and that her own childhood had been difficult as her own mother had been a drug addict and her siblings had been in care. Kath had started to build a relationship with the mother and as a result could offer support even if this parent did not want her advice.

Kath went onto explain how part of her development as a HV was about recognising when things did not seem quite right: "*You're kind of getting a feeling that maybe they're not OK*...". Kath continued stating that you begin to recognise when clients are talking about one thing when there is an underlying issue that maybe they want to talk about instead as illustrated by the situation above. This highlighted the

importance of being able to communicate effectively and develop a supportive relationship. She realised that health visiting was not about telling clients everything she knew about a topic, rather encouraging them to explore what they knew and then helping them to fill any gaps. Kath had been really impressed by how good at this her CPT was, highlighting the significance of role models. Wenger (1998) suggests that changing roles and using a different knowledge base can lead to conflict but for Kath this was not the case. Instead, she demonstrated participation and awareness of her changing role facilitating her changing identity. Kath's identity development could have been supported by brokering between CoPs as she had expertise in two different areas (Wenger 1998).

Kath recognised communication was particularly important in relation to assessing maternal mood and not jumping in with assumptions, thereby avoiding having a *"tick-box"* mentality. She stressed how important it was to build up relationships as this helps to develop trust: "*If you kind of have built that ...they trust you*".

Another important code in this theme was prevention. Kath reported that trying to prevent problems was one of the reasons for training to be a HV: "*Like someone has poured coffee over themselves… I thought it would be nice to try and be on the other side*". She explained she had been involved in challenging situations and how part of her role was to monitor these and offer support to try and prevent future problems. However, Kath did not discuss safeguarding specifically; this could be due to her limited exposure in the programme due to the location of her placements. An example of a challenging situation was the mother who was agoraphobic and had no support. Kath felt it was part of the HV's role in K2 to keep the baby on her radar and ensure he had all the opportunities he required to develop and to ensure that the child's mother was coping. Prevention links closely to another code, "*making a difference*". On several occasions Kath talked about how important this was, giving the example of the teenage mother who, following a visit from Kath and her CPT, had decided to breastfeed: *"An amazing thing to change someone's mind*...".

Kath linked making a difference to empowering people, supporting individuals to make their choices:

> *Whereas obviously this is completely different... The way you speak to people, how are you finding this?... Rather than me sitting there and saying I think you should do this.*

She expanded on this by saying she would take her time with clients and revisit them rather than tell them what to do; she saw this as part of relationship-building. Kath was illustrating here that she has both engaged with the knowledge base of health visiting and was developing her 'ownership of the meanings' and she was identifying with becoming a HV and both link to her changing identity (Wenger 1998).

Two more codes that link together are community and home visiting. In K1 Kath acknowledged that she had minimal experience in the community, and this was something she was looking forward to developing: "*I wanted to be in the community... I'd never done it before".* One aspect of being in the community is visiting people at home. Kath indicated this was challenging for her: *"I found it was, to start off with, it was a little bit more difficult ... you're there in someone's house, it's quite hard".* She found it difficult to be in someone's home and to structure visits as clients were often very welcoming, treating her like a guest offering tea and coffee, and it was difficult to move from this to the purpose of the visit. This challenge could also link to the difference between working in a hospital and in the community. Initially this was an issue for Kath but as her confidence developed, she reported that was much easier. Kath was able to use her skills and confidence to work with families. Wenger (1998) suggests that identification is required through engagement, imagination and alignment to the point where one feels like a member of a community. This seems to be what Kath is illustrating here.

Teamwork was considered by Kath to be a crucial part of becoming a HV. She valued having team members to come back to the office and discuss visits with; this was part of reflection and working with other professionals. She was also able to discuss her decisions with other members of the team and explore the different approaches: "*Everyone talks about stuff*". She was pleased that even very experienced team members would discuss what they had done and seek other ideas about ways to approach issues. She felt this increased the collegiate nature of the team and highlights the role of participation illustrating identification and negotiability

both being key for identity development from Wenger's (1998) perspective. Discussing issues highlights 'ownership of meanings' as there is a shared understanding and if the group develops their meaning to concur with the wider organisation's meanings this demonstrates 'economy of meaning' and will according to Wenger (1998) increase identity formation.

Overall, the codes that comprise becoming a HV illustrate the multi-faceted components of the role and the areas that Kath felt were important for both her development and effective practice. However, there are a few links with the other identified themes as this analysis demonstrates. Kath's explanation of how she was becoming a HV relates to Wenger's (1998) ecological framework for identity development. She was identifying with the role through participation and shows her engagement with her new role and has begun to show imagination in recognising how aspects of health visiting coalesce. She was also showing her alignment with the new role. She was demonstrating increased 'ownership of the meanings' of health visiting i.e. the knowledge and practices.

Theme Three: Personal Qualities

Throughout interviews K1 to K3 Kath explored several of her own personal qualities that had become apparent during the programme. There were seven codes that link to this theme; they will be discussed individually.

In K1 confidence was raised in relation to being a nurse, but it was discussed frequently in K2 and K3 in relation to her confidence in herself. In K2 Kath reported that she was very pleased that she had started in a quiet caseload because she had limited experience in the community and building the knowledge gradually was increasing her confidence. She recognised that she still had a lot to learn but she felt: *"The more you find out the more you realise there is to go"*. She was able to give an example of how her confidence was developing and the impact this had on her; she explained how she had been able to support a breastfeeding mother who was cluster-feeding at night*: "I felt much more confident when they asked me the question... I think it was just my confidence really".*

She acknowledged the role of theory, knowledge and skills, as discussed in theme four, but for her it was confidence that needed to develop in order to apply the ideas to practice. Kath finished K2 saying: *"I feel that I can see where I might be going".* Kath linked her progress to dipping her toes in the sea and realising that for her when she was immersed it was all fine. This was the second time she used this metaphor the first time it linked to her identity, but confidence is also important.

In K3 she appeared much more confident and she confided: "*I've definitely got more confidence".* She reported that when she was on telephone duty she now had the confidence to ask questions: "*I just phoned her back and I said can I just ask you about this?"* Here she was demonstrating she felt able to manage any response. She went on to say: "*that the more you know and the more confident you get that you feel, you know, that's more satisfying".* Her growing confidence links to theme two as it demonstrates her developing understanding of what it means to be a HV. This is further supported by Wenger's (1998) explanation of identity requiring participation and negotiability as Kath needed to understand and interpret the required knowledge for herself before being able to apply it effectively.

There was a balance between anxiety and confidence in the second two interviews. In K2 Kath reported feeling anxious because she knew she was changing placements to a busier area, but she also felt that it was time to be tested: "*I feel like I have been in this little bubble for long enough".* She reported the anxiety was effectively fear of the unknown and once she was there and knew what she was doing it would be fine. She went on to say that over the last few weeks she had been less anxious in visits because she knew she had to get into them and relax and as a result the clients seemed to relax too.

In interview K3 she reported that she had been extremely anxious during the consolidation phase when she was in a new placement, almost to the point of wanting to leave the course:

> *got myself in a right old tizzy. It was just everything they did was different... You just felt like you should know...then you didn't and you felt really bad.*

This could be viewed as an example of non-participation through lack of alignment both in relation to negotiability and identification (Wenger 1998) and highlights that non-participation is central in identity development as it helps with recognising who you are. However, later in the interview she reported feeling less anxious and more confident and able to challenge herself to do new things: "*Yes I think it is getting better".* She went on to say: "*I kind of go yes every time I do a new challenge*". This avowal suggests that as her confidence grew, she was less anxious and was willing to try different experiences to facilitate her development. Kath demonstrates here that becoming for her was a process over time (Wenger, 1998) and that she aligned and imagined her identity through knowledge and practice.

Experience is another code in this theme, particularly in K1, where Kath reported how much she valued her nursing experience, and this helped her to be confident in her new role. She also felt that having recently undergone a 'Return to Practice' programme she was used to being in challenging situations and this had helped her in the beginning of the health visiting programme as she did not expect to be an expert like some of her colleagues. Wenger (1998) indicates the value of experience in relation to participation, being able to engage with practice and use imagination to envisage the bigger picture and develop feelings of belonging to a community. The other aspect of experience that was important for Kath was being able to link back to her experience as a paediatric nurse:

> *Just knowing about child development, knowing how... but I think it is probably a gut feeling based on what you've seen before.*

Alongside experience, frustration was an important issue for Kath. She was frustrated by her new knowledge that indicated how problems could be prevented, for example parenting courses helping parents to cope, but the lack of resources stopped change. She also discussed the frustration that there often was not a clear-cut answer to many of the issues she encountered. She had previously said how she liked a policy or procedure for a problem, but this was often lacking due to there being many ways to address issues. Wenger (1998) suggests that being able to interpret policies is part of identity formation as it facilitates both 'ownership of meaning' and the wider 'economies of meaning'. For Kath not having policies to discuss caused frustration and may possibly have hindered her developing identity.

Autonomy was another code from this theme. Kath liked being able to make decisions and then discuss them; she felt this was completely different to being on a ward where even if you were in charge you still might not be able to make decisions. She also recognised that going into people's homes allowed autonomy, but it meant you were unclear what you might find, and this could be challenging. This is discussed further in theme two.

Values were also important in this theme. Kath discussed her values and the values of society. Kath recognised that as a nurse you would not impose your values on others, but she felt this was more pronounced in health visiting because of going into people's homes and seeing them on their terms. In K1 she discussed how clients routinely having the television on was a surprise to her and how the CPT negotiated with families to turn it down so they could talk. She also explored how advising a person on childcare was very personal and it was important to ensure that one's own values did not affect the advice that was given.

In K2 she returned to the importance of individual values, explaining that the programme had helped her to see the bigger picture and understand people's situations. She had spent some time with the alcohol dependency nurse: "*one guy he was only 27, he was autistic and he had been in care, ... getting out of his head every day was really the only way."* She recognised that people made choices in different ways depending on their values and she linked this to the frustration of sometimes not being able to help. She gave the example of a mother who was having problems relating to her child but because at the time there were no safeguarding issues there was little they could offer her apart from her support. This highlighted for her the values of the society as well as the individual, in that resources are invested in those with obvious needs but not necessarily for those with less acute needs. In K3 she returned to values and was very concerned that, as a profession, HVs were undervalued and she felt that this impacted on the care they could give clients. However, Kath did not discuss the values of the profession explicitly. By the end of K3 Kath had fully aligned herself with health visiting and from Wenger's (1998) perspective felt she belonged, and it was an important aspect of her identity.

The final code, which underpinned many of the ideas discussed so far, was being reflective. In K1 Kath reflected on her experience as a student nurse going out with the HV and reported that she had found it uninspiring at the time because all she could do was observe. However, now she realised how valuable that observing could be and now when she observed others it gave her an opportunity to think about how individuals related to clients as discussed in theme two.

In theme one reflection was a way of differentiating how she had been a nurse and she went onto say: *"find I am being more reflective on what I am doing"*. This was partly due to having the opportunity to discuss visits with the rest of the team and she reported valuing this. She was also able to reflect on her own about how specific visits went and she gave the example of asking clients routinely about domestic violence and how difficult she found this. She realised that she was not actually asking in a way that was clear: "*actually I feel like I am uncomfortable about it".* This was why she could not ask, realising this meant she could ask in a direct way and get answers although no one confided they were being abused they were able to have a conversation about the issues which might lead to future disclosure. Using Wenger's (1998) framework this could be seen as an example of non-participation in that Kath found it difficult to align with both the knowledge and practice of this aspect of her role, leading her to reflect on who she was. It was also an opportunity for her to reflect on her communications skills.

Kath felt that part of developing as a HV was being aware of the ongoing nature of reflection on the positives as well as any challenging situations: *"you know, that bit was good... I'll think about it in the car and I'll think, well that bit of the visit went really well*". Kath was able to reflect on her own situation: *"You reflect on your own sort of life …you've built in the resilience to cope".*

Self-awareness and resilience are vital qualities when working with clients, especially in situations like Kath's where autonomy is a key component of the role and these qualities have extensive links to being reflective. This also links to alignment and engagement with the profession, helping Kath to feel she belongs and that she is developing her identity (Wenger 1998).

This theme focussed on how Kath perceived herself and her development; she highlighted several of her personal qualities all of which linked to her becoming an effective HV. The theme demonstrates her developing identity as a HV and illustrates her participation in relation to engagement, imagination and alignment (Wenger 1998). Participation in negotiability is also demonstrated and she becomes more confident with the knowledge required to be a HV developing her 'ownership of meaning' (Wenger 1998).

Theme Four: Learning

For Kath the learning on the course overall was significant, she found it an enjoyable experience. She reported that although she found it hard to balance the demands of academic work and practice, halfway through she said she was: *"really happy...it is a bit more intense than I thought it would be ... I have never been to uni"*. Kath felt that the university-based HV course encouraged her to question practice and to ask what the evidence was, this was a new experience for her, and it was something she valued. Again, this illustrates Wenger (1998) 'ownership of meaning'. However, she did find some of the academic work challenging particularly in relation to assignments as they were often not prescriptive, instead they were reflective and could be interpreted in several ways, with no set answers. Whereas she said: *"don't mind just learning a fact, and spieling it back, ... I quite like an exam"*" She reported it was hard to ascertain what the lecturers wanted, and she felt that the best way was to write the assignments and then see what the feedback was. This approach seemed to work for her. Wanting to produce work that met the specific requirements of the university could be viewed as striving to develop 'economies of meaning' rather than being focussed on her 'ownership of the meanings' and could be seen as part of her identity development (Wenger 1998). Another interpretation of this could be that Kath viewed education as a CoP that she was struggling to access. Kath was delighted to have achieved a degree, saying at the end of K3: "... *oh I've got a degree".*

Overall, she reported that the course prepared her, but she did say that she would have liked another six months and once she qualified, she reiterated how much she

missed attending university and how much she enjoyed the programme and valued hearing other people's views. Wenger (1998) might suggest that this illustrates her emerging identity as she became more confident with her own knowledge and wanted to participate with others to develop her 'economy of meaning'. Or it could be that Kath was developing her identity through legitimate peripheral participation and needed contact with her cohort (Lave and Wenger 1991).

Theory and practice and knowledge and skills often overlapped in the coding of the interviews. This is possibly because it is difficult to apply theory to practice without having the requisite skills and knowledge. Therefore, they are discussed together here. Specific skills are discussed under personal qualities too in theme three.

In K2 Kath shared the story of a visit where she had seen a young woman who was on her own with a new baby and limited support. Through recounting this story Kath was able to illustrate why she needed a good grasp of theory and how to apply it to practice as well as having both the skills and knowledge to address sensitive situations linking to Wenger (1998) and the importance of negotiating with knowledge to own it and to recognise 'economies of meaning' as this linked not just to Kath's understanding but wider NHS Policy and to the underpinning constructs of health visiting. Kath was able to ascertain that the young mother had read lots about childcare but was unable to apply the theory to practice. An example was safe sleeping. Kath asked the mother:

> *Do you understand about the safe sleeping guidelines…, what could you tell me about that? And she said all this stuff she had obviously read it and yet the baby was lying on the bed ...So she could talk the talk but couldn't apply it to the baby.*

There were other issues such as the baby was being fed on goats' milk because the mother's half-brothers had eczema but she did not want to breastfeed and she did not want immunisations because her half-brothers were autistic. All these issues would need to be addressed in an understanding way over time and supported with up-to-date evidence. Kath went on to say that this situation had illustrated how important it is to be able to apply theory to practice.

Wenger (1998) might intimate that this example illustrates increasing awareness of the ‘economies of meaning’ in that Kath wants to share her interpretations with the wider organisations. The example certainly shows how Kath was becoming more confident with her ‘ownership of meaning’ and that she was participating through engaging with and aligning her knowledge.

Breastfeeding was an area that Kath initially felt very unsure of. In K2 she reported that her knowledge and skills were developing following sessions in university and in practice. However, in the third interview Kath explored a situation where a breastfed baby was not gaining any weight and the mother was reluctant to offer any other feed. Kath was able to use her skills to support the mother to help the baby. Kath felt that her developing knowledge about breastfeeding enabled her to recognise that the baby was not well and to seek help, she was able to use her skills to empower the mother to make changes rather than overriding her initial choices:

> *you really want to support don’t you that breastfeeding journey and you don’t want to give them formula... because kind of everything you've learnt about.*

Again, this reveals the links between theory and practice and the importance of the knowledge and skills that combine to facilitate effective practice. This demonstrates that Kath was developing her ‘ownership of meaning’ as she can interpret knowledge and ‘economies of meaning’ in that she was aware of national policy about supporting breastfeeding (Wenger 1998).

In K3 Kath acknowledged that she did not have enough knowledge or skills to be effective in the Child Health Clinics. This was partly because her first placement had been a quiet rural one and she was now working in a busy town environment. She needed to develop her skills in this environment and make links between theory and practice. She reported: “*I’m doing exposure therapy on clinics*”. Being aware of what she needed to do to become a HV and develop her skills and knowledge links again to theme two. The overall analysis of Kath’s interviews has demonstrated that the themes interlink and for her becoming a HV has involved development over time leading to a specific identity, illustrated at the end of the third interview where she explained health visiting: *“it’s just a lot of things, isn’t it?”*

Then she indicated that she intended to stay in health visiting and that she thought: "*it's more of an evolving role, isn't it, than I think a nursing one is"*. Again, this statement shows her identification through alignment with health visiting which Wenger (1998) indicates is essential for developing identity. This also demonstrates the idea of becoming which Wenger (1998) suggests is a process that develops over time.

Participant 2: Caroline

Caroline was in her mid-40s and had been a health professional for five years. Before she started her midwifery training, she worked in customer services and she reported she has always enjoyed working with people. When she had her own two children she became very interested in the roles of the midwife and the HV. She completed a health and social care course at her local college before training to be a midwife. She had investigated both health visiting and midwifery and decided to train to be a midwife as there was no direct entry health visiting, and she was not interested in becoming a nurse. From the beginning of her journey it was health visiting that was her goal. She reported that she enjoyed her midwifery training and she practised for a year after qualification. She completed a SCPHN course between September 2017 and September 2018 at level 7.

Caroline participated in three interviews: (November 2017; April 2018 and October 2018) which varied in length from 40 minutes to just over an hour (C1-C3). In all the interviews she was very enthusiastic about her course and her experiences as a student HV.

Initial analysis identified numerous codes however many of these overlapped and interlinked. The codes were amalgamated into three themes being a midwife, personal qualities and becoming a HV. The themes are explained below and as in the analysis of Kath's interviews Caroline's interviews are explored in more depth through application of Wenger's (1998) Social Ecology of Identity model

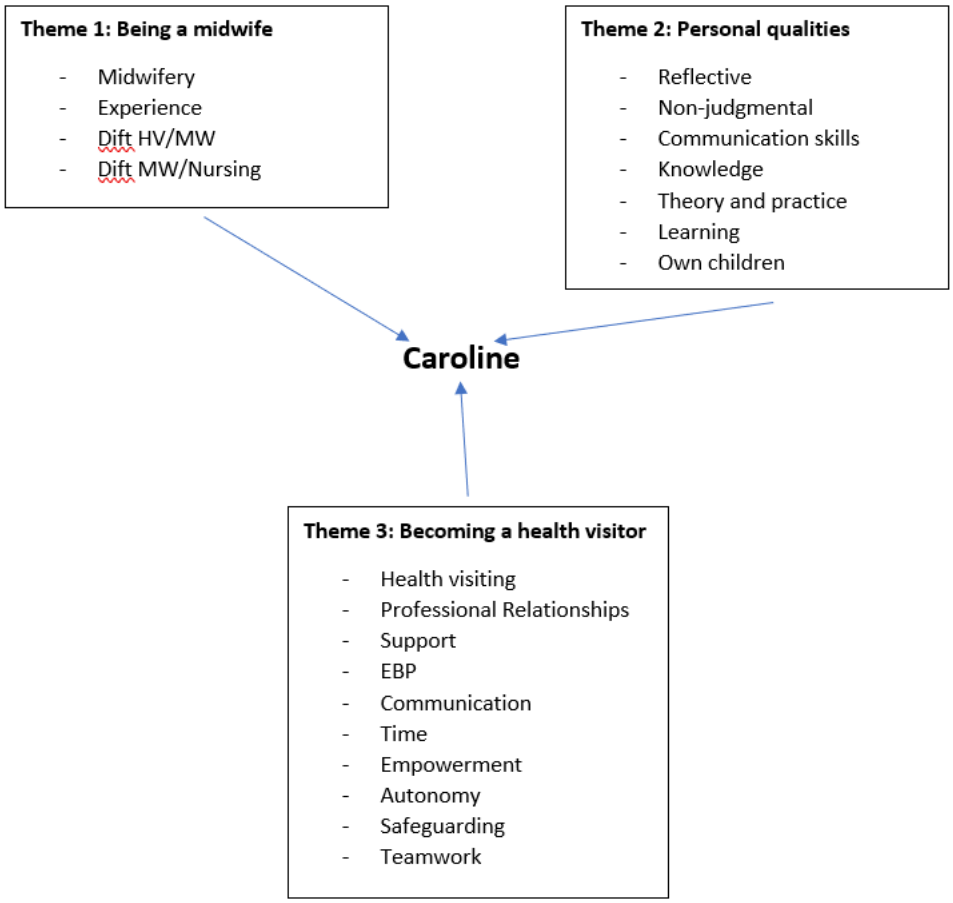

Figure 5 Caroline

Theme One: Being a Midwife

This theme linked to Caroline's previous experience and her view of midwifery. Caroline reported that there were: *"loads of aspects of midwifery that I love, but the high intensity and labour ward were not for me"*. She found midwifery stressful and although she enjoyed working with the mothers and babies and would have liked to be a community midwife, but she did not want to go into the labour ward: "*it was just the buzzer and the stress and the anxiety".* It was not that she disliked the birth as she enjoyed home births and the birth centre.

From the beginning of her midwifery course she had been interested in health visiting and she mentioned that if there had been direct entry health visiting, she would have taken this pathway. However, she identified that the knowledge from her midwifery course was essential and in K2 she said: "*I still draw on that knowledge and experience*". In K3 she stated that: *"I feel like I'm a Health Visitor but I ... use a*

lot of my midwifery skills". She went on to give an example of a six-to-eight-week check where the new mother had asked about a very heavy period and Caroline was able to explore this with the mother and refer her to the GP because Caroline recognised that she was probably anaemic. Caroline felt on this occasion her midwifery knowledge was key and she was concerned: *"Would somebody else have known to explore that heavy period?"*

Caroline felt it was important to have been a midwife but for her it was a dichotomy; she had no intention of continuing to practise as a midwife so was concerned about whether she should still call herself a midwife however, she knew she had to maintain the registration. Analysing this incident with Wenger's (1998) model, Caroline was demonstrating participation in two CoPs - health visiting and midwifery. She was aligning herself to both and recognising the value of both.

Caroline reported that there were many differences between midwifery and health visiting and in C1 when she had just started the course: *"I have noticed over the last 6 or 7 weeks that I'm thinking if I was a midwife I would have done that*". In this quote Caroline is demonstrating non-participation in the midwifery CoP and beginning to show her alignment with health visiting (Wenger 1998). Caroline reported that health visiting was much more holistic than midwifery and this was often due to time. This suggests she was using imagination to show her participation in health visiting as a CoP (Wenger 1998). Time is explored further in theme three. She also stressed that midwives were less supportive of students than HVs were, again because of time, the issue of support is also discussed in more depth in theme three. Midwifery did not allow time for reflection either as an individual or in teams as discussed in theme two.

Caroline reported that the health promotion messages between midwifery and health visiting were very similar, but the supportive role was different because of the length of the relationship in health visiting. In midwifery it was short and intense but in health visiting it can last five years or more and was deeper. For Caroline this meant a change of approach: *"You can still show empathy and support, but I've just had to have a bit more of a professional ... be less familiar."*

As a midwife the focus was on the mother and that was where the relationship was focussed but as a HV it was on the child and family; there was always the potential that safeguarding might become an issue, both relationships and safeguarding are discussed further in theme three. Caroline went on to suggest health visiting combined with her midwifery knowledge enabled her to: *"bring all those bits that I absolutely loved with me,…but it's that support of families"'.*

However, she recognised further changes in her approach in C3:
"it is very different but over this last year ...now, how I view things...even going into sort of people's houses, what you're sort of looking at". She reported she was more holistic in her observations as a HV Student than she had been as a midwife. Again, she is identifying with health visiting as opposed to midwifery; this is another example of her engagement with health visiting (Wenger 1998) through using one of the principles of health visiting searching for needs (CETHV1977).

Caroline also commented on the difference she perceived between being a nurse at entry to the course and being a midwife. She suggested that: *"I would have come from a different perspective if I'd done nursing"*. She based this on the differences she had observed between direct entry midwives and those who had done nursing first; the nurses approached issues differently and had a more medical focus. Nevertheless, she acknowledged there were times when more medical knowledge could have been useful as a HV she went onto say: *"... if I had to go down the nursing route I probably wouldn't have done it".*

The other important aspect of this theme is Caroline's experience. She had made the decision to become a midwife following her experience as a mother and even at this point it had been health visiting that had inspired her: "*I'd wanted to do it for such a long time, ..., I think I said to you actually even before I became a midwife".*

Caroline reported that she felt there had been a transition between her roles, but she was used to making transitions and felt she had coped well. She had found her own coping strategies and that for her making a transition had become ingrained over the last few years; she was used to change. She reported that although her experience as a midwife was limited this had helped her to adapt more quickly to her new role

than colleagues who had lots of experience: "*if I knew my job inside out coming into this I would be flailing a little bit as well".* She went on to say: "*for them they are like a fish out of water, I'm not.*" Caroline is illustrating that some of her colleagues might have had difficulties with their change of identity because as Wenger (1998) states identity development requires identification and negotiation, but feeling one's ideas are not being utilised can lead to reduced 'ownership of meanings' and not being fully engaged could be a symptom of this. Although Caroline did mention feeling deskilled at times, she balanced this with her previous experience of constant change: *"I'm in this changing environment now but that is OK for me".* She went on to say she was used to having to ask all the time and to not being an expert as she had not been in her previous role long enough to develop expertise. However, she did feel that being a midwife: "*opens up your perspective and gives you a bit of first-hand knowledge of things that happen".* Caroline linked this to the role of evidence-based practice in theme three and she highlighted that although she thought having had children herself had helped her, Caroline did not want to base her practise on this. Being able to bring together knowledge from a range of experiences could help Caroline to develop her 'ownership of meaning', her understanding of local issues as well as developing 'economies of meaning' understanding of the wider meanings of the organisation (Wenger 1998).

Furthermore, Caroline made sure that she took advantage of all the opportunities the course offered to work with other professionals and develop her experiences. For example, she spent time with the Domestic Violence HV and the Safeguarding Leads. Her placements on the course were diverse but even so she recognised her own limitations and reported that:

> *It is really good to get different aspects and to know that actually, it doesn't matter where you are you could always be faced with something*.

Caroline summarised her position in relation to her experience before the course as: "*my whole life, my working life and my life outside as well has set things up quite nicely".* Caroline demonstrated that being a midwife was important to her at the beginning of the course and throughout the course she valued the knowledge from her midwifery training. However, over the year through her participation in the health

visiting CoP she has increased her engagement and alignment with health visiting (Wenger 1998).

Theme Two: Personal Qualities

Caroline reported several personal qualities that had made a difference to her during the course. The first quality is being reflective. As highlighted above, she considered there was no time to be reflective in midwifery but as a student HV it is encouraged. In C1 Caroline said:

> *I have learnt more in the last 6 or 7 weeks... whether it be with your team or your CPT or somebody just talking through something.*

Caroline continued saying that being able to reflect helped when something happened that she was uncomfortable with. She gave the example of a woman who had not disclosed a previous domestic violence incident. Reflecting on what had been said in the visit helped Caroline to decide what to do next. However, Caroline also recognised that having time to reflect was a learning experience for students and being able to follow families up, such as a woman who had had a traumatic birth, was a luxury that qualified HVs might not enjoy. Lave and Wenger (1991) suggest that it is the participation that facilitates identification with the CoP enabling individuals to move from a peripheral view of the community to being legitimate members of the community. Reflection is part of this process and helps with learning. Caroline gave the example of the links between the theory days in university and practise, highlighting that reflecting on child development had helped her enormously. She also explained that reflective opportunities are there for support too, for example with the safeguarding lead. In C3 Caroline gave a pertinent example of the importance of being reflective as a newly qualified HV because there is often more than one way of approaching an issue as in the case of supporting a client with mental health needs:

> *I spoke to a couple of different people ...I noticed that they all came at it from a slightly different angle. So, it was like OK, so it is OK, there isn't one prescriptive way of doing it...*

Caroline went on to report that there was always someone there to discuss issues with: "*And I will come in and even if I say have you just got fifteen or twenty minutes*

that I can chat through something". Recognising the variety of ways of approaching an issue not only illustrated that Caroline was a reflective practitioner but it also shows that she had engaged with both 'ownership and economies of meaning' which Wenger (1998) suggest are key to identity development. Furthermore, Wenger (1998) highlights that being reflective indicates that an individual is combining engagement and imagination leading to an identity where different perspectives can come together and be part of who we are.

One of the other qualities that were important in facilitating her development was the growth of her personal confidence. Over interviews C1-3 she gave some examples of how she had become more confident and, just from talking to her, her increased confidence was obvious. Wenger (1998) suggests that a combination of participation and non-participation in communities influences identity, however engagement with the meanings of the community is also key. Caroline's growth in confidence could mean that she has developed her own understanding of the core knowledge of health visiting. From the beginning she said she was able to say to clients if she was unsure about something and as her knowledge grew, she felt more able to do this. In C3 she reported that she was able to give advice confidently. This was most apparent in relation to safeguarding where she could see how her confidence had grown, attributing this to the course structure:

> *So when they first go through it at uni then you're working alongside you hear things in practice...then they go through it again and then they go through it from a different angle and then they do a mock case conference so last week I sat in on a case conference for someone else on my own... I feel confident in this.*

However, her confidence was threatened by some anxieties especially linked to being responsible for situations and not knowing what a visit might include. She went on to say that she was less anxious if she approached situations with an open mind.

Being open minded links to one of her other personal qualities, her attitude which was open and non-judgmental. From the beginning Caroline recognised that there was a difference between being someone's friend and discussing what worked for your children and a professional using EBP. This was a recurring notion across themes: the importance of having a wider perspective and not relying on her own

experience with her children. This might tenably be described as an example of Wenger's (1998) 'ownership of meaning' which is an important facet of identity formation. Caroline acknowledged the importance of being open about her role; in C2 she used the example of a mother who was very defensive about the role of her ex-partner, so Caroline said to her:

> *I might seem and I apologise if it comes across this way, like I'm being really nosey,...I'm not wanting to know just for my benefit but so that I can support you and your children*.

Following this honest approach, the woman relaxed. By C3 Caroline was acknowledging that this was a recurring issue and having an open attitude was beneficial. She gave the example of visiting a woman who had transferred into the area. There was a misunderstanding about the time and rather than insisting on visiting she was very pragmatic and as a result had a very productive visit and was able to help the woman with sleep problems for her child. Although the woman had initially said Caroline could only stay ten minutes, the client changed her mind: "*I said do you need to go? And she went oh no it's OK.*" Caroline commented that it is easy to put people's "*backs up*" and then they never want to see you again but by being open this can be avoided. However, she did recognise that there were times when it would be more difficult, and this is explored under safeguarding in theme three.

Caroline talked throughout C1-3 about developing trust so that people can open up to her; she felt that this was a privilege that was earned again; thereby demonstrating her understanding of the 'economies of meaning' in health visiting (Wenger 1998). However, she did recognise that sometimes there is disguised compliance and she gave the example of a safeguarding case where the mother was a hoarder and had to make the environment safe for her children. In a visit the downstairs of the house was perfect but after looking upstairs where there was no change Caroline said: "*And that makes for not quite trusting"*. She realised by the end of the second interview she needed to be more critical and not accept at face value and be more cautious.

Caroline stressed the importance of having good communication skills and she thought she had brought these with her from midwifery but during the course she

developed her skills linking openness and honesty to improving her communication skills. By the end of C3 she demonstrated how her skills had developed explaining about a phone call with a woman she had met once briefly: "*I didn't expect her to open up on the phone but she started sort of like letting all this very personal information out"*.

The final four qualities in this theme link together very closely and influence each other. They are knowledge, theory and practice, learning and intuition. Over the course Caroline developed her knowledge about new areas such as child development and built on her knowledge of infants. She also developed her knowledge about different cultures and recognised when it was appropriate to challenge clients in a non-judgmental way for example about having a cot bumper. She had also increased her knowledge about issues she was already confident about like breastfeeding but as she said: "*I didn't necessarily particularly enjoy it as a midwife and now I'm going in as a Health Visitor and I'm like oh I love it... you've got time to do it".* This could be viewed as an example of her 'ownership of meaning' and of her identifying with health visiting but at the same time moving away from midwifery identifying herself as a HV and as a result of the identification being acknowledged by the CoP as a HV (Wenger 1998).

Linking theory to practice had been an important part of the course for Caroline. She gave a few examples of this from using clinical assessment tools such as the Edinburgh Post Natal Depression Scale and the Ages and Stages Questionnaire to recognising opportunities for learning for clients. She explained about a visit to a family and how she was able to link theory to practice and help them:

> *the cot had the side down and there was a gap between the side and the bed ... it is just giving that safety advice and they were very receptive to it but I think it is about how you deliver it as well.*

She went onto say that: "*I still think I can improve ...I am always sort of watching how people do it*". She identified that her learning generally had increased: "*I've kind of enjoyed working through some of the challenges and then getting to the end ...I sorted that out".*

Finally, she recognised how much of her learning was linked to her intuition, which had developed further over the course. She recognised when situations did not seem right, for example in relation to the example of domestic violence, it was not what the woman said but how she said it that alerted Caroline to exploring the issue further:

> *How she spoke, she's been quite measured up until that time. And then when I started asking her about him and their relationship ... she was speaking quite fast and almost like she's trying to justify.*

Occasionally Caroline reported she was frustrated by clients not changing even though there is evidence that change would be beneficial, but she tried to remain non- judgemental.

Theme Three: Becoming a HV

This theme is the most complex containing multiple codes, but these are all intertwined and are discussed together. It focuses on how Caroline described herself becoming a HV.

The first code was health visiting. From the beginning as already discussed Caroline knew she wanted to be a HV; she discussed her colleagues on the course having doubts but for her: *"I know it's the right thing, I know already"*. She thought that health visiting allowed her to slow down, take her time and bring together all the elements of the roles she previously held. During C1, seven weeks into the course she stated that: "*Yes you can see, ...what your priorities have changed and the focus has changed".*

As mentioned previously, intuition, communication and being non-judgmental are all given as important attributes in being a HV and Caroline gave examples of all of these in C2. She reiterated how much she had learnt from her colleagues especially her CPT who in relation to a safeguarding case:

> *doesn't come across as judgemental, … but it is factual … She'll say things like this is really good that you've put in all the effort downstairs but I have to say that it is still not up to a safe standard upstairs.*

Caroline linked her CPT's approach to Evidence Based Practice (EBP*): "She came out with a lot of evidence-based reasons rather than just saying this isn't OK"*. EBP has been important throughout the interviews for Caroline, who wanted to make sure that she always used EBP to support her advice and decisions.

Caroline also explained in C2 how much she felt she was developing in the role:

> *I am just blown away by how quickly your outlook does change. ..., I feel I'm definitely much more in a role, where yes of course I am there to deliver the public health message ...but it is the safeguarding role, it's much more of a protective role I think.*

This is an example of Caroline showing her 'ownership of meanings' in health visiting which links to her developing identity (Wenger 1998). For Caroline the big change was that:

> *I'm looking at the child… at her needs and what's the effect of her home life, the effect of the parents ... you don't know actually how much interaction there is.*

As discussed in theme two, in health visiting there is often more than one way of approaching an issue and Caroline was used to being autonomous as a midwife but as a HV she felt: "*I need to stand by and sort of justify my decisions*". She discussed how the role is driven by Key Performance Indicators but it is up to her to choose her priorities and sometimes this can be "*quite scary*". When she first met families, she used the opportunity to explain the service to them and this demonstrates how she saw her role: "*A supportive service for families so that their kids can flourish*". She goes onto say about HVs:

> *They have lots of little hats ...we're there to make a positive change that would be my biggest thing. So in whatever way it is, whether it be with health promotion or child safety or with health*

Her view of being a HV was influenced by her view of being professional, having a role, which she emphasised in C1. This linked to the importance of having a questioning mind or professional curiosity. The first example of this has been referred to previously in relation to the client who did not disclose domestic violence: *"You could tell, you could tell there was something.... she was justifying everything"*

For Caroline, as a professional with a role, she needed to follow up and ascertain what the issue was. However, as a HV she felt that this was achieved differently to when she was a midwife: *"It has taken me a while to realise, not that I ever thought I was anyone's friend but not to be over friendly or over familiar"*. She needed to get her "*pitch right*" in Midwifery she might have approached it differently given a hug or offered reassurance but in Health Visiting it was often unclear whether it would be okay:

> *You just need to take a few steps back, you know. You're not and I know that I'm not there to be their friend and never would try to do that anyway*

Part of being professional for Caroline was to reiterate on a regular basis her role:

> *You know in a nutshell what we as a HV we do. And I kind of say we are here to support parents, but our main aim is to help this child thrive and grow in the best environment.*

Caroline demonstrated her identity with the health visiting CoP both through identifying herself as a HV and through identifying with health visiting as a process. Wenger (1998) describes this as participation and reification.

Caroline's view of her role was clear by the end of C3; it was to support parents so that they can help their children to be the best they can be. She saw this as happening in a variety of ways and recognised that it would differ depending on the caseload with different areas having different priorities but for all of them safeguarding and new births were always a priority. Decisions are made logically; the locality lead helped: *"She sent ... a traffic light system thing, to help you prioritise".*

During the course Caroline had a variety of placements, the first one involving a high level of deprivation whereas the second was quieter: "*The level of safeguarding was minimal but it was good because I kind of felt like I really got to grips with my sort of universal visiting".* The range of placements helped her to understand her role. Having the opportunity to participate in a variety of placements helped Caroline to

become a member of the CoP and helped her to see what health visiting is and what it is not (Wenger 1998).

The other aspect of being a professional and being clear about her role that Caroline highlighted was working with others. She recognised that she would work with midwives although she did identify that this relationship could be fraught and for Caroline this could be a key aspect of developing her identity because identification with one role can lead to moving away from another. Wenger (1998) suggests that identification is not just how we view ourselves but includes social organisation, so it is dynamic and constantly changing. Caroline's point about the fraught nature of the relationship with midwives could illustrate her moving away from the CoP of midwifery and identifying herself with health visiting. She recognised that she would work with school nurses, social workers and GPs but she also felt that part of her role was: "*getting it out there in a professional arena"*. Knowing when to involve others for example in the case of the woman with mental health issues, visiting antenatally was not a priority because the woman had others visiting regularly but it was essential to devise a plan for postnatal care when it would be just Caroline on a regular basis.

Two other key aspects of this theme were relationships and support. From the beginning Caroline was looking forward to building long-term relationships with clients rather than the short intense relationships that had been the norm in midwifery: "*it would be great because you have them for longer, you have more of an opportunity to build up a relationship.*" She recognised that some of these would be challenging relationships and in C2 she outlined some of the difficult areas than needed to be addressed within a professional relationship for example the family who were on a Child Protection plan for hoarding she explained how her CPT had approached issues using her professional relationship as demonstrated above and this had been a good learning experience for Caroline. She also explored the case where a Mother had had a traumatic birth and it was their relationship as client and HV that supported the Mother through this: "*You know you can't force somebody to do something, so she knows all the resources that are out there"*. But Caroline felt she had helped her: "*So I have felt like with her"* Caroline suggested it was important to be aware that sometimes a phone call can make the difference to a client coping

or not and that this kind of support was an important part of her role. Caroline thought that offering support empowered clients. Referring to the same client: "*I feel like it is important for her to have somebody".* The woman was reluctant to visit her GP because she was concerned that the GP would think she was depressed but following a number of conversations with Caroline she was able to go for her GP for help, Caroline reported: *"She said, OK, I feel a bit more confident now".*

As illustrated earlier, Caroline tried to approach all interactions with clients in a supportive way; she explained about giving health promotion messages to new mothers in relation to smoking she stressed it was a question as a PHN she needed to ask:

> *She said only 5 a day ...And I was like I'm not here, I'm not going to go oh my god you know... My role is that I'm here to deliver this and support you with this.*

The earlier example of the transfer in visit where time was an issue and the child was overweight also highlights how Caroline tried to be supportive and empathetic rather than prescriptive:

> *I said we can help you with some sleep support, ...I know we will have to touch on his weight of course we are, but in the first meeting I don't need to go there.*

Caroline offered a number of examples of how she had been supported by her colleagues linking very much to teamwork: *"Where I am at the moment I am very lucky to be working in a very supportive team. I've got a very good CPT".* When she was changing teams, she commented: *"I am wondering what will my new team will expect?"* However, at the end of C3 she commented that wherever she had been, even on study days, all the HVs had been extremely supportive of her:

> *They all seem to. It doesn't matter how long they've done it for they all seem to go, I remember what it was like so don't worry".*

She contrasted this with midwifery colleagues who didn't have time to be supportive: *"I don't feel it was because of the lack of, that they wanted to be supportive.... it was purely time".* Although Caroline reiterated throughout the interviews that she felt she

was a HV she was careful not to be overly critical of midwives' practice; this could indicate that she still felt part of their CoP or it could be she wanted to maintain good relationships with the midwives she worked with. It is possible to be part of a CoP and be critical of it and this might demonstrate self-awareness. Wenger (1998) suggests that membership of multiple CoPs can be advantageous, encouraging alignment of perspectives that leads to an identity that bridges two perspectives. It could also be indicative of brokering between the two CoPs being willing to transfer elements of practice from one CoP to another (Wenger 1998).

Time was a big issue for Caroline, from having time to form relationships as opposed to the 20 minutes allowed per visit in community midwifery to having time to reflect*: "I feel like I have become a better practitioner because I have time to reflect"*. Caroline felt this helped with her development.

The other aspect of her role that Caroline spoke about throughout C1-3 was safeguarding; examples have been given already of how she felt supported in this by the University and the teams. From C1 she was apprehensive about this part of her role but as the course progressed and she watched others address challenging situations she felt more confident. Her initial placement was in an area of deprivation where she had experience of safeguarding issues. She was able to follow a family through the processes. By the time she qualified Caroline felt:

> *I really sort of pride myself on being non-judgmental but at the same time I know my role and you know my priority is to look after children...that is going to be a massive learning thing for me, ...you're obviously going to upset people.*

Caroline also felt that building relationships had helped her to develop her role so that rather than asking lots of questions she was able to *"Have much more a conversation and it flows actually.*" Caroline linked developing a professional relationship to being able to make a difference which she sometimes felt unable to do in midwifery, where she had made an impact but not always to the extent she wanted to and this again often linked to time.

During the year Caroline's PI evolved. She began by saying she was a midwife and she did not think that would change as many of the team she worked with still said they were midwives even though they had been HVs for a while. She thought her midwifery skills would always be helpful. However, by the end of C3 she said about her identity as a HV she felt *"really strongly yeah I think it is because I have taken all aspects from the job I did before and put them in this job*". Later she said: *"I think of myself as a Health Visitor"*. She reported she had no intention of practising as a midwife again so maybe she had found her identity as a HV and was not going to link her identities together (Wenger 1998).

Coda

Over their three interviews Kath and Caroline paint a picture through anecdotes and explanations of their development as HVs. Both highlight the importance of their previous experience and the links between theory and practice. They also emphasize the importance of their developing confidence and the impact this has on their view of themselves as HVs. Both report that they see themselves principally as HVs. Wenger (1998) explains the importance of participation and non-participation, in helping to develop identity but for both Kath and Caroline participation is the key. Caroline does indicate some non-participation as she moves away from midwifery to the CoP of health visiting. Kath valued her experience, knowledge and history as a nurse but over the three interviews relied less and less on what she knew before the course and focussed on her new knowledge. In contrast, Caroline reported building on her midwifery knowledge to become a HV. Both demonstrated 'ownership of meaning' and investigated 'economies of meaning' (Wenger 1998). Over their three interviews they explained how their views of health visiting changed and both appeared to have identified with the role through Wenger's (1998) three characteristics. By the end of the interviews they were confident in their new roles and appeared to have adopted the identity of HVs.

Following completion of the analysis of these two interviews I returned to my reflections which I had completed after each of the interviews. My reflections concurred with the points made above: I reflected on their enthusiasm for their role; the significance of the links between theory and practice; their developing confidence and, in the final interview, how they identified with being a HV. However, I was surprised by two reflections, I felt that Caroline's reasons for becoming a HV were very similar to mine. Secondly, I commented how much I would miss our conversations, Caroline had commented on this too. Josselson (2007) highlighted that relationships do develop in research and is something to be aware of.

As indicated earlier, thematic analysis was conducted for all five participants' data and although the analysis has not been fully reported here, however, it is in appendix E. Clandinin and Connelly (2000) suggest that individual themes can be combined to generate overarching categories, however, these do not produce generalisable truths instead they illustrate what the participants thought overall. In this study there are three categories from the corpus of interviews which are explained below. These are similar to Kath and Caroline's themes.

The thematic analysis presented in Appendix E alongside the thematic analysis presented in this chapter helps to demonstrate how the categories were identified. .In category one their previous experience, whether as a Community Staff Nurse (CSN),paediatric nurse or midwife, was discussed by all five and for the majority of them experience of change was viewed as very significant in adapting to their new role as opposed to their experience in their previous role. They were all clear about the difference between their previous role and the role of the HV and explored this in depth throughout the interviews.

In category two, personal qualities, four out of five participants explored the role of the university course and the impact this had on their development, making links between theory and practice. They all discussed the importance of being reflective and for four out of five their existing communication skills were also seen as key even though they all recognised that these had developed further during the year.

In category three, becoming a HV, all participants discussed the HV's role, relationships, and working together as key aspects of their understanding of health visiting. All bar one discussed safeguarding as being an essential component of the role. Autonomy and being confident were also important to them all and they all discussed their identity as a HV as part of this category although as illustrated in the next chapter, their ideas were not all the same in relation to this but as stated earlier generalisability is not the focus of NI. Working in the community and home visiting were important for most of them.

Scrutinising the categories helps to give an overview of the key issues for the five participants. The codes intra participant vary but the overall categories inter participant are similar. The categories suggest that all five participants experienced a similar journey in becoming a HV.

The codes and categories are outlined below:

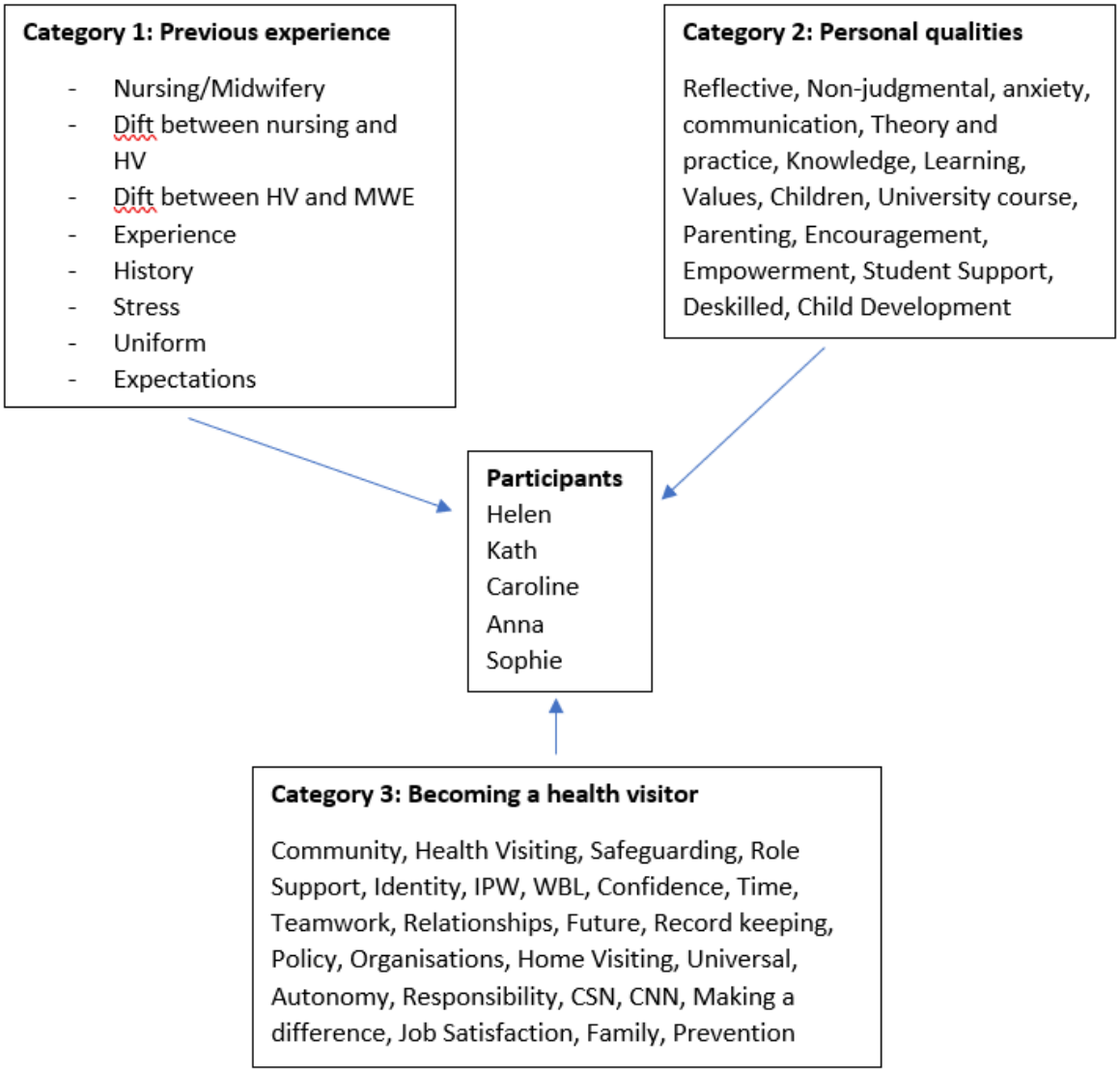

Figure 6 Categories

Initial thematic analysis and application of Wenger's (1998) CoP was informative but, as the two interviews demonstrate, was extremely prolix; this level of analysis for all five interviews may have been tedious and led to repetition. Therefore, in the spirit of Kim's (2016) assertions about being open minded, a second level of analysis was adopted for the remaining participants - dialogic analysis. While thematic analysis breaks down interviews into their constituent parts and looks for detail, dialogic analysis focuses on the interpretation of the data (Riessman 2008). Applying different types of analysis enables the researcher to ensure that analysis is holistic (Leiblich, et al 1998). Thus in the next chapter dialogic analysis is carried out on the three remaining participants: Sophie, Helen and Anna.

Chapter Five: Findings- Dialogic Analysis

Introduction

The main principles of dialogic analysis are outlined in Chapter Three. However, due to the interpretive nature of this kind of analysis different interpretations are an inherent part of the process (Hartman 2013). Both the researcher and the reader are part of the interpretive process bringing their values and beliefs to the interpretation. Riessman (2008) suggests it is a fundamental tenet of this approach that the interpretation links explicitly to what was actually said, moreover suggesting that through the text the identity of the participant is being performed and linked to wider social issues. Furthermore, she suggests that at every reading different interpretation could occur, again influenced by the values and beliefs of the reader. In the three participants' interviews that are analysed dialogically below the focus is on identifying occasions that demonstrate each theme through a conversation between the participant and the researcher and reveal elements of PI as Riessman (2008) suggests this kind of analysis allows: 'The construction and performance of identities' (Riessman 2008:137).

Therefore, my voice is present alongside the participant as illustrated in Appendices F, G and H; this increases the need for reflexivity and adds clarity as to how interpretation was carried out. Riessman (2008) suggests that Goffman's (1959) ideas of performing a persona underpin this type of analysis where participants dramatise situations to preserve face and show their most desirable self.

Excerpts from the three participants' interviews are analysed in terms of key linguistic features that Riessman (2008) suggests indicate a performance is taking place. Firstly, examples of direct speech were identified; these help to build credibility and illustrate each participant's view of themselves. Next, asides were identified when the narrator speaks directly to the audience. Repetition was used to mark key moments and expressive sounds were used to identify pivotal moments. Finally, the use of verb tenses was analysed to demonstrate performativity.

Alongside these linguistic features, analysis was influenced by McCormack (2000), who suggests that analysis includes viewing the interview transcript through multiple lenses by engaging with the transcript through active listening; determining how the story was told; acknowledging the language of the text and the context as well as noticing when something unexpected happens.

The three interviews per person were considered as one story, i.e. the story of how the participant became a HV and the impact this has had on their identity. The interviews are co-constructed through a conversation between the interviewer and participant (Hunter 2010). Excerpts are presented in the appendices from the three remaining participants' interviews and referred to below. Each participant is introduced via a brief life history and career timeline.

Participant 3: Sophie

Sophie was a direct-entry Midwife. She started her midwifery training when she was 19, qualified when she was 22 and practised for four years, working in both community and hospital settings. She commenced her SCPHN training in March 2018 and completed it in March 2019. Sophie was interviewed in April 2018, November 2018, and April 2019. The interviews lasted between 40 and 55 minutes (S1-3). Sophie trained with one Community Trust and then went to work for a different Trust.

In the thematic analysis three areas were identified as being important for Sophie: her history, her skills and being a HV. The excerpts presented link to the themes and indicate Sophie's views. The excerpts were chosen following repeatedly listening to the interviews and link to either transitions or insights.

In S1 I asked Sophie why she became a HV student. Riessman (2008) stresses that who asks the questions is important, as this will influence what is said and how it is interpreted. Therefore, I will have influenced what was said as Sophie was talking to me, a qualified HV and from the way she was talking she wanted to emphasise that health visiting was a conscious choice that she had planned as part of her career

trajectory. Sophie spent quite a while explaining why she wanted to be a HV and why she wanted to leave midwifery.

The analysed extract is presented in Appendix F1 and is from the beginning of S1 and links to her history.

Sophie hoped that by changing to health visiting she would be able to emphasise working in the community and using her relationship skills and that there would be less emphasis on the clinical role. Analysing the excerpt using Riessman's (2008) framework illustrates the significance of these two issues. Sophie uses direct speech to explore the importance of relationships and reports directly what her mentor said "*just hold back",* she said, "*because you're trying to resolve things that can't be resolved".* This emphasises the difference between the clinical focus of midwifery and the relationship focus of health visiting which Sophie explained was one of her reasons for wanting to change role. Sophie identified asides, and spoke directly to me as the audience to ensure that I was engaged with her explanation; this was illustrated by her emphasising that she had researched what she wanted to do, *"In that time, obviously, I'd done some research, Healthy Child Programme, that sort of thing".* Repetition was used to mark key moments such as when Sophie highlights the importance of being in the community: *"So I did a few bank shifts in the community, the overtime shifts, again, fell in love with it again",* "*because where I'd been in community"*, "*when I was in community, I got that sort of thrill to want to stay in community"*. She emphasised that for her this was an essential part of the role and enabled her to fulfil her need "*I need to get out in the world".* Similarly, repetition was used to illustrate the significance of relationships. A distinction was drawn between midwifery, where "*you only see the women up to sort of two weeks afterwards"* and health visiting where "*it's more about communication and about supporting"* and less about clinical skills. Sophie was very enthusiastic about this change in focus. Finally, the use of verb tenses is analysed to demonstrate performativity; Riessman (2008) suggests that the historical present tense is used to increase immediacy; this is when a verb in the present tense is used to refer to something in the past. An example of this is "I need to go for it", when Sophie refers to deciding to apply. Sophie was demonstrating how and why she decided to be a HV and why this was

an important step for her future career. The dialogic analysis emphasises how important this decision was for Sophie and shows the depth of Sophie's feelings.

In S2 Sophie reported feeling very disillusioned with health visiting. She had wanted to build on her midwifery skills and have the opportunity to develop relationships but she found that the Trust where she was working did not offer a service that promoted her ideals. She was very passionate in her views and wanted to engage me with her reasons for why she was no longer eager to become a HV. This ties to both her history and her desire to be a HV.

In Appendix F2 Sophie highlighted that she thought health visiting was about building relationships and working long-term with families but in the trust where she was working much of the HCP was carried out by Community Nursery Nurses (CNN), who were not qualified nurses. Analysis of this speech shows it was an explanation about how she felt which was disillusioned. She used repetition rather than any of the other linguistic techniques illustrated in the previous example. However, as Riessman (2008) indicated, what she said was influenced by her talking to me in a series of interviews about her PI: "*I'm still kind of struggling a little bit with the identity of a Health Visitor I feel that it's not as strong as being a Midwife"*. She reported feeling more like a midwife: *"I don't know if I'll do health visiting primarily. I think my love for midwifery is very strong.*" This contrasts with her initial interview but, as highlighted in this interview, this is the halfway point of the course and could be viewed as a transition. She goes on to say, "*I feel a bit like, midwifery had it but I don't think health visiting does".* She expands her views:

> *I'm not doubting, you know, what they do, but I'm saying, for me as an individual, I think coming from a midwifery background, you're very much on the front line.*

This observation stresses that midwifery was more clinical and this was what she enjoyed whereas previously she had wanted to be less clinical. McCormack (2000) suggests that this is theorising why something has happened and is an important lens to consider in analysis. Furthermore, Sophie refers to HVs as "*them*" and "*they"* distancing herself from the profession but recognising the value of health visiting and again this may have been influenced by her talking to me. In contrast, for midwifery

she uses "*you're"* to highlight her affinity with the profession. McCormack (2000) suggests that use of language is another lens that helps to demonstrate identity and relationships. Sophie recognised that her disillusionment might solely be due to her placement but at the end of the interview I recorded in my field notes that I would not be surprised if Sophie did not complete the course.

However, despite my concerns Sophie did complete the course and in S3 Sophie discussed in detail what she thought health visiting was about and she was enthused again, specifically about having developed her clinical skills further, linking to themes two and three. She also referred to HVs as "*we"* in S3 on several occasions demonstrating her links to the professional group. At this point she had changed Trusts going to work for the Trust where she had completed her alternative placement and she had just received her confirmation from the NMC that she was registered as a SCPHN, so she was an autonomous HV.

In Appendix F3 Sophie is focussed again on being a HV; she was very aware that the focus of the interview was PI and she was keen to discuss this without any prompting. Analysis of the extract showed she was performing what she perceived health visiting to be but as Riessman's (2008) observation on researcher influence implies, this was probably induced partially by her talking to me. Sophie used direct speech to illustrate how much she had learnt and how experienced her colleagues are, she asked for help "*what shall I do about this?*" It could be that she still regarded herself as a novice and presents herself as newly qualified and needing support as a way of coping with the changes in role. Her use of expressive sounds rather than words to demonstrate crucial ideas '*they go dada de de'* may highlight how much she respects the other HVs' knowledge base, but she does not link this to her own. She sometimes refers to "*them"* rather than *"we"* for example: "*So with them being more hands on with the babies",*but in S3 Sophie used *"we"* in relation to the HVs in the new trust . Analysis with McCormack's (2000) lens might indicate uncertainty in Sophie view of herself. However, when she refers to practise in her previous Trust, "*Just weight and we got the mums to lift the babies on to the scales*" this could indicate ambivalence about her new role especially as she refers to midwifery as 'my midwifery'. Or it could be because she was maintaining her identity as a midwife too

and trying to maintain two professions, which she stated, was important for her. Later in S3 "*I will always be a strong link with midwifery*".

Nevertheless, through repetition she does emphasise the importance of her new clinical skills "*I'm learning clinical skills*" and "*I'm finally doing something clinical along with caring and using communication*" which Sophie regarded as an important part of her role and her identity. Sophie could be illustrating the importance of action in relation to her identity and this could link to Goffman's (1958) concept of performing. Sophie used repetition to underline that she felt that the HVs she was working with had a strong identity: *"I feel like there is a stronger identity here"*. She reported that this was because they were autonomous and made decisions using their experience. Later in the interview she returned to the notion that there was a strong HV identity where she was working, and she linked this to autonomy which she felt was absent in the previous Trust and enjoying her role.

These three excerpts illustrate the developing nature of Sophie's PI; she appeared to still have a durable identity as a midwife, but she was developing her links to health visiting. She reported that her colleagues were supportive and had a strong identity themselves and were helping her to cultivate her PI. Interestingly there was less focus on the university course helping with this, but the course did help with her skills development.

Participant 4: Helen

Helen was in her late 30s and had three children. She qualified with a diploma in adult nursing in 2005 and worked in care of the elderly as a staff nurse and then worked on the nursing bank to allow flexibility when her children were small. She worked as a CSN alongside HVs between 2015 and 2017 when she started SCPHN training. Helen completed her SCPHN course between September 2017 and September 2018 at level 6. She participated in three interviews November 2017, April 2018 and October 2018. Her interviews varied in length between 40 and 55 minutes (H1-3).

Analysis of the interview excerpts takes place through both Riessman's (2008) framework or McCormack's (2000) variable lenses to illustrate the issues that Helen thought were fundamental to her PI and reasons for becoming a HV.

In H1 Helen talked about her PI as a nurse; this linked to her personal experiences and being empathetic. Her sense of PI influenced her choice to become a HV which she saw as a specialism of nursing. The extract in Appendix G1 explains two reasons why Helen chose health visiting; these were moving away from caring for people who are dying and having had her own children. The third reason for becoming a HV was Helen's experience as a CSN. She said that if she had not taken this role, she was "*ninety-nine per cent sure"* she would not have become a HV.

When Helen was asked about her PI as a nurse, she equated this with enjoying and valuing her role as a nurse and reported she always felt she had done a good job. She used repetition to emphasise this: *"I was very proud to be doing what I was doing"* and later she said "*I felt like I was doing quite an important job"* again she reiterated *"I would feel satisfied I had done a good job"*. Again she says *"I always went home and felt satisfied that I was doing the best I could for that patient*" and at the end of the excerpt she said "*that was what I enjoyed most about being a nurse I actually that I felt satisfied that I was doing a good job".* The value placed on her role as a nurse was further supported by the reported direct speech from her husband: *"you've earned your place in heaven now".* This highlights that nurses are often seen as good people, but Helen disputed this and reported some nurses worked for money and others lack empathy. She emphasises this through her use of an aside to me *"I think nurses are doing that for a whole wealth of reasons aren't they?*" Helen wanted me to agree with her and as such was engaging me in her argument as to why people become nurses. Being empathetic was important to Helen; she demonstrates this by her use of *"I" – "I learnt a real sense of empathy"* and emphasising that it was part of her "*I had that empathy within me"*. This was one of the reasons she went into nursing and she reported that she often saw other nurses who were not empathetic, but she did not give examples of this. This excerpt, although lengthy, gives an account of Helen's understanding of her PI as a nurse and how this influenced her to become a HV student.

Having explored her PI as a nurse Helen went on to explain how she saw being a HV and how this differed from being a CSN. Helen started H1 explaining her role as staff nurse and was very confident in what she was doing however by H2 when she was over half-way through the course and her views had changed. The next excerpt in Appendix G2 demonstrates Helen's view of the difference between a CSN and a HV.

In this extract Helen recognised the difference between a CSN and HV due mainly to increased knowledge gained from the course but also due to an increased awareness of other significant aspects such as evidence-based practice. She suggested that CSNs carry out developmental reviews as a task whereas for a HV is it more in depth. Analysing this extract using McCormack's (2000) lenses reveals the fundamental ideas. One of the lenses is to look for the unexpected and for Helen she is surprised when she looks back at herself as a staff nurse at her lack of knowledge "*it was more of a task... more of a sort of a tick box thing as a staff nurse"*. She recognised her depth of knowledge now. Furthermore, McCormack (2000) suggests the context is important too. In the first interview Helen was confident in her experience as a staff nurse but now as she has gained knowledge, she questioned her previous role further and recognised how it differed from being a HV. This demonstrated her self-awareness. McCormack (2000) also suggests that language is important. Helen uses past tenses to link to nursing that could indicate she is distancing herself from nursing: "*knowledge I had as a nurse*", later she says: *"I was an adult nurse trained"*. Whereas when she talks about health visiting, she is much more positive about the level of knowledge she has: *"given me such a more powerful insight into the development review"*. This could indicate that Helen is changing her views about what is important to her. It could also indicate the significance of the concrete experience too.

The next extract from H3 again emphasises the importance of Helen's increased knowledge and skills and how as a result her confidence has grown. This is in Appendix G3.

McCormack (2000) indicates that active listening is an important feature to look for when analysing interviews. Listening to this interview showed Helen was extremely enthusiastic about her new role and appeared confident which was a change from her previous interviews. She began by explaining she had felt deskilled due to lack of autonomy and there was some hesitation about how she would cope in challenging situations: "*I just hope that when I'm in that situation, somehow it all comes together*". Generally, she was much more positive "*I feel like I've got my skills back, but I feel like I've gained a whole load".* She was looking forward to new situations:

> *well I'm going to a core group today by myself, so I feel like I've gained knowledge to be able to sort of do that, and that's quite a big step*

This shows development of autonomy again as she can make decisions for herself. However, she recognised that she had to be sensitive: *"So I'm quite wary that I don't want to say the wrong thing".* The context of this interview is important. It is five weeks after completion of the course and Helen is working independently but her NMC confirmation of her registered SCPHN status had not come through, yet which is causing her some problems. But as she states she is going to the core group for a safeguarding case by herself, so this is a positive development. Her faith in herself was emphasised by her repeated use of *"I"* in all the examples above; she was relying on herself rather than on others. Later in the interview she went onto say "*I am a Health Visitor now*' on several occasions, again demonstrating her confidence in her new role.

Participant 5: Anna

Anna was a direct entry midwife in her late 20s. She had been qualified for seven years, having trained in Europe but had only practised in the UK, in hospital for three years and then working in the community. Immediately before training to be a HV she worked in a specialist midwifery role. She reported that she really enjoyed midwifery, particularly working in the community, but she found working in the specialist team very stressful and this was why she left. Anna started her SCPHN training in March 2018 and completed it in March 2019. She was interviewed in May 2018, November 2018 and April 2019. All three of her interviews were quite short, lasting approximately 40 minutes each (A1-3).

In A1, Anna was very candid and explained that she had not intended to become a HV rather that her last job had been very stressful and she left without a job to go to and then saw the health visiting student advert and applied and was accepted.

Anna began by explaining why she thought she would always be a midwife at heart but that it was the impact that her role had on her life overall and her work-life balance that had caused her to leave. She emphasised how stressful she found midwifery in A1-A3 but was less vehement about this in the final interview.

Analysis and interpretation of Anna's interviews identified her key issues as her identity as a midwife, the differences between midwifery and health visiting culminating in her view of what health visiting is really about. The excerpts in Appendices H1-4 illustrate these issues. The excerpts were chosen after repeatedly listening to the interviews.

Anna explained that she did not view herself as a nurse and had found the change of title to PHN very difficult. She had a strong identity as a midwife and felt that this was an important part of how she viewed herself and how others viewed her too.

The excerpts from Anna's interviews are analysed using Riessman's (2008) linguistic techniques to identify the salient points. Anna used repetition in H1 to indicate that she was not a nurse: "*they keep saying, you're a Public Health Nurse. And I'm like, no, I've always not been a nurse"* she goes on to say "*apparently, I'm a nurse and I don't feel like I'm a nurse. I'm happy being a Health Visitor but a nurse is different to me*". She repeated her point *"I've never been trained as a nurse, I was direct entry. So I've only ever been a midwife because I didn't want to be a nurse"*. This conversation took place in the first interview and Anna went to great lengths to emphasise that her identity was as a midwife: *"I'm a midwife, so there's that difference*". Furthermore, she states "*I think as a midwife, we've got a very strong identity with our profession, like as part of who we are, and people react very strongly to it"*. Her use of pronouns when referring to midwifery indicates her identification with the profession for example "*we"* and "*I'm"* in the above extract whereas "I'' in relation to nursing is preceded by "apparently" as a way of distancing

herself. However, Anna's views may have been influenced by my replies to her due to my background (Riessman 2008). As a result of this her views could have been co-constructed.

Anna viewed the difference between health visiting and midwifery as significant. She reported that there were aspects of midwifery she had not agreed with; the example in Appendix H2 from A1 illustrated this. Although becoming a HV had been as a result of happenstance rather than planning. Anna found her values coincided with those in health visiting and that this was a positive.

Anna indicated that as a midwife the focus was on the mother but that she felt that sometimes when working in the specialist team that this was an error of judgement because the focus should be on the child. This had led her to question her role as illustrated in Appendix H2 "*I was more, I should be more the voice for the child, in situations that are difficult*". She repeated this point "*no, but I've always felt I should be the voice for the child, even if that is not nice".* This had caused disagreements with colleagues "*a colleague of mine, also from the team, was like, no, I'm there for the mother. I'm not there, primarily, for the child*..." Anna performs her role as the child's advocate in this example by using direct speech in relation to the social work manager indicating the significance of this moment "*no, we need more evidence that the child really can't stay".* Furthermore, Anna uses asides (Riessman 2008) to ensure that I am engaged with her reasoning, an example of this is when she starts the answer by asking me a question *"I think, because I have been thinking, what's the difference in role".* From this extract it is apparent that Anna has strong views about her role.

At the end of A1 it was clear that for Anna being a Midwife was an important part of how she saw herself and she reiterated this in A2 where like Sophie she was quite disillusioned with health visiting and was unsure that it was what she wanted to do long term. However, by A3 she had a clear concept of what health visiting was and was enthusiastic to continue and had accepted that maybe in doing this she could use her midwifery skills but would not be a practising midwife. She reported that she had come to terms with this in Appendix H3. For Anna her PI as a midwife had waned but she still did not seem able to say that her identity was as a HV. However,

it was important for her to still be able to use her knowledge and skills from midwifery which implies more of a dual identity. Nevertheless, she said she was confused, and she linked this to her change in personal circumstances: she was newly pregnant and not feeling well.

Anna's view of being a HV is someone who helps and supports families. Anna performed being a HV in Appendix H4. Anna begins her explanation of what it is to be a HV with an aside to me "*I think it's about; I think helping parents"* beginning with her explanation of what she thinks the role is. My analysis illustrates how she uses direct speech to empower a client. She reports the client said: *"oh I'd love to go, I'd love to get to*" and "*oh that's just around the corner from me*". This indicates how significant empowerment was to Anna as part of her role. She also used expressive sounds rather than words to indicate important ideas: "*And you try and say like, go there, de, de, de, but then they don't do it"*. Through this she was illustrating that empowering was about giving people choices which some clients relish and act whereas others do not. In her discussion of empowerment she uses repetition to exemplify her point that it was about choice "*oh I tried to help and I try not to arrange that for them because I know she can pick up the phone, you know, but she chose not to*". Later on she said "*you need to step back a little bit then*". Again, emphasising choice. McCormack (2000) highlights the importance of language and Anna uses pronouns to indicate links to what she was saying for example she talks about "you" all through the discussion of empowerment which implies some engagement with the role. However, greater engagement might be demonstrated if she said "I".

Anna seems to be developing her PI, but she still has strong links to midwifery. Throughout the interviews she reports that the course has helped her by developing her knowledge and skills but interestingly she didn't feel she learnt anything new rather that the course developed her ability to link the theory to practice or it could be due to her having completed her midwifery in a different country and the curriculum being different.

Coda

These excerpts from the three participants yield some rich insights into how they view health visiting and how their views link to their PI. Over the year their attitude towards their PI changed but in distinct ways which are emphasised below.

In relation to Sophie, her identity appeared to be a dual one and her identity as a HV was linked to her maintaining her identity as a midwife. She started her SCPHN programme with a lot of enthusiasm for health visiting and presented this change of role as a planned career trajectory. Sophie performed being a HV in earnest during her interviews. However, her passion for health visiting waned significantly midway through her SCPHN programme. Nevertheless, by the end of the year she had regained her interest in the role and she appeared to have been able to develop her skills and knowledge as a HV and integrate it with her identity as a midwife. For Sophie, one of the noteworthy factors that influenced her renewed eagerness was the change of location of her practice following her qualification.

Helen had two years of experience as a CSN and it was this opportunity that had inspired her to train to be a HV. Initially she had strong views about being a nurse and this was her PI. Over the year she recognised how much she had gained during the SCPHN programme and she had a clear view of herself as a HV. She states this is her PI and appears to move away from her identity as a nurse. For Helen the change appeared to be cumulative.

Anna started her SCPHN programme following disillusionment with midwifery. She had a definite identity as a midwife but over the year long course her identity changed. Although she struggled with the concept of being a nurse initially, she was pleased to be a HV. At the end of the course she reported that she was happy to let her midwifery identity lapse, but she was unsure about her identity as a HV. She reported that her values reflected those of health visiting as opposed to midwifery but interestingly she did not feel she had learnt anything new during the programme.

At the end of the analysis I revisited the reflections I carried out after each interview. My reflections on Helen's journey supported her gradual transition into her new role. In relation to Sophie I have already said that I was concerned after the second interview that she might withdraw and my reflections highlight my concerns that she

would be a loss to health visiting but after the third interview I was gratified at how enthusiastic she was. Anna was unforthcoming throughout the interviews and I commented on how hard interviews one and two were in my reflection but in the final reflection I was pleasantly surprised by her intention to continue as a HV and her identification with HV values.

Dialogic analysis has highlighted what PI means to these three participants and has demonstrated the process of how it has developed over their year- long programme. Dialogic analysis has expanded the understanding of the data and helped to explain how the PI of these three participants developed. For each of them the journey has been slightly different, and the end point has also varied.

In the next chapter the significance of the data presented in these two analysis chapters will further expounded by linkage to my observations, CoP and the literature from the background chapter to address the question that this thesis poses.

Chapter Six: Discussion

Introduction

The purpose of this chapter is to broaden the outcomes from the findings chapters, to focus on the areas of commonality that were identified in the analysis and to consider these in relation to relevant theory and wider literature considered at the outset of the study Three lenses are used with the intention of evaluating the findings and identifying the original contribution of this study to the existing research on PI. The lenses are: 1.my personal observations linked to the data as collated throughout the project in field notes and my reflective journal;2.the theoretical framework of communities of practice and 3 the existing literature on PI. In all the sections only the most salient areas that resonate with the findings are discussed. The decision about which areas are included is based on the strength of the data, with those areas that are reported consistently in the data being the focus. The lenses are presented in ascending order based on the degree of understanding and illumination offered. The first two sections are succinct, but they help to foster insights into the links between my observations and CoP and the data. However, the most extensive insights are afforded by the third section where the dialogue with the literature is reported.

Personal Observations

My personal observations are significant because of my role as an insider researcher and the active role I played in data collection and analysis as explained in Chapter Three. They are also noteworthy as it was my own view of what it is to be a HV that inspired this research study.

The data reported in the findings highlights three key areas that link to my personal observations in relation to the data: relationships; differences in role and connections to nursing and midwifery. These are outlined below.

Personal Observations: Relationships

Before I commenced this project, I completed a short autobiography and in this I reflected on my view of being a HV as it was this that had prompted my interest in the topic of student HV PI. In my autobiography I reported how my view of health visiting changed throughout my year as a student and at the end of the year I maintain that a crucial component of health visiting was listening to people, respecting them and supporting them to achieve the best health they could. In essence I felt it was about relationships and support rather than my experience of nursing and midwifery which had been less holistic, and more task-focussed. Health visiting seemed to be very different to either of my two previous professional roles.

The findings support the suggestion that long-term relationships with clients that offer them support are key components of the role and link very much to the PI of the participants and their view of what it is to be a HV. Developing relationships seemed to be related to the participants' experience as a nurse or midwife. However the participants' ability to develop and sustain relations improved as part of being a HV.

Personal Observations: Differences in Role

The differences between the role of nurses and midwives and those of HVs were an important facet of this study from my perspective. In my autobiography I was adamant that, from my experience, being a HV was a different role from being a nurse or a midwife. This impression was supported by the history of health visiting which shows how, over the last 150 years, health visiting has changed from an independent profession to being a specialist role within nursing. Health visiting has historically been a profession in flux, and this appeared to have affected my PI and the identity of some of my colleagues. However, in the findings, the participants by the end of their course saw themselves as HVs but this was a very individual journey. Only one of the participants found this journey to be uneventful with no major disruptions; the others all found it challenging and this impacted on their identity.

Personal Observations: Connections to Nursing and Midwifery

Having conducted the study I would still assert that health visiting is distinct from both nursing and midwifery but the links to nursing and midwifery are stronger than I

initially believed as demonstrated by all the participants. Experience and previous skills all appear to be essential in developing the PI of the students as HVs. All the participants felt that their previous experience and the skills and knowledge they had gained were essential in their becoming a HV. Only one of them reported that being a HV had been their aim from the beginning of her career. This could be because direct-entry health visiting has not been a possibility in the UK since the inception of the NHS. Interestingly even though Caroline wanted to be a HV from the beginning of her career as a healthcare professional she agreed with her fellow participants that direct entry health visiting was not a good idea. This may be due to all of them feeling that their previous experience had supported their transition into health visiting. Only one of the participants was adamant that she was not a nurse, but she was happy to be a HV; the change of title to Specialist Community Public Health Nurse was introduced in 2004 by the NMC (NMC 2004) and distressed this participant.

Communities of Practice

CoP theory (Lave and Wenger 1991, Wenger 1998) was introduced in the methodology with the focus on three significant aspects of the theory: mutual engagement; joint enterprise; and shared repertoire and their links to legitimate peripheral participation. In this chapter the data is brought into dialogue with the aspects of the theory which appear most apposite to the situation. These areas are used as lenses to understand the process of moving from one role and identity to another and as such help to understand the transitions that are taking place. However, for this group of participants it is important to acknowledge that they belonged to a number of CoPs; as students in the university; as a group themselves as well as in their placements which are highlighted below in relation to their relationships.

Communities of Practice: Mutual Engagement

Relationships develop out of engagement in practice. Wenger (1998) suggests they are essential for a CoP to function. For this group of participants, several relationships were perceived as being vital. Firstly, their relationships with each other - they all reported how much they valued the support they received from each other

through being able to talk about their experiences. The time in the University enabled them to do this. Three of the participants completed their course and went to work in the same town where they were based together and were able to discuss their experiences and support each other.

Relationships with other HVs including their CPTs were also considered to be key for all of them. They found being able to discuss what happened in practice and share ideas invaluable. This was both a way of learning and of gaining support through reassuring themselves that they were performing their roles effectively.

Relationships with clients were also crucial. The opportunity to develop in-depth relationships that lasted over a period attracted the three midwives to the role. All of the participants reported that it was these relationships that enabled them to carry out their role, develop their identity and support the families they were working with which accords with the theory of health visiting suggested in both the Principles of Health Visiting (CETHV 1977) and Cowley et al (2015:474) ‘orientation to practice’.

Communities of Practice: Joint Enterprise

Joint enterprise refers to mutual accountability and understanding of what is required. It links to being resourceful and not necessarily all doing things in the same way (Wenger 1998).

Two specific areas appeared significant in the data for all five participants. Firstly, working in the community as opposed to in hospitals was a significant issue. They had variable amounts of experience of this before commencing the course, but it was something they all wanted to do, and all reported it was an important part of their identity. They all recognised that going into people's homes as a professional required them to adjust their approach and to consider different ways of working.

The second salient area was their understanding of being a HV. From discussion with colleagues and their experience, they acknowledged that there was not one way of working and they all needed to develop their own approach by linking theory to practice. However, they all recognised the importance of policy in defining what they

should do but embraced their own professional autonomy and growing confidence in how they would do it. For some this was a straightforward process but for others it took time.

Communities of Practice: Shared Repertoire

The study findings also appeared to validate Wenger's (1988) notion that a "shared repertoire" is a signature feature of a CoP. For all five of the participants the skills they brought with them into the course were important and were built on. During the course they combined being reflective and the ability to be non-judgmental through their communication skills all of which were essential. They learnt to use specific tools such as the: Edinburgh Postnatal Depression scale and the Ages and Stages Questionnaire and growth charts to support them in their role rather than as an end in themselves. They all commented that this was part of being a Health Visitor, utilising their in-depth knowledge to use tools, rather than seeing them as tasks to be completed.

However, being part of a CoP did not explain why they all felt deskilled during the development of their shared repertoire. This could be because communities of practice are very much focussed on the novice-to-expert trajectory and the participants were already expert practitioners in a different field.

These three essential elements of a CoP help to clarify the journey the student HVs undertook. However, LPP (Lave and Wenger 1991) is also pertinent in helping to gain insight from the participants' experience. They had a specific reason for being in practice with teams who were there to support them and they were then encouraged to become full participants in the teams as their skills, knowledge and experience grew over the year. By the end of the course they all designated themselves as HVs even if, as for one participant, it was in conjunction with being a midwife. However, the reported feelings of being deskilled could also link to LPP. As explained in Chapter Three one of the criticisms of LPP is that it does not recognise previous experience (Fuller et al 2005) leading to alienation (Philip et al 2019). Feeling deskilled could be a way of expressing this.

Dialogue with the Literature

It is important to bring the study findings into dialogue with the existing literature and theoretical conceptions of PI outlined in Chapter Two. This section is divided into the three categories that were identified in Chapter Four (P114). In each of the categories there are subdivisions and the salient areas are explored in relation to the literature on PI to illustrate the impact on HVs as a professional group. The dialogue with the literature is the key lens for understanding the findings and involves some repetition of the previous lenses.

Dialogue with the Literature: Previous Experience

This category includes experience, expectations, difference between previous role and health visiting, and transitioning to the new role. Each of these are discussed in turn and connections are made to the existing literature.

All the participants spoke at length about their previous experience particularly in the first interview. All five had relevant previous experience before commencing the health visiting course. To recap, two were nurses and three were midwives. All of them were able to articulate a developed conception of their existing PI and its importance to them. The research participants independently recognised and articulated several of the constituent elements of PI as defined by Rasmussen (2018). All five ascribed the label of either being a nurse or midwife to themselves at the beginning of the course. The label was a significant part of who they were and what they were doing. Sophie reported that being a midwife was part of who she was; Helen stated that she was proud to be a Nurse. Anna stressed she retained a strong identity as a Midwife and she was very frustrated by the title PHN as she was adamant that she was not a Nurse and that she was a Midwife but was happy to be a HV, corresponding with Machin et al's (2012) findings, where participants expressed disquiet about the title of SCPHN including nursing . Kath reported she used her identity as a Nurse to gain clients' trust and acquire access to their homes.

Caroline averred that initially she thought of herself as a Midwife even though she had not been qualified for long. She indicated that she had always wanted to be a HV but that her midwifery skills were important to her. She reported that as a Midwife she often felt she was failing to do the job well because of lack of time; Jay et al (2016) agree that lack of time is one reason midwives change to health visiting. However, when I first met Caroline, 7 weeks after she started her course, she stated she had already started to think differently as a HV. She testified that she was used to transition because she had been in her previous role for such a short time. She claimed that this was in many ways an advantage as she was used to change unlike some of her cohort who had many years of experience in their previous roles and as a result were struggling with their new role and she reported they were unclear about their PI and were in a state of flux. This would appear to suggest that those with more experience found transition to the role of HV more difficult. Kath agreed that those with more experience seemed to find the transition challenging, both Kath and Caroline's assertions contradict the findings of Arrowsmith et al (2016) who suggested that the amount of experience as a nurse mediated the stressful aspects of role transition indicating that this could be an area for further exploration .However, Caroline's identification of the links between role and identity aligned with the findings of King and Ross (2004).

Caroline's and Kath's description of their colleagues' struggles appears to concur with Norwegian research with PHN students (Hjalmhut 2009). The students went through a three-stage process in their training: *positioning*, where initial identity was misplaced emphasising their previous identity and being unsure of their role; this could be what is being described above; *involving,* where they participate but are anxious about being assessed; and *integrating*, whereby they realise their full potential and develop their new PI. PHN training in Norway is very similar to the UK therefore this framework appears applicable, particularly in the light of all the participants' initial emphasis on their previous identity.

Recognition of their previous experience was important for Kath, Anna and Helen. Kath's declared preference for being introduced as a children's nurse who was doing extra training to become a HV reflects a dynamic model of PI which mirrors that described by Hughes-Morris and Roberts (2017) in their study of students

commencing the SCPHN course. They suggested that returning to student status had an emotional cost and could lead to a lack of self-worth and self-esteem and not feeling valued if previous experience was not acknowledged. Anna also reported that she felt valued when her CPT introduced her as a midwife who was doing extra training. However, Hughes-Morris and Roberts (2017) reported that the feeling of not being valued is mitigated by a feeling of accomplishment at the end of the course. Helen initially stated that being a CSN meant that she was well prepared for her new role. She saw HVs as specialist nurses. Thus, she claimed this combined her knowledge from being a hospital nurse with being a HV student. Research suggests that if previous experience is not acknowledged by colleagues this can be challenging for professionals who are changing roles (Darvill et al 2014). In her study of post- registration children's nursing students, Begley (2007) found that when years of previous experience were disregarded it caused stress for the students and led to them not feeling valued concurring with the participants' views. Despite some reservations about their current situation all the participants illustrated during the course that their PI changed, linking to who they were, their role and the context of what they were doing (Rasmussen et al 2018).

The data suggests that experience of health visiting and participants' expectations of the role before they started the course was extremely important. All the participants valued their experience. Caroline had wanted to be a HV before she started midwifery because of her experience as a Mother, however she stressed that if she had needed to be a nurse first she would not have become a HV, whereas Helen had become a CSN after seeing an advert for the role and decided it would be a good way of utilising her experience and changing direction. It was only following her experience as a CSN that she had decided to become a HV. Helen claimed her experience meant she had realistic expectations, but it took time for her to recognise the difference between the two roles. Kath had limited experience of health visiting, but her expectations were that the role would link all her previous experiences together. Sophie had limited experience of health visiting and her expectations focussed on building relationships over a longer period than had been possible in midwifery. Research by Arrowsmith et al (2016) indicated that changes in role are less stressful for qualified nurses who used previous abilities and experience to

alleviate the change, the above examples support this which contradicts the earlier discussion but enhances the argument to explore this issue further.

Anna had not intended to become a HV; she had been stressed and burnt-out in her previous specialist role and had applied for the health visiting programme to facilitate a change in role. Research indicates that some midwives want to become HVs to permit holistic client care as this is not possible due to pressure of work in midwifery, however, midwives perceive that being a HV will enable this approach (Jay et al 2016). Furthermore, Jay et al (2016) suggest that some midwives want to become HVs due to experiencing burnout in their previous role; Anna's experience corresponds with the research.

The reported dissatisfaction of two participants (Anna and Sophie) with the HV role midway through the course may well have been due to the transitional nature of the programme, its purpose being to move from one role to another NMC (2004) or it may have been due to unrealistic expectations or to differing values. Sophie's reported perception that the Trust she trained with had very different values to herself were reflected in the Trust's view of health visiting being a crisis service rather than a preventive one. Professional value conflict can cause difficulties with PI (Whittaker et al 2017) as can conflict between roles and policy as indicated by Dahl and Clancy (2015) in their Norwegian study of PHN. These might be the reasons why Sophie struggled with her identity midway through the programme.

Anna, Helen and Kath reflected on the differences between their previous role and being a HV and for all of them these were positive differences. Anna's view that there was better alignment between her personal values and health visiting than there had been with midwifery aligns with Johnson et al (2012) who suggest personal values influence choice of profession. Moreover, expectations of a role develop before joining a profession and this links to identity formation (Baxter et al 2011, Johnson et al 2012). It is influenced by experience before joining a profession and by professional education (Sim 2011, Arreciado Maranon and Isla Pera 2015). Furthermore, expectations link to career aspirations and professional and personal values which meld as PI develops (Clements et al 2016); understanding of values can improve recruitment and retention (Whittaker et al 2017).

Kath's desire to prevent problems and her recognition of the impact of social mores intersects with Cowley et al's (2015:474) view of health visiting as an "orientation to practice". Helen too wanted to ensure children had a healthy start; the latter two examples are linked to making a difference which is discussed further later and, again, links to values and the core constructs of health visiting.

The importance of understanding her role was demonstrated by Helen who had been a CSN and in the first interview reported that this had stood her in good stead for her new role. However, by the second interview she recognised the two different roles: many CSNs had limited theoretical knowledge and had a more task-focussed approach to their role whereas HVs had a more in-depth understanding of the links between theory and practice. King and Ross (2004) highlight that identity links closely to an individual's role as well as the history and social expectations of a profession. Machin et al (2012) found that understanding of the role of a HV was essential for effective practice of that role.

Sophie also recognised differences in her role but for her it was not a positive experience. Initially she reported being disillusioned with the clinical nature of midwifery however midway through she was lamenting the lack of clinical practice in health visiting. This could indicate expectations which do not match the reality of the situation which Spoelstra and Robbins (2010) suggest makes transition between one role and another more difficult. Sophie reported that frustrations with her role, in the Trust where she trained, were due to CNNs undertaking many of the routine contacts that in other Trusts were carried out by HVs. Sophie based her expectations of the HV role on the Healthy Child Programme (DH 2009) but found the reality of practice differed from what she had expected. This appears to concur with Dahl and Clancy's (2015) findings which suggest that conflict between policy and practice impacts on PI formation due to a mismatch between knowledge, role and expectations. However, it is also important to note that negative experiences are part of development and facilitate individuals' understanding of their role (Trede et al 2012). Ultimately Sophie was positive about her role and she was pleased she had made the change, but this was partially because the Trust she worked for after qualification took a different approach to the HV role.

Transition is a change which can be stressful but usually has a positive outcome (Hughes-Morris and Roberts 2017). Noble et al's (2014) study of pharmacists suggested that a successful role transition for students is supported by a cohesive PI. Studies examining transition in nursing have generally focused on the change from student to qualified nurse (Arrowsmith et al 2016) but there have also been studies that have explored the change from working in the acute sector to working in the community (Sullivan Bentz et al 2010, Ashley et al 2016). For the five participants in this study, changing to the community was not an issue as four of them had community experience. Only Kath was new to the community and, although she initially found home visiting unnerving, Kath viewed it as a positive aspect of her role and adapted quickly; this concurs with Spoelstra and Robbins' (2010) view that any transition can be challenging but that realistic expectations can help to overcome any barriers.

Darvill et al (2014) in her study of newly-qualified children's nurses transitioning to working in the community suggested that the process of transition has three phases: *shadowing* an experienced practitioner*; visiting alone* with cases gradually becoming more complex; and *emerging identity* linked to being recognised as part of the team with experience being acknowledged. As four of the five participants already had community experience, these phases may be slightly different for them but all five commented that they valued the time with their CPT when they were protected. from the stress of managing a case load and able to focus on developing their skills Furthermore, they highlight the same negatives as the nurses in the study by Darvill et al (2014), in that they wanted previous experience to be recognised and did not enjoy being observed. They all reported that visiting alone was a significant moment for them. Helen's view was that her role as a CSN had prepared her for this transition as she had been autonomous and managed her own diary but there were still challenges when she recognised the difference in the depth between her two roles. The gradual increase in complexity was significant for Kath who reported relief that her first placement was somewhere quiet and her initial visits were routine which supports Darvill et al's (2014) findings and links to Benner's (1984) notion of novice to expert. By contrast, Caroline who started in a complex area reported developing her skills quickly. This may have been due to Caroline having had some previous

experience of home visiting in the community as a Midwife. Both Sophie and Anna reported feeling confident following community midwifery experience. Only Kath reported anxiety about home visiting which Machin et al (2012) suggest is a core aspect of being a HV. All five reported changes in identity linked to being part of the team and their ongoing experience being acknowledged. Both Caroline and Sophie on completion of the programme emphasised the supportive and inclusive nature of their teams and how important they had found this. This is supported by the work of Deppoliti (2008) who found that supportive relationships lead to successful transitions. Furthermore, positive transitions have been linked by previous research to remaining in the profession (Cleary et al 2009, Darvill et al 2014).

Experience, expectations and understanding of their new role seem to have been very significant in supporting the five participants to integrate their existing role and with their new role and identity. How the actual transition has been managed also seems crucial. As indicated previously, role appears to be an important consideration in relation to identity. Their views have been supported by existing research which helps to create a picture of the changes that have occurred. So far, this chapter has focussed on the first category of previous experience. The next section moves onto identifying the personal qualities of the participants and the impact that these have on their PI.

Dialogue with the Literature: Personal Qualities

This section offers an interpretation of the significance of the participants' personal qualities and how they relate to the pertinent literature. Personal qualities were chosen as the title for this category because the participants all mentioned a variety of attributes they considered they possessed and those that they developed during the course. The iHV (2019) suggests a core curriculum for HVs which recognises the personal attributes that students bring to the course alongside those they develop, these are similar to the ones the participants discussed. In this section the attributes or qualities are divided into those that ostensibly supported growth and those that caused difficulties. The supportive qualities were: being reflective; recognising own values including being non- judgmental; developing knowledge and skills; linking theory and practice; and embracing the benefits of the university course. Accessing

support as students from the team, university and CPT were also key. The challenging aspects of their qualities linked to being a student again, feeling deskilled and feeling anxious.

One area that all five participants agreed was important for their development was the ability to be reflective. They all reported that during the course both in practice and in the University, they were facilitated to be reflective. Caroline indicated that this differed from midwifery in that there was time to reflect not only on her own and with her CPT between visits but with the team in the office, she suggested this was one of the most significant ways of learning for her and was a source of support. She also noted that reflection with her colleagues was used to make decisions as there was often no definitive answer. This was perceived to be a good learning experience, but it could be frustrating. Kath, throughout her interviews, talked about reflecting on what she was doing and how she sometimes found the lack of a right answer frustrating, but she reported that she reflected consistently. Helen agreed that this was essential. The remaining participants gave examples of reflecting on what they had learnt and on their changing roles. Trede et al (2012) in their review of studies on PI development indicated that reflection leads to personal transformation and increased self-awareness which seems to be the case for all five participants.

Reflection links to values; being non-judgmental was emphasised by all the participants. Helen explained how she found it was essential to be empathetic and compassionate; Sophie stated it was vital not to be condescending and linked this to her improved communication skills. Kath found that during the course she became more aware of her own values and those of society. She consistently made links between an individual's life chances and their situation. Again this reflects the importance of Cowley et al's (2015:473) 'orientation to practice' for HVs in that they need to support the values of the profession and its key constructs. However, Sophie raised the issue of when the values of the profession differ from those of the employing Trust this can cause conflict as it did for her. It was the conflict in values that influenced her to change Trusts when she qualified. This links to having realistic expectations but could also be significant in retention of students. Notably it is suggested that it is one of the roles of professional education to clarify professional values, but this can be challenging if values are unclear (Johnson et al 2012). King

and Ross (2004) further suggest identity links to the values and key constructs of a profession thus recognising these is essential and relates to the significance of 'orientation to practice' (Cowley et al 2015:473) and the Principles of Health Visiting (CETHV1977) linking to expectations. Nonetheless, development of PI is supported by professional education; this is one of education's key roles (NLN 2010, Noble et al 2014). Education facilitates the development of skills; knowledge; professional values and professional socialisation (Baldwin 2008, Whittaker et al 2017). All the participants reported how much they valued the HV course. Kath reiterated how much she enjoyed the new knowledge and the opportunity to discuss issues; Helen reported the course was challenging but she appreciated developing the theoretical knowledge that could be applied in practice. Sophie stated that she knew from the outset that the course was intense but that students needed to adjust their mindset accordingly and be proactive. Sophie explained that she had learnt a lot from the course especially in relation to mental health, which she reported was well taught. Caroline stated that the structure of the course was excellent because of the way that issues were revisited as experience and knowledge developed. She gave the example of safeguarding, which was discussed several times in a variety of ways until the students were confident and then they were given the opportunity to practise the theory through role play thus demonstrating transformational learning (Trede et al 2012). Anna reported that she had not learnt anything new on the course only consolidated previous knowledge, but she did think that the course was very well structured. Anna's lack of perceived learning may have been due to her having been very experienced in a comparable role or it may have been that she did not recognise the new knowledge. Or it could have been that as Anna's midwifery training took place in the European Union (EU) the curriculum was different and she may have already addressed the curriculum from the SCPHN course in her midwifery course. Prior to 2021 midwives who had trained in the EU could have their qualifications recognised automatically with no inspection of the curriculum (NMC 2020b) and this may account for her perceived lack of learning.

Having recognised the value of professional education and how it influences the development of theoretical knowledge and its role in socialisation, it is also apposite to consider the role of practise. Being part of a group that is supportive, being accepted as part of the team and having positive role models helps with PI

development (Machin et al 2012, Walker et al 2014). Being part of a cohort of students was mentioned by all the participants as being important for learning and support. All the participants reported that as students they were very well supported by their CPTs, who were praised by all participants for being a positive role model as well as a source of knowledge and inspiration on how to practise effectively. Baldwin et al (2017) in their research with nurse academics suggest that in order to be role models those supporting nurses need to reconcile their own PI, this may well be the case for CPTs. Previous research in the UK (Adams 2013) has recognised the valuable role of CPTs in offering support and in socialising students into their role. Sophie reported her CPT reflected with her regularly and was very well informed. Baldwin (et al 2017) asserts that role modelling is also significant in this relationship. Caroline admired the way her CPT approached challenging situations and maintained professional standards. For her this was an important learning experience. Mentors were viewed as a positive support by Begley (2007), who reported that it was the lack of mentors that caused difficulties in adjusting for many of the students in her study. Likewise, in Hjalmhult's (2009) study, mentors were an integral factor in student development. Helen's view that her mentors in both of her placements were supportive aligns with Sullivan Bentz et al (2010) research into Primary Care Nurses' transition into their new role in Canada where it was highlighted that support from a mentor was a fundamental factor in a successful transition. Furthermore, all the participants indicated that the teams they worked with were always willing to stop and listen and offer advice; they too were positive role models of health visiting; this chimes with research by Machin et al (2012) that highlights professionally socialising with other HVs is essential for development of PI. Sophie recognised that not just the HVs were supportive but the CNN too.

So far in this section the focus has been on the factors that supported the students on their journey to becoming a health visitor. Hughes-Morris and Roberts (2017) studied the impact on SCPHN students of becoming a student and in this study lack of recognition of previous experiences and feeling deskilled were identified as negative aspects of the change in role. For the five participants in this study there have been occasional mentions of the downside of being a student such as feeling deskilled at different stages in the course. Furthermore, previous experience was not necessarily recognised. This was alluded to in category one in relation to Kath, but

Helen also found this was a struggle because she had worked in the community for two years as a CSN. Helen found it challenging being a student because her role had changed within the team; there was some frustration about the overall different expectations of her. Hughes-Morris and Roberts (2017) agreed that changes in role could cause frustration. Moreover, Helen acknowledged that as a CSN her role had been very task-oriented and linked to superficial competencies, especially in relation to child development where any abnormalities were referred to the HV. She was uncomfortable that she was now the person concerns were referred to and who needed to make decisions. As a student Helen felt that being observed doing things she had previously done as a CSN made her less confident; this could relate to the costs of being a student as indicated by Hughes-Morris and Roberts (2017). It also reflects the second phase of Hjalmhult's (2009) framework *(involving*) illustrating that students were constantly afraid of getting something wrong when assessed. Helen initially found being a student challenging however when she qualified, she commented she no longer minded being observed and that she had her skills back along with many more; this illustrates Hjalmhult's (2009) third phase *integrating*.

Anxiety is the final issue that will be discussed in this section. It is counterbalanced on some occasions by developing confidence which links to the feeling of becoming a HV and is examined as part of the next category.

Caroline, Kath and Helen all reported feeling anxious during the course and this had an impact on their performance, Duchscher (2012) comments that anxiety links to transition as illustrated by Kath. Kath was anxious initially about the change in her role, but this intensified when she changed placements for the consolidation period. She reported that she wanted to leave due to anxiety. Everything was done differently in the new placement so that she felt she had to learn everything again. She did adjust but reported it was stressful. Change is an area that requires extra support and realistic expectations (Cleary 2009). For Kath it may have been due to the change from a less challenging placement to a more demanding area and she may not have been sufficiently prepared. Although placements can cause general stress and anxiety, Walker et al (2014) emphasise that being part of a group and having a mentor as discussed previously is essential for developing PI as is being in

placement (Hurley 2009). Kath's perceived anxiety in the consolidation phase may also have been due to spending less time in university and having less peer support.

Helen expressed anxiety initially, but this was retrospective referring to when she had started as a CSN and the challenges as a result of home visiting. Kath mentioned this too but for the others this was not an issue as they had all had experience from midwifery. However, both Caroline and Anna reported that home visiting as a HV involved a far broader remit and this had required some adjustment, but they did not report that it caused them anxiety. As explained earlier, Helen reported feeling anxious about her change in role; she was concerned that she would no longer be able to refer concerns to the HV as she had when she was a CSN. Ashley et al (2016) indicate that anxieties due to changes in role can be ameliorated by educational provision and support from colleagues, as the course progressed this appeared to be the case for Helen.

Caroline's anxiety was linked to lack of knowledge and experience; she had limited experience of safeguarding and this was something she was very aware of but she was able to cope with the anxiety by rationalising her worries and by recognising that the university was offering lots of support and knowledge on the topic as discussed earlier. Her other anxieties linked to concerns about her new role, but she recognised that these would be overcome by support from her colleagues and increasing experience again as indicated by Ashley et al (2016). At no time did she seem overwhelmed by anxiety as Kath had been.

To conclude this section, the results and literature have suggested being reflective, recognising one's own values; developing knowledge and skills through both the university course and practice are beneficial in supporting growth of HV PI. However, feeling deskilled and lack of recognition of previous experience had a negative impact on PI as did anxiety. From this study it is central to note that either differing values or anxiety could have led to a participant withdrawing from their course and not working as HVs.

Dialogue with the Literature: Becoming a Health Visitor

The previous section examined the personal qualities of the student and the impact that these would appear to have had on the development of their PI. This section brings the participants' descriptions of becoming a HV into dialogue with relevant literature. The salient components of this category are: health visiting - both role and identity; making a difference; support from peers and other practitioners; relationships with clients and colleagues; confidence; autonomy and safeguarding.

It is immediately apparent that the data set shows a strong correspondence with the extant literature regarding the previous categories. However, in relation to understanding becoming a HV the collective experiences of the participants patently add more detail and nuance to our existing knowledge base on student HV PI. The five participants started by discussing how the HV role differed from their previous roles as explained in category one but perhaps more significantly their definitions of what being a HV consists of changed over the year. Kath reported that as a role it was different from what she could have imagined; it was so much more. Caroline suggested that it was what her whole professional and personal life had been working towards. Caroline reported '*it is quite a privilege'*, referring to being in people's homes and sharing significant events with them. This was also one of the key themes from Whittaker et al's (2017) study linking to the importance of prevention. Helen too reported that there was so much more to the role than she had initially understood even though she had been working with qualified HVs for two years. Anna's view of being a HV changed positively over the course as she clearly articulates in the previous chapter, whereas for Sophie her view changes depending on where she was working. During my study all the participants illustrated that over time their health visiting knowledge grew and as a result of this, they were able to articulate their in-depth understanding about their role how this would influence their future practise. This process is described in parallel by Machin et al (2012) who suggested that being aware of the key concepts of health visiting was crucial to the development of health visiting as a profession and to practitioners' PI. Lack of clarity about the key concepts of health visiting has been an issue for the last 150 years (CETHV 1977, Cowley et al 2015). As their in-depth understanding of the role developed, they illustrated Darvill et al's (2014) third phase of the transition: *emerging identity* as understanding develops and comparisons are made leading to a successful transition and formation of PI. Sophie commented that although her

colleagues at the previous Trust had helped her, they had been stressed and unmotivated themselves leading to some negative experiences. This may have linked to her PI not changing or it may be that as both Baldwin (2008) and Begley (2007) suggest it is possible to have more than one PI.

Sophie and Helen both reported concerns about their identity during the study. Identity formation begins with noting how one has the characteristics of one group but at the same time are different from another group; this connects to understanding the differences between roles (Dahl and Clancy 2015) and supports Lawler's (2014) notion that identity is a matter of identifying who you are similar to; who you differ from and who you identify with highlighting that identity is fluid and constantly evolving (Beauchamp and Thomas 2009). Sophie's reported perturbation at the role of CNN can perhaps be best understood by utilising Lawler's (2014) notion of identity as she began to recognise the different roles. Initially she was frustrated that CNN were used instead of HVs but over time Sophie became clearer about the different roles and reported that CNN were often not used to their full potential but were used as a less expensive alternative. Similarly, Helen gradually increased her understanding of the role of CSNs as explained in Chapter Five, initially she reported the role of HV and CSN were similar but as her experience grew, she recognised the differences and she understood the different roles. Again, this demonstrates Lawler's (2014) concept of identity and suggests the value of recognising different roles in identity development. In contrast, Iwasaki et al (2018) who researched the roles of Japanese PHN demonstrated that if roles are not clearly defined then this can impact negatively on identity.

Becoming a HV was also linked to socialising with others who were HVs or who were undergoing the process. Kath mentioned how much she missed contact with her cohort once the course was over. The participants' mention of making recourse to an online messaging group aligns with the notion postulated by Green (2018) that peer support enhances PI. Caroline greatly admired her CPT and found that observing her approach to clients was an excellent way of learning. Helen stated her CPT had always been encouraging even when Helen was a CSN by encouraging her to undertake the HV training. Sophie reported her CPT was outstanding too and suggested that anyone who had the opportunity to work with her would be extremely

lucky. She went on to say that she felt that the HVs she was working with once she qualified were so much more inspiring than those she had worked with previously whom she describes as '*wishy washy'* and constantly moaning: working with role models that she perceived to be strong appeared to help her with developing her identity. Machin et al (2012) and Whittaker et al (2017) concur in their studies that socialisation is a significant factor in becoming a HV. The importance of socialisation also highlights that the participants were part of more than one CoP as a University student, part of a cohort and in practice and all seem essential for PI development.

Machin et al (2012) report that being part of a group helps to increase collective identity but that the group needs to be cohesive and have agreed core constructs; this may be why Sophie struggled so much in the middle of the course as the team she was working with were also disillusioned. Walker et al (2014) concur with the notion that being in placement helps to develop identity; although Walker's research was with nurses, the results stressed the importance of positive role models helping with identity formation.

One of the reasons that all the participants gave for wanting to become a HV was making a difference; this referred to having a preventive role working in the community rather than being reactive as is often the case when working in a hospital setting. Both Helen and Kath wanted to move away from managing crises and times of stress due to illness to helping individuals and families to maintain their health. All five continued to mention this as part of their understanding of health visiting throughout the year. Machin et al (2012) report that making a difference was one of the key ideas postulated by both student and qualified Health Visitors in their study of PI. Furthermore, students in Whittaker et al's (2017) study reported that they found this aspect of the role inspiring and that making a difference was their overall goal; the comments made by Sophie, Anna and Caroline correspond with these findings highlighting the importance of their preventative role and that this was what motivated them as HVs.

Alongside making a difference, relationships with clients and families were also referred to by the participants as being an essential part of health visiting. Dahl et al (2014) emphasised the importance of relationships in PHN fulfilling their roles and as

an essential part of their identity. All the participants echoed these findings and salient examples are outlined below. Caroline recognised that her relationships in health visiting were different to those in midwifery, partly because they lasted longer and were less intense but also because they were about more than comforting clients through a difficult time, thus requiring her to be less trusting and have her professional barriers in place. Caroline reported that it was through relationships she was able to fulfil her role. Sophie also indicated that having longer relationships was one of the benefits of health visiting for her as a practitioner. Both indicated that health visiting offered the opportunity to develop supportive relationships over time and work with families, whereas midwifery did not enable this to happen mainly due to time constraints. For Sophie her training placements did not fulfil her expectations as explained in Chapter Five and it was only when she changed Trusts on qualification that she saw how this could happen. Anna too relished the longer relationships and indicated that it was through these relationships that much of the HV's role could be fulfilled. Helen recognised that relationships could be challenging, and she too felt that she needed to be wary and maintain a professional distance. Helen gave the example of a client who had not wanted any support and how challenging she found this. Kath acknowledged that as a paediatric nurse her relationships with parents were often superficial whereas in health visiting, they lasted longer and were more in depth, but that they needed to be professional relationships and she saw their development as one of the essentials of being a HV. The centrality of relationships to HV practise is emphasised by Cowley (2018a) thus supporting these findings.

Recognising how complex relationships can be in health visiting connects to one of the other key issues that is often linked to the PI of HVs-safeguarding. The importance of being competent in relation to safeguarding as a part of a HV's role was not explored explicitly in any of the literature about identity. However, in my study safeguarding was an area that four out of the five participants felt was an important part of their role and identity. It is also a specific aspect of most HV job descriptions and could link to the importance of organisations needing to be clear about expectations and roles as postulated by Machin et al (2012) who suggested that organisations need to have clear role outlines to support HVs in undertaking this aspect of their role. For all the participants apart from Anna who had previous

experience in safeguarding it was a challenge, but they all recognised that it was an essential part of what they needed to do. Kath, Caroline and Sophie all had limited experience of safeguarding before starting the HV course. At the beginning of the course they all indicated that it was something they were concerned about. Caroline stated that being aware of safeguarding had changed her approach to relationships with clients but as explained earlier she felt her knowledge, experience from observing her CPT and the links between theory and practice had prepared her for addressing any issues. Sophie too reported that she had been adequately prepared. Kath rarely mentioned safeguarding although she recognised it as an essential part of her role, she had limited experience in practice but even though her final job was in an area of deprivation she appeared unfazed. Helen had some experience as a CSN but had always been able to refer to the HV and recognised the change in her role.

Increasing knowledge and skills in relation to safeguarding linked to the two final areas in this section, autonomy and confidence. Participants' views on autonomy varied considerably, Anna initially reported that as a midwife she had been an autonomous practitioner but she felt that HVs were not autonomous, in contrast by the end of the course she stated that she realised now how much HVs could do and how autonomous they were. For Helen autonomy was also an issue she felt she had worked autonomously as a CSN and she disliked being observed and assessed and reporting to others. However, by the end of her course she reported that she had regained her autonomy. Sophie acknowledged that the HVs she was working with in the second Trust were autonomous, but she felt that the HVs in the first Trust were not and this impacted on their role and possibly their job satisfaction, highlighting the significance of autonomy in health visiting. In previous research Hughes-Morris and Roberts (2017) noted that lack of autonomy is often a factor in transitions and can cause frustration. Machin et al (2012) suggested that being autonomous practitioners was one of the core constructs of health visiting and as such had an impact on PI. Kath and Caroline agreed that it was the lure of autonomy that had initially attracted them to health visiting whereas for Sophie it was the absence of autonomy alongside her expectations not being fulfilled that led her to consider withdrawing from her course. Machin et al (2012) suggest that the core constructs need to be agreed within the profession or this can cause discomfort for individuals who are unsure

what is expected of them, this in turn will affect PI. Both the Principles of Health Visiting (CETHV 1977) and Cowley et al's (2015:474) 'orientation to practice' outline the core constructs and include the need for autonomy.

Initially, as discussed above, most of the participants reported feeling deskilled but over the year as their understanding of their role developed and they began to increase their knowledge, skills and experience, their confidence in themselves grew. Generally, the five participants agreed that their confidence had increased as they progressed through the course and became recognised members of a team. This concurs with Maxwell et al's (2018) finding that being part of a team leads to growth in confidence especially if the team acknowledge the individual's existing expertise. Anna settled in a new area and reported that she was confident and that if she had any concerns, she knew she could always ask the team, she felt the team trusted her to recognise when she needed help. Anna began the course very sure of herself as a midwife; by the end of the course she was saying that she primarily saw herself as a HV but that the midwifery knowledge would remain useful. She acknowledged that it might have taken her more time to come to this conclusion because she had made a hasty decision to become a HV whereas the others had all taken time to consider their career path. Kath began saying she was unsure whether she would like the role but by the end of the course, despite her anxieties in consolidation, she felt that she was achieving what she needed to in her role and she was adamant that she saw herself as a confident Health Visitor. Caroline too became more confident as the course progressed and her experience increased; she was able to recognise when she needed help from others, she stated she was definitely a HV. Helen was initially very confident but questioned her skills and knowledge midway when she realised the difference between being a CSN and a HV but by the end of the course she was confident that she had the knowledge and experience she needed and designated herself as a HV. Sophie started the course full of enthusiasm but recognised her knowledge deficits and her confidence increased along with her experience. However, midway through the course she lost her enthusiasm and to some extent her confidence but by the end of the course she was confident in her role. Sophie was the only one who reported that her identity remained with her previous role as a midwife. Walker et al (2014) support the notion that increasing confidence links to time spent in placements and that identity

formation is supported by this time but it is a process. The gradual development of confidence could indicate formation of PI. Sullivan Bentz (2010) suggests that increased confidence leads to practitioners seeking new challenges in their role and this may be the case for all the participants as they spend time in their new role.

Conclusion

This chapter has partially answered the question 'How do student Health Visitors perceive their professional identity?' However, in the preceding sections it has become more apparent that a clear understanding of the role of the HV is key to the development of PI, suggesting that identity formation requires articulation of the role. Alongside recognition of an individual's perceptions, the roles of others and how these integrate also seem to be important and this appears to link to experience. Successful transition from one role to another also seems to be central to the development of PI. This highlights that developing identity is a process rather than a one-off event and again is related to experience and that identity changes; it is not static. Thus, for this professional group who are changing their role significantly PI is key in helping them come to terms with the changes in their role, knowledge and skills that take place during the year long course. Although the results from this study are mainly confirmatory of previous studies it is an original contribution to existing knowledge because of the specific nature of the professional group student HVs in England which has not been examined previously.

Individual qualities can support the development of PI, especially being reflective and non-judgmental. It seems that individual and professional values are also significant in both understanding the role and the growth of PI. Theory, practice, knowledge and skills were also key components of identity and both the university course and practice experience appeared to have an equally noteworthy effect. Anxiety and feeling deskilled could impede PI formation but these seemed to improve with increased knowledge and skills.

Becoming a HV links to socialisation into the role through practise education and through support. A number of authors (Machin et al 2012, Cowley et al 2015, and Whittaker et al 2017) have discussed the essence of health visiting and although

there is debate about what this consists of for this cohort: specific knowledge; relationships; confidence and autonomy seem to be the essential factors that need to be present for PI to grow.

In summary, this chapter has explored the central issues that inform the PI of health visiting students. The factors that support their change in identity have been outlined alongside the factors that can impede identity. In the final chapter the implications of the findings are discussed, and these are linked to the initial question and recommendations are made for UK health visiting and HV education.

Chapter Seven: Conclusion – Implications for Policy, Practice and Professional Education

My thesis posed the question- How do student Health Visitors perceive their professional identity? Alongside this there was consideration of whether the student HVs perceptions of their PI was demonstrably influenced by their experience on a Higher Education SCPHN or HV course, to ascertain, the extent to which, educational intervention can be said to have a discernible influence on identity development . The question was influenced by the complex history of health visiting acknowledging it has been a profession in flux and assuming that a cohesive PI can be beneficial for the profession in terms of workforce wellbeing, retention and outcomes. In this chapter the research approach is summarised, the results are reiterated, and the limitations of the study are explored before recommendations for future research and the implications of the findings are outlined.

My research study was a NI where five student HVs participated in three unstructured interviews each, over the duration of their year-long SCPHN course. All five of the participants were attending a HEI in South East England and they were sponsored by two different Trusts. Three of the participants were midwives and two were nurses. The Interviews were analysed using a two-phase approach of thematic and dialogic analysis, looking for themes per person which were then developed into constructs across the cohort. The findings were examined through three lenses: my observations, CoP theory (Wenger 1998) and the broader literature. I found in answer to the research question that the PI of the research cohort developed throughout the year. Respondents unanimously began by stating their PI was that of their original profession-nurse or midwife- but by the end of the programme it had evolved and for four out of the five designated themselves as Health Visitors. From this it was apparent that for this group of students PI is fluid and changed according to their role leading to them becoming a HV. PI like identity has multiple components: it is influenced by the self, who we think we are and who we are not and who others

think we are (Lawler 2014) therefore PI is socially constructed. I argue that the participants all went on a journey that varied in its intensity and that the experience on the course they attended did have an impact on their PI, but other factors were also relevant and some of these were specific to HVs as a group. These were: their expectations prior to the HV preparation course; their experience both pre course and during the course; their relationships with peers, colleagues and clients; socialisation with other HVs; support from their colleagues; and understanding and interpretation of the HV's role leading to increased confidence and autonomy. They became a HV over a period of time and this was related to the key constructs of the HV role. This led me to conclude that student HV PI is complex and professional education is key alongside support and the student's individual understanding of their role.

As the first substantive data set on UK student HV PI perceptions and experiences' the findings from my study are mainly confirmatory of existing research on PI formation among allied health professionals but it is a unique participant group and the findings concur with research from other countries about learning the PHN role (Hjalmhult 2009). The participants elucidated a three-phase process whilst developing their understanding of their role. The first is *positioning,* which included initial concern about their existing identity and appearing to lose this identity linked to becoming a student again. The second is *involving* where they became more involved in their new role but express concern about being assessed and making mistakes which could be linked to anxiety and finally *integrating* where their confidence developed, and they recognised their full potential in the role. The participants in my study demonstrated these phases: at the beginning of the study they were concerned about being a student but rather than losing their initial identity they were more certain about it; they illustrated phase two through expressing their dislike of being assessed, finding this difficult and this impinging on their confidence. By the end of the course they were all confident in their new role and expressed their identity as a Health Visitor, demonstrating phase three.

Previous research indicated that PHN in Norway (Dahl and Clancy 2015) had difficulties with their roles when the role was not clearly linked to policy or there were differences between policy and what they were expected to do. The participants in

my study demonstrated difficulties when their role was not clearly stipulated or there was a mismatch between what policy stated they should do, for example the HCP and what they did in practice.

This emphasises that health visiting is influenced by policy which is dynamic and ever changing thus HV education and practise needs to be compatible with policy. All of the participants were very focussed on relationships with clients illustrating the importance of Cowley et al's (2015:474) notion of 'the service journey' and how this was an important part of their role but this is in contrast to the focus of health visiting from a policy perspective in the HCP.

Additionally, my study indicated the importance and educational value of both HV students and educators having a clear understanding of what the HV role consists of as this would appear to be intrinsic to successful PI development, course completion, and positive outcomes. Previous research has wrestled with the question of what health visiting consists of. There have been ongoing debates about whether it is taking a population-based approach or whether it is based on relationships or whether it is a combination of the two (CETHV, 1977, Cowley 2015 et al). Previous literature on HV PI indicates that having defined constructs for the role is associated with a cohesive PI Machin et al (2012). Therefore, being clear about what health visiting consists of would appear to be imperative. All the study participants indicated that their understanding of their role grew over the year and this seemed to relate closely to their view of their identity.

Previous research has highlighted the relationship between PI and effective multi-professional working (Machin et al 2012). However, in my study this appeared to be less of an issue. Students mentioned the importance of working with other professionals, but their focus was on helping others to understand the role of the HV rather than developing multi-professional relationships. This is an area that requires further research.

Repeatedly the research participants stressed the importance of relationships with their peers and with other HV colleagues. This relates to the importance of socialisation which takes place in both practice and education. The findings of my

study emphasise the importance of the student cohort and colleagues in practice offering support. From the perspective of a HV educationalist the role of this support must not be underestimated and this is especially cognisant during the current COVID 19 pandemic when most courses are online with minimal face to face interaction.

Student HVs during this study, unlike many other post-qualified nursing students, were also supported in practise by CPTs and mentors. The students reported that this was beneficial and that both offered support as well as being role models, helping to socialise the students into their new roles. Since I collected my data the role of CPTs has changed (NMC 2018) and the impact of this on student HVs should be considered in the future.

However, the findings of my study were limited by data collection ceasing at the point of qualification; it would have been apposite for the study to have continued to include the first 6-12 months of qualification as a HV, the views of the participants may have changed significantly in this time. This could be a pertinent area for future research. Another limitation was the power differential between myself as an experienced HV and lecturer and the participants. Although the focus was on developing a relationship and foregrounding my role as researcher, the participants may have been reluctant to confide their feelings to me with regard to their experience and their changing PI. Using a different method of data collection such as peer interviews might have overcome this but it might also have led to other complications such as bias due to the interviewers becoming too embroiled in the stories. A different approach may also have caused challenges in maintaining the essence of NI.

Furthermore, the positive impact of experience could be explored in more depth. In my study the participants repeatedly stressed that their previous experience as either a nurse of midwife was beneficial during role transition. This assertion is supported by Arrowsmith et a l(2016). However, the participants also suggested that members of their cohort who were very experienced in their previous roles appeared to

struggle during the course, possibly linking to feeling deskilled or due to the change of status in that they were a student again (Hughes-Morris and Roberts 2017).

Moreover, the focus on PI meant that the stories told were very personal and the preparation course itself was not evaluated therefore it may not have had an impact on the development of PI per se. Evidence suggests that explicit discussion of PI in the curriculum enhances PI development. This was not raised in my study but maybe a significant issue for future consideration. Additionally, CoP theory highlighted the vital role of socialisation this may have had more impact than the professional preparation course; it is difficult to assess this.

As is often the case in NI, the number of research participants in my study was small and self-selecting meaning that there were more midwives than nurses in the study, this may not be typical of other cohorts. The study took place in 2017/2018 when there was uncertainty about the future funding model for the SCPHN programmes and as a result local cohorts were smaller than usual this may have affected interest in the study from participants. Additionally, as the participants were from two Trusts their roles and experience may have been atypical of employees in other Trusts.

My study uses aspects of CoP theory to explain identity formation (Wenger 1988). It also uses CoP as an analytical lens which is a unique approach and both have helped to increase understanding of how identity develops over time and how the formation of PI requires the students to both understand and interpret the body of HV knowledge. Additionally, CoP theory emphasises the significant role being part of a professional group has on PI formation highlighting the need for socialisation into new roles. CoP theory focuses on the novice-to-expert trajectory; my study challenges this as the participants were already skilled practitioners. Furthermore, the study adds to the body of knowledge relating to analysis in NI through effectively using a two-phase approach to analysis. This increases the depth of understanding of the collected data and increase the rigour of the analysis.

My work contributes to the literature on HV PI identity by charting the experience of a previously unexplored professional group, student HVs in England and recognising

that clarity about role and expectations for this professional group is an issue for individuals, policy, professional groups, educators and commissioners of education as explained below.

My findings are pertinent for potential HV students enabling them to investigate the personal impact of undertaking a HV preparation course. It is essential that they consider the difference the change in role might have on their view of themselves and ensure that they have adequate support both personally and professionally. Individuals need to spend time considering the implications of their change in role and if possible, work with a qualified HV before applying and discuss the course and the impact it has in depth with recent students. Therefore, all potential applicants should have the opportunity to find out more about the role by spending time with a qualified HV.

The findings from my study are of interest from a policy perspective. Government policy guides the role of the HV and Local Health Trusts need to ensure congruence with policy. For example it is important that frameworks such as the Healthy Child Programme are applied consistently. Role expectations would then be fulfilled and entrants to roles such as health visiting would remain in the profession, rather than leaving because they feel disillusioned or experience cognitive dissonance due to the disparities between policy and practice.

My findings are also relevant to the groups that represent health visiting as a profession. Influential groups such as the Institute of Health Visiting and UKSC need to continue to nurture the key constructs and shared conceptions of health visiting, aiming to clarify the role and continue the dialogue about where the profession wants to go. This will be influenced by the pending revised standards for SCPHN. The implications of this are that the dialogue needs to continue to clarify the key constructs of health visiting to ensure as a profession it remains relevant and contemporary. Additionally, it is imperative that the constructs once agreed are widely publicised so that those considering health visiting are clear about the role.

My study has highlighted the implications of understanding PI from an educational perspective. It has demonstrated that HEIs must work with Local Health Trusts to ensure that the relationship between policy and practice is reflected in the curriculum. Furthermore, HEI's would do well to review the curriculum to ensure PI is explicitly included and to ensure that iHV (2019b) suggested curriculum is addressed. To reduce attrition and support successful HV identity development, HEIs need to ensure students are offered continuous support both from their cohort and in practice to enable PI development, the changing role of CPTs may impact on this so alternative forms of support need to be considered as socialisation is a component of PI and takes place in practice as well as in HEIs. HEIs should work with trusts to recognise and utilise students' previous experience and work with Trusts to aid retention through ensuring realistic expectations of the role. Both HEIs and Trusts need to monitor the changes to training and support such as apprenticeships and the changed role of CPTs and ensure HV education remains at the forefront of professional education. Being aware of the importance of PI, role clarity and expectations is also an issue for the curriculum design of the HV course for the future as these issues need to be incorporated into the curriculum in a cohesive manner.

Furthermore, commissioners of HV education currently Heath Education England should be cognisant with the findings of my study and recognise the relationship between professional identity, experience and expectations. Thus when commissioning places on SCPHN programmes they should ensure that these are addressed. They also need to be aware that the findings of other studies that have highlighted the role PI has in retention, recruitment and quality of care are relevant for this group of professionals too.

Additionally, all the above who are involved in the recruitment education and retention of HVs should be made aware that the findings from my study indicate that having a clear understanding of one's role and feeling positive about it relates to PI which in turn improves the quality of care that is offered by individual. This supports previous research in relation to other health care professionals recognising links between PI and quality of care (Hensel 2013).

As a result of my study, further research might well be conducted in order to ascertain if the experience of this group of students is transferable to other student HVs and to consider the impact of PI on other qualified nurses who significantly change their role. In a small way this research could contribute to the debate about the future of health visiting emphasising the need for clarity about role parameters. It also highlights the need for continued support in post- qualification programmes. PI is key to being part of a professional group and enhancing ongoing development therefore PI needs to be fostered.

In conclusion, HV PI does appear to be influenced by students' experience on an educational programme but the complex nature of PI means that this is in conjunction with a range of other factors which are of equal importance. Awareness of all of these factors needs to be borne in mind when considering education for HVs as a professional group. Therefore, HEIs need to ensure that PI is included in the curriculum helping students to understand the changes they may go through and that developing PI is a process. Furthermore, practice teachers need to consider the phases that students may go through whilst their PI develops and be there to offer support and guidance.

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Appendices

Appendix A: Invitation letter

02.10.17

Dear Health Visitor Student

Invitation to participate in a study of student health visitors' perceptions of their professional identity

I am a health visiting lecturer at [redacted] and I am completing an educational doctorate focusing on health visitor education.

I would like to invite you to participate in the above study. The purpose of the study is to find out more about student health visitors' perceptions of their professional identity as they undertake and complete the yearlong health visiting course. Further details about the project are contained in the attached information sheet.

I would very much value your opinion about the issue of professional identity and I hope you decide to take part, but you are under no obligation to do so. If you wish to take part or would like more information please get in touch by emailing me on [redacted]

Thank you for taking the time to read this invitation.

Yours truly,

Jane Goodman-Brown
EdD Student

Appendix B: Information Sheet

Information Sheet

Study Title
Student health visitors' perceptions of their professional identity

You are being invited to take part in a research study. Before you decide whether or not to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully.

What is the purpose of the study?

The aim of this study is to identify the perceptions of student health visitors (HV) in relation to their professional identity as a result of undertaking the health visiting course. Health visiting is part of nursing but historically it is a profession in its own right. A strong professional identity is linked to role cohesion, as well as recruitment and retention to the chosen profession. This is an under-researched area in relation to health visiting. A clear understanding of professional identity may help with identifying the support needs of students, future course design and development of the profession. This study will last for one year and will consist of interviewing student health visitors about their view of their professional identity. The study takes a qualitative approach using narrative inquiry and as such participants will be asked to tell their stories.

Why have I been invited to participate?
You have been selected to participate because you are undertaking the health visiting course at. The whole cohort will be invited to take part, the study requires 8-10 participants and participants will be selected on a first come volunteer basis.

Do I have to take part?
It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If

you decide to take part you are still free to withdraw at any time and without giving a reason and take any information you have given with you.
I am a lecturer in health visiting at [redacted] where I am also undertaking an Educational Doctorate(EdD). I am not a member of the course team at [redacted] therefore, your taking part or not will have no impact on your marks, assessment or progress on the HV course.

What will happen to me if I take part?
You will be asked to participate in three unstructured interviews where you will be asked about your professional identity. You will be asked to tell your story in relation to choosing to become a health visitor and what that means to you in relation to your professional identity. These interviews will be spaced throughout the year course from October 2017 to September 2018. Each interview will take about one hour. The interviews will be at a venue of your choosing either at University or a mutually convenient place. Interviews will be audio recorded. You will be sent a transcript of the interviews to check for accuracy.

What are the possible disadvantages and risks of taking part?
There should not be any disadvantages to you taking part but you may find that discussing your professional identity calls you to question your career decisions. If you feel any distress or discomfort about issues raised in our conversations, you will be offered support if required and can access the student support services at University You are free to leave the study at any time, before or after any of the three interviews or after reviewing the transcript of the interviews. You will also be able to withdraw any of the interview data that has not been processed.

What are the possible benefits of taking part?
Taking part may further develop your understanding of health visiting as a profession and help you with your professional development. As a post qualification student taking part in a research project may also enhance your understanding of the research process. Learning from the project will help develop and possibly alter the health visiting course once the support needs of future health visiting students are better understood. Further understanding of professional identity will help develop the health visiting profession and ultimately improve the health visiting service.

Will what I say in this study be kept confidential?
All information collected about you will be kept strictly confidential (subject to legal limitations). Data will be stored in Google Drive, for which the University has a security agreement. Because this is a qualitative research study and the cohort of potential participants is small, it is impossible to guarantee complete anonymity but all information will be de-identified and all data treated as confidential. The institution where the research has taken place will not be named. Each participant will be allocated a pseudonym and the list of names of participants will kept separate from the transcripts. Data generated in the course of the research will be retained in accordance with the University's policy of Academic Integrity and will be kept securely in paper or electronic form for a period of ten years after the completion of a research project.

What should I do if I want to take part?
If you are interested in finding out more information or would like to take part in the study please contact the researcher by [redacted] or by telephoning or texting [redacted]

What will happen to the results of the research study?
The results of this research would be used to complete my EdD thesis. I also intend to share the research findings via publication in professional journals and via conference presentations. I would offer each participant a summary of the published research .

Who is organising and funding the research?
I am undertaking this study as a student on the Doctorate of Education programme in the School of Education, Faculty of Humanities and Social Sciences at Oxford Brookes University. This study is being overseen by my supervisory team, [redacted] (second supervisor).

Who has reviewed the study?

The research has been approved by the University Research Ethics Committee, Oxford Brookes University and by the ethics committee for…... If you have any concerns about the way in which the study has been conducted, you can contact the Chair of Brookes University Research Ethics Committee on ethics@brookes.ac.uk

Contact for Further Information

For further information please contact the researcher Jane Goodman-Brown by [redacted].

Thank you very much for taking the time to read this information sheet.

Appendix C: Consent Form

CONSENT FORM

Student health visitors' perceptions of their professional identity

Jane Goodman-Brown
EdD Student
[redacted]

Please initial box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason.

3. I agree to take part in the above study.

Verbal consent will be sought again before each of the three interviews

Please initial box

Yes No

4 . I agree to the interviews being audio recorded

5. I agree to the use of anonymised quotes in publications

Name of Participant Date Signature

Name of Researcher Date Signature

Appendix D: Ethical Approval

OXFORD BROOKES UNIVERSITY

Dr Roger Dalrymple
Director of Studies
School of Education
Faculty of Humanities and Social Sciences
Oxford Brookes University
Harcourt Hill Campus

17 August 2017

Dear Dr Dalrymple

UREC Registration No: 171128
Student health visitor perceptions of their professional identity

Thank you for the email of 15 August 2017 outlining the response to the points raised in my previous letter about the PhD study of your research student Jane Goodman-Brown and attaching the revised documents. I am pleased to inform you that, on this basis, I have given Chair's Approval for the study to begin.

The UREC approval period for the data collection phase of this study is two years from the date of this letter, so 17 August 2019. If you need the approval to be extended please do contact me nearer the time of expiry.

Should the recruitment, methodology or data storage change from your original plans, or should any study participants experience adverse physical, psychological, social, legal or economic effects from the research, please inform me with full details as soon as possible.

Yours sincerely

Dr Sarah Quinton
Chair of the University Research Ethics Committee

cc Annie Haight, Supervisory Team
Jane Goodman-Brown, Research Student
Maja Cederberg, Research Ethics Officer
Jill Organ, Research Degrees Team
Louise Wood, UREC Administrator

www.brookes.ac.uk

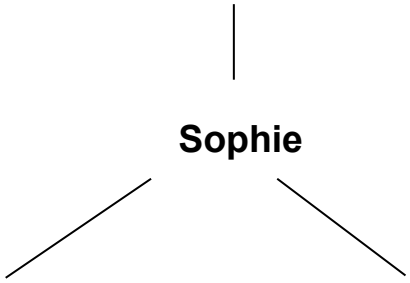
Appendix E

Thematic analysis Sophie, Anna and Helen

The following figures illustrate the codes and themes from the thematic analysis of each of the three participant's interviews. These were not reported in the main body of the thesis. Most of the codes were similar and data saturation was reached for the overall thematic analysis .These themes informed the overall categories.

Sophie

Theme 1-Being a Midwife
Midwifery,Experience,Dift
MW/HV,Transition,Uniform,
Expectations, Nursing, Short
relationships ,Clinical skills

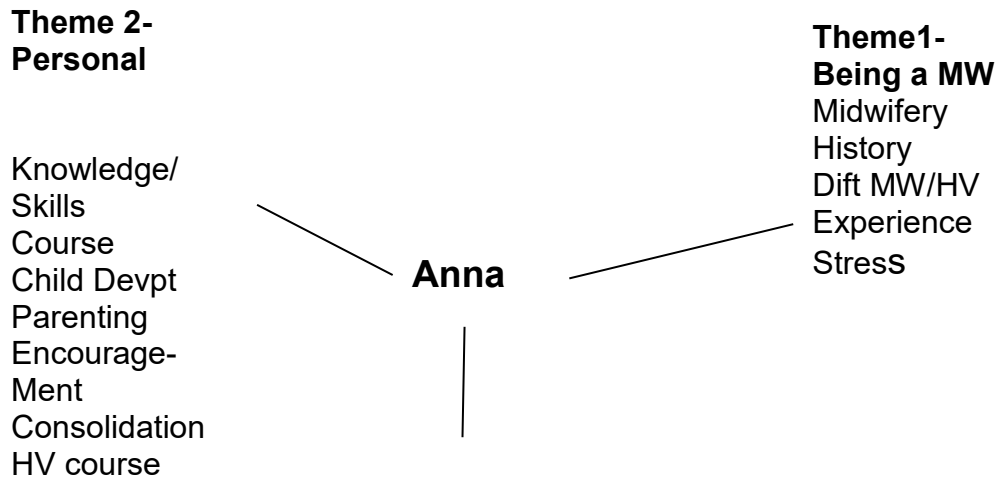


Sophie

Theme 2-Personal Development
Student,Learning,
Univ Course,
Student support
Skills
Communication
skills
Deskilled
Reflection

Theme 3-Becoming a Health Visitor
Community Making a difference
Relationships Support for mum
Health visiting Autonomy
Family ,Identity
Home visiting Nursery nurse
Confidence Workload
Safeguarding Organisation
IPL , Responsibility
Universal EBP
Prevention

Anna



Theme 3- Becoming a Health Visitor

Health visitor role , Community, Safeguarding, Support,
Identity,Nursing,IPW,WLB,Relationships, Confidence, Time , Teamwork, Future, Record keeping , Policy, Organisation, Values, Autonomy , EBP,
Empowerment
Prevention

Helen

Theme 1 Personal

History, Frustration, Trust, Part time, Transition, Own children,Empathy, Experience, Intuition, Communication, Anxiety, Reflection, Expectations, Non-judgmental
HV course- being a student

Helen

Theme 2 Being a CSN

Theory/practice, Skilled/deskilled,CSN –role , Learning, CSN competencies, Dift CSN/student, Dift CSN/hospital nurse
Being observed, Knowledge -child development and safeguarding

Theme 3 -Becoming a health visitor

Health visiting, Role, Support Relationships, Job satisfaction Responsibility, Safeguarding. Working together, Autonomy Confidence. Identity, EBP, Values . Prevention- making a difference .

Appendix F

Sophie F.1

The extracts in the next three appendices were analysed using either Riessman's (2008) key linguistic features or McCormack's (2000) lens. The text is in italics and the feature or lens is annotated. This analysis was shared with my supervisors.

Analysed using Riessman's (2008) key linguistic features

S : *So I did a few bank shifts in the community, the overtime shifts, again, fell in love with it again*. Repetition And I just thought, gosh, you know, I'd started my preceptorship in community for a year,

R: Yes yes

S: I was very reluctant to go to the wards but understood I had to, to complete my suturing and cannulation and so on. Then I did these bank shifts and I thought, this is what I need to do.

R:Yes yes

S: So again, I looked into it again, and I thought, "you know, *I need to get out in the world, because where I'd been in community*, Repetition you only see the women up to sort of two weeks afterwards". And I just thought to myself, "I need to see more of their journey."

R : umm

S : Because I can't, I didn't want to just stop at that, sort of, you know, we're going to discharge you now to the Health Visitor. And I thought, right, I need to look into this again, you know, being quite, you know, doing shift work and things, it was quite a lot for me. And two of my colleagues who I'd trained with had become Health Visitors.

R: Oh right

S: So I contacted them and I said, gosh, you know, "how is life as a Health Visitor? "They're based in London, so they said, "they could only tell me, obviously, what it was based in London, and they thoroughly enjoyed it and they loved it". And I said, "gosh, you know, *when I was in community, I got that sort of thrill to want to stay in community*".Repetition So I spoke to them and then I was looking for about six months on NHS Jobs for opportunities to start Health Visiting.

R: umm

S: In that time, obviously, *I'd done some research, Healthy Child Programme, that sort of thing.* Aside And then, you know, with NHS there's a lot of cutbacks, so the vacancies weren't coming up so often.

R: Yes yes

S: So then when the X Trust came up, I just thought*, I need to go for it.* Historical present tense

So I went for it and then got it,

R: Wow

S: And then the next day I handed in my notice to midwifery. And then that was January the 10th and we started March the 5th.

R: So how does it feel, health visiting compared to midwifery? Because one's very hands on and the other's very much about communication skills and supporting people, isn't it? How does that feel?

S: I feel like midwifery is very clinical and I think it's become very clinical on the wards.

R: Right

S; So you're sort of more doing. So there's more of that aspect of, you know, I'm going to do your blood pressure now, I'm going to do a palpation now, you know, and those sort of things. Whereas, in health visiting, it's more about communication and about supporting, rather than trying to resolve things. And I think, when I first started in, so, obviously, March, April, May, like three months, I found it quite challenging to stop trying to fix things.

:R: Right ,Yes, a big change, yes.

S: Yes. And my mentor did actually say, she said, "*just hold back",* she said, *"because you're trying to resolve things that can't be resolved".* Direct speech So I thought, right, OK, and the lecturer, Y really helped in his mental health module, to try and tell us, especially the midwives of the group, holding back and just listening more, rather than trying to resolve things, you're going to benefit more.

Sophie F.2

Analysed using Riessman's(2008) key linguistic features

S: *I'm still kind of struggling a little bit with the identity of a Health Visitor. I feel that it's not as strong as being a Midwife*. Repetition And I find, even if someone asks me what I do, I put Midwife.

R: Isn't that strange, yes.

S: I'm a Midwife but I'm training to be a Health Visitor.

R: But it's half way through though, isn't it? So it's a transition.

S: Yes. Yes, but I think in the long run, *I don't know if I'll do health visiting primarily. I think my love for midwifery is very strong* but not my love for full time midwifery. Repetition

R: So do you think, in an ideal world, you'd like to try and combine the two?
S:Yes. Yes, so I'll do, I'll start off, because I'll do my preceptorship as a full time Health Visitor but I think, looking long term, I think I would ideally like to do maybe two days midwifery, two days health visiting per week. I think, yes, I think the clinical aspect I'm missing.
R:You're missing it, are you?
S:Yes, I love it. I love the clinical aspect of being with the women. I find it very rewarding when I do a visit and I give all my health promotion and, you know. I really feel like I'm engaging the woman and that's kind of it. It's like, *I feel a bit like, midwifery had it but I don't think health visiting does.* Repetition

R:So do you feel that it's difficult to quantify what a Health Visitor does, is that part of the problem?
S:Well I know what they do on a daily basis and, of course, I think if you've got a very good Health Visitor, that promotion that you give, the advice you give and really using

your knowledge is more than beneficial. And I think if you've got a really good Health Visitor, you've got a fantastic foundation for the next generation. *I'm not doubting, you know, what they do, but I'm saying, for me as an individual, I think coming from a midwifery background, you're very much on the front line.* Repetition

then, I guess, the aspects of health visiting for me, was also the sociable aspect and not being on the shifts, which is what I said to you before.

R:Yes. And also, you were saying, weren't you, about your relationship going on for longer?

S:Yes. Yes, but even then it doesn't because you hand them to the Nursery Nurses. So my anticipation was to do the new birth visit, well actually, do a lot of the ante natals, which they only do if they've got a high score , and it's run by the Nursery Nurses. So that first universal visit isn't being done by the Health Visitors. Then the second is always done by us, that's the new birth visit, which I love. But if they're universal, they then get put back into the Nursery Nurses to do a six to eight week, a nine to twelve month and a two and a half year.

So this is what makes me decide that I'm not going to work in a unit that does that. But elsewhere, there are ones that do, do universal, but even then, when I did my alternative practice, they did antenatals for everyone who turned up. So it wasn't just secluded to high scores. They did new birth and they did the six to eight weeks and *they* reference to HVs can decide whether they keep them on. So I want to work in somewhere like that.

Sophie F.3

Analysed using Riessman's (2008) key linguistic features

S: Maybe I need to look into it. It is all new, it is so fascinating lot more hands on with the babies here, so they do weighing length and head circumference.

R: Didn't you do that ?

S: Just weight and *we* linking self to health visiting got the Mums to lift the babies on to the scales.

R :Was that because they were risk averse- they thought you might drop them ?

S: I don't know, they never did the length and they never did the head circumference and now I am doing it and I'm learning clinical skills and now they look at the leg creases a lot more for hip dysplasia

R: So you are getting some of the clinical things?

S: That I want, yes.

R: Because you said you were missing that.

es that's what I really enjoyed because coming from midwifery where it is so hands on it felt like I was almost deskilling in some of the things that I thought that I wouldn't. So with *them* reference to Hvs being more hands on with the babies , I feel like *I'm finally doing something clinical* Repetition

along with caring and using communication

R Right because I think one of the things that you had said previously was that you were wondering was communication the only skill

S: Yes

R: But now maybe its more than that?

S: I'm still doing my midwifery 1day per week I'm 30 hours to health visiting I do 1 day a week as a midwife... But I finally feel that maybe I may have a balance.

R: That's really nice. When we last spoke you were really missing midwifery

es I was, because I think like what you're doing in this experience the identity of a Health Visitor *I feel like there is a stronger identity here.* Repetition

R: That's really interesting. Can you give me an example of that the stronger identity?

S: I feel like there's maybe a bit more autonomy, they just kind of, they get on with it they make their decisions, they're like, I don't know they are strong

R And that's what you said Midwives were before

S Yes

R But you said Health Visitors were wishy washy but here you feel

S Yes like I don't know whether it is the experience that they have, but there is experience from different like some have been 20 years some 2 years .

R So there is a range

S Yes and I just feel like when I talk to them they are so knowledgeable. When I say "*oh gosh what shall I do about this*?" direct speech *they go da da de de and I say oh wow*. Expressive sounds to demonstrate key ideas I feel like I have learnt a lot.

Appendix G

Helen G.1

Analysed using Riessman's (2008) key linguistic features

R So I am kind of interested in professional identity. What does your professional identity as a Nurse mean to you? How do you see it?

ell as a Nurse *I was very proud to be doing what I was doing*. Repetition

I knew the role of the Nurse and I was very comfortable with the role of the Nurse *and I felt like I was doing quite an important job* Repetition

. I felt very comfortable with what I was doing. I felt that I was delivering good care actually. As a Staff Nurse

I would go home and generally *I would feel satisfied I had done a good job* and delivered good care Repetition

R Ahh that's really nice

H My husband said to me *" you've earned your place in heaven now"*Direct speech

R Isn't funny the conception people have of Nurses that you are always a good person

H Yes but I think nurses are doing that for a whole wealth of reasons aren't they? Aside I worked with a lot of Philipino nurses who were working and sending the money back home.

R Oh gosh

H And I saw some nurse who if I am being honest really lacked empathy and I saw you know because I come form a background of dementia care it is a long winded story but my Mum had residential homes looking after people with Alzheimer's and dementia and she built those up from nothing. When my parents divorced when I was 9 she moved 3 people into our home who had Alzheimer's disease. I don't know if the law is the same now but with learning

bilities too you could have 3 people.So she did that and eventually we moved out and she turned our home into a residential home. So from a young age I was brought up *I learnt a real sense of empathy* Repetition

R Gosh yes lots of exposure

om a very young age and that is what propelled me into nursing especially ending up working on a care of the elderly ward I have always had such an exposure to dementia that *I had that empathy within me* Repetition

R And have you found within nursing that you have been able to use that empathy?
H Definitely definitely. I have found that I wanted to be in situations where people needed that reassurance for example if an elderly person is dying and they I have their family around them I have found a lot of satisfaction from being there and supporting them. There's a lot of unfortunate situations on the wards. There is a lot of elderly patients in beds alone in the middle of the night and they are dying and that's probably another reason why I wanted to move away from the job I was in because I was getting quite down about it(laughs).
R So there is only so much of yourself that you can give isn't there?
H Yes without getting depressed about life in general. I think I was wanting to I would be there and I would go an hold their hand in the middle of the night, which was why my husband said that "I'd earned my place in heaven now "but I found that I was starting to get more and more emotionally involved in these people's deaths.
R Which is really hard?
H Yes and that's another thing that propelled me to Health Visiting I thought let's go to the complete other end of the spectrum you know and try and experience some happiness.
R Yes and often Health Visiting is about happiness people have a new baby and things are good. Obviously not for everyone not all the time.
H No no
R But for a lot of people there is a lot of joy and you are in a very privileged position aren't you.
H Yes, so sorry you were saying about professional identity I found myself I could see what was happening my emotions were changing. Whether it was I don't know maybe it is having children.
R Well for a lot of people that does make them think about it
H Yes yes
R But obviously you get HV s who don't have children they still manage quite well
H Yes yes

R But sometimes having children can make you feel differently. So you always felt happy with your professional identity?
H *I always went home and felt satisfied that I was doing the best I could for that patient* Repetition
R That's good.
H And that was *what I enjoyed most about being a nurse I actually that I felt satisfied that I was doing a good job.* Repetition

Helen F.2

Analysed using McCormacks (2000) Lenses

H: I just think in my mind, I think I looked at every aspect within health visiting, I looked at every contact, I looked at, you know, the five universal contacts. I looked at everything, and I just sort of took it apart really and thought, and just took it back to basics. And tried to also, have in the back of my mind, *the knowledge I had as a nurse,* context but just break it all down and then kind of build it back up, you know, from the perspective of the Health Visitor, so I was sure that there was nothing that I was missing I wanted to sort of really look at it from that angle, you know, is there anything that I'm missing? I know what I know but, you know, what
R: What don't you know?
H: What don't I know, yes. And I knew that the picture of what I didn't know, is going to be a lot larger than what I did know, because there's so much more to it really, it's looking at it in a lot more depth. It kind of made me realise as well, that when you're a staff nurse within the health visiting team, it's, you know, you're kind of training is really the competencies, and I know that they were reviewing the competencies before I left, but yes.
R: Can you think of any examples of where you've noticed the difference between being a staff nurse and being a Health Visitor?
H: I think with the development reviews, definitely. So when I was doing development reviews as a staff nurse, I mean I was taught, I had the training on how to deliver an ASQ and I got some very good support from the Health Visitors that were around me. But now, as a student, having gone to University and learnt about child development, done an essay on child development, really learnt about all of the theory behind child development, that's *given me such, a more powerful*

insight into the development review. Context So it's given me a lot more knowledge really, when I go in to do the ASQ, than I had before really. *So it was more of a, it was more of a task, you know, more of a sort of a tick box thing as a staff nurse*. Looking for the unexpected Whereas, as a Health Visitor, I'm now looking at it more, you know, I've got the knowledge behind me, hopefully. No, but I think, I feel I have, that I kind of can look at it from the angle of a Health Visitor a bit better.

R: So do you think your knowledge as a Health Visitor is more specialist?

H: Yes, definitely, definitely. I think the training that you get to do ASQs as a staff nurse is quite limited really, probably because of time, and you don't go on a course, do you ,or anything?

R: No.

H: So you kind of learn from the team around you and they're usually quite stretched and busy and don't always have the time. They want to get you up and running, you know, as quick as they can and as quick as, you know, comfortable to be up and running. So although, you know, I was given time to do that, you don't have a course, you don't have any sort of, you know, training on child development like you do in this course.

R: No. I suppose it's very different, isn't it, when you're a staff nurse. You've got your knowledge from nursing but you don't get much on child development there, do you?

H: No.

R: And you've got your knowledge from people, from experience, but then it's very, it is, it's more in-depth.

H: And especially*, I was an adult nurse trained*, context link to nursing past tense so, and then going into child development, it's completely different. I remember when I first started as a staff nurse, my main thought was, how am I coming at this from the angle of a professional, rather than the angle of a mother? You know, how do I know that what I'm telling these mums is, you know, professional evidence based advice, rather than, I've had three children, this is what I know about being a mother, you know.

Helen F.3

Analysed using McCormack's(200) lens

R: How different does it feel to when you started, can you kind of reflect back?

H: Yes, when I can, when I first started I felt quite deskilled. I felt quite, well just deskilled really and I felt quite, I think it's probably because, having gone from working autonomously as a staff nurse, and then to having everything you do watched ,observed, picked on, critiqued. So I don't know, maybe it's that.

R: I think you talked before about how difficult that was, about it being, about being observed, because you were used to being autonomous. And, I suppose, you've gone through the process now, haven't you? Now you're not observed. So how does that feel?

H: So now I don't mind being observed at all and I think I probably empathise with people, when you are, when I'm observing people, because I haven't yet, but I'm sure I'll be in the situation where I will be. So that's given me an empathy, which I'll then have towards them.

R: Do you feel you've got your skills back?

H: I do and more. *I feel like I've got my skills back but I feel like I've gained a whole load.* Positive I've gained a whole load of knowledge I feel and I've gained a whole load of

R: Can you kind of give examples of the things that you've gained, what kind of things do you think you've gained?

H: I think, *well I'm going to a core group today by myself, so I feel like I've gained knowledge to be able to sort of do that, and that's quite a big step*, Positive I think, for me. with this particular family, I'm meeting her today for the first time.

R: Right, so that's quite a

H: Yes, so really, for me today, it's about introducing myself and sort of explaining what my role will be. And I have to be quite sensitive because it's quite, she's had previous children removed, so there's a question mark over whether this

R: So she's pregnant, is she?

H: She is pregnant again and there's a query over whether she'll be able to keep this baby once it's born. She's with a new partner, so there's lot of, more

investigations going on. *So I'm quite wary that I don't want to say the wrong thing, I'm quite wary that I've got to be sensitive*. Positive

R: Yes. That's quite a difficult situation to be in, isn't it?

H: Yes. So it's, yes, it's learning to deal with those difficult situations. And I went on the DV (Domestic Violence) training yesterday as well, and that was about having difficult conversations and about being involved in difficult scenarios. And you just listen and just think, *I just hope that when I'm in that situation, somehow it all comes together.* Positive

Appendix G

Anna G.1

Analysed using Riessman's(2008) linguistic features

R: So how does that kind of professional identity as a Midwife, how do you see that?

A: It's very interesting, that's why I took part, because I was like, oh that's interesting because *they keep saying, you're a public health nurse. And I'm like, no, I've always not been a nurse*, Repetition I've always strongly been, like when people say, oh you're a nurse. Like no, I'm a midwife, so there's that difference. Where now, *like apparently, I'm a nurse and I don't feel like I'm a nurse. I'm happy being a Health Visitor but a Nurse is different to me.* Repetition

R: Yes, yes, very different, but some Health Visitors would say that they're not nurses, and the title, Public Health Nurse, is relatively recent. And so, for me, I mean I've been a Health visitor, I don't know, thirty odd years, and I don't think of myself as a nurse, I think of myself as a Health Visitor, which is why I'm interested in this. Interested in how this course helps you to change.

A: Yes.

R: So being called a Public Health Nurse is difficult for you?

A: Yes, in a way, yes, because I think you train, *because I've never been trained as a nurse, I was direct entry. So I've only ever been a midwife because I didn't want to be a nurse.* Repetition So I think that was a conscious decision and *I think as a midwife, we've got a very strong identity with our profession* Repetition , like as part of who we are, and people react very strongly to it. So if you say, you're a midwife, everyone's like, oh, and then, you know.

Anna G.2

A: *I think, because I have been thinking, what's the difference in role*? Aside One of the things I think is, as a midwife you're an advocate for the mother. And, of course, I think this was the interesting thing, being, for the vulnerable women, that you're always an advocate for, especially a vulnerable child. But you're mainly actually there as an advocate for the woman.

R: So that's very different?

A: That's very different. Health visiting, you're there for the child. And I think a lot of midwives do feel conflicted because we have had some conversations about, *I've always felt I was more, I should be more the voice for the child, in situations that are difficult* Repetition . Yes, so where, *a colleague of mine, also from the specialist team, was like, no, I'm there for the mother. I'm not there, primarily, for the child,* Repetition which is a very interesting thing. So midwives have that advocacy for women and I think that's different in health visiting, very different.

R: Yes, it is, yes. I mean the child is, yes, you're often told to not get side-tracked by the family, that you're there for the child, which, yes, so that's a big change.

A: Yes, I think that is. But I think that's always what I wanted, that's maybe why I wanted, felt that the decision was right. That I thought, no*, but I've always felt I should be the voice for the child, even if that is not nice f*or the, Repetition like if children are being taken from parents, I usually agree, where others might feel very conflicted about that. And I usually don't, I'm like, no, but this is the best. I've even advocated for a child to be taken away, where the social workers didn't agree, and in the end they had to do it anyway because we were like, yes, of course, you know.

R: So what happened in that situation?

A: It was just crazy, there were already two or three children taken from that family because of neglect or severe domestic violence. There was drug use from him, she had learning difficulties and very dangerous behaviours that she showed, very, very dangerous, just not putting the child at the centre, not thinking about the child even sometimes, making very dangerous decisions. And we weren't happy with her going away from the hospital and going home. And we did tell a social work manager that, the manager didn't agree with us, she said, *"no, we need more evidence that the child really can't stay"* direct speech , which we couldn't understand. And the social worker didn't either, she didn't agree with her manager. And they waited, I think, three weeks,

Anna G.3

Excerpt illustrates acceptance of change of identity

R. When we talked last time, we talked about how you felt you'd always be a midwife first and a Health Visitor would be an add-on, how does that feel now?
A: I'm not sure. I think I do feel, I'm not sure. … because I do feel like I know what I want and I know what I'm doing. You know, you'll feel a bit insecure about, is this normal? But I think that will always be part of me because I can't forget that. So it's always part of me but I don't know if my professional identity, I don't know.
R: You don't know yet.
A: I don't feel as strong as before. That I felt like, no, I'm a Midwife. It's sort of like, no,I think because I'm forced to let the work go and I'm actually OK with that
R: You're OK with the change in status?
A: Yes. It took a while.
R: Your knowledge and skills will always be there but you'll kind of build on them and build new ones, won't you?
A: Yes. And I think I still feel like I can give a lot of my midwifery in health visiting, you know, when you're doing new births, I know much better, I can give specific advice around the birth or like, you know, if they ask me questions like that when they're pregnant, I'm really happy, so I still feel I can use that.

Anna G 4

Analysed using Riessman (2008) key linguistic features

R: So how do you view health visiting now, what do you think it is, what's it about?
A*: I think it's about, I think helping parents*, Aside well it's about helping the child, obviously, to make sure, you know, that anything to be picked up. But in the end, you kind of, you're, you know a lot about, especially about things that you don't know in-depth about things. So you have kind of an interesting role, you're kind of in the middle between a lot of professionals, but most, I think you know the families quite well and you know where to signpost them to. If everything is OK and, you know, families have got good support and everything and all is fine, Health Visitors can help them, give them some confidence, but they're not right or, you know. But if there's some

vulnerabilities, I think it's, a Health Visitor can really make a difference in how parents relate to their children, you know, help them be connected to groups and things like that, and resources.

R: So it's kind of about empowerment and, rather than doing things for people?

A: Yes, absolutely.

R: Have you had many opportunities to empower people?

A: I think so. Sometimes it's hard, if you give someone, say like, like there was a breastfeeding problem with one of the mums and I really had a little bit of, I couldn't find out what the real issue was. Like, well you need to go there, you need to go to that clinic, you need to, or ring this person to kind of get more expertise because I cannot see like, again, helping you further, you're doing the basics right . *And you try and say like, go there, de, de, de*, Expressive sounds but then they don't do it, and then it's really difficult to think like ,*oh I tried to help and I try not to arrange that for them because I know she can pick up the phone, you know, but she chose not to*. Repetition And then it's quite difficult where, with some people you get the idea they will do what you ask them or what you suggest.

So I think there's, like one mum, she was quite isolated and we were talking about groups, and she was really like, *"oh I'd love to go, I'd love to get to, and she was like, "oh that's just around the corner from me".* Direct Speech And so I could see she would do that and that's nice. But you always have to address that people then, *you need to step back a little bit then*. Repetition