

Health Visitors' Professional Identity and their Lived Experience of
Service Change

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Abstract

This qualitative extended study explored 20 health visitors' (HVs') perceptions of their professional identity and their experience of living through a time of significant service change. Specifically, it investigated, how, and in what ways the changes affected HVs and their professional identity. The study spanned from an initial restructuring of the health visiting and Children's Centre services by one NHS trust in England in 2018, through to, and including, the initial peak of the Covid-19 pandemic in 2020. It was set in the wider context of the transformational NHS Long Term Plan (2019) and the radical service changes based on government directives in response to the Covid-19 health crisis.

The study methodology was informed by phenomenology. Data were collected from face-to-face, one-to-one interviews using a visual art-based approach in the form of collages, complemented by entries in participants' diaries. Analysis was conducted using interpretative phenomenological analysis (IPA). Of the original sample of 20 participants, 15 were interviewed after a year (plus) to compare data. A significant early finding was establishing HVs' perception of their professional identity. An understanding of the effects of the service changes emerged through mapping the HVs' experiences against core dimensions of their professional identity. The findings prior to the Covid-19 pandemic suggest that there were a number of changes that challenged HVs' practice. The more radical changes necessitated by the pandemic further affected practitioners and their practice.

Based on the evidence gathered, this research thesis is that HVs' perception of their professional identity, and their aspirations, remained strong and stable, transcending the service changes. This is in spite of the challenges of the changes and the impact of these on HVs and their practice. The professional identity dimensions identified in this study are important if HVs are to be able to practise effectively as public health practitioners. This is in accordance with their professional principles, values and mission to '*make a difference*' to the lives of their clients (Whittaker et al., 2013: 8, original emphasis).

Acceptance of, or resistance to, externally-driven service changes appeared to depend on the maintenance or disruption of a number of inter-related aspects of practice and how the changes affected HVs as professionals and persons. The various aspects of practice included the core dimensions of their professional identity, the 'three core practices' of the HV-client relationship, home visiting and needs assessment established by Cowley et al. (2013: 12), and their principles and values. Individual HVs reported that the effect of the service changes often meant that they were unable to enact their role as they aspired and therefore considered leaving the profession. Consequentially, HVs' professional identity and associated operational and aspirational factors need

to be recognised and maintained by those designing and implementing service changes if they are to be more readily accepted by HVs, especially in light of the link between chronic work stress, absenteeism and high staff turnover (The King's Fund, 2020e).

While it is acknowledged that this study was limited to a relatively small group of HVs in one locality, the insights to be gained are important in a wider setting. It is suggested that this study's findings are useful for policy and decision-makers, and all those actively engaged in educating, organising and directing the health visiting workforce. Through applying knowledge from the findings, the vision to optimise public health, reduce health inequalities, address health needs and safeguard children, shared by practitioners and those who direct their service, may be better realised.

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Chapter 1 Introduction

1.1 Background and Context

After over 25 years of commitment to health visiting as a practising health visitor (HV), and latterly community practice teacher, this researcher was driven to explore the lived experience of a group of health visitors (HVs) working through a time of service change, and its effect on their professional identity. This study builds on this researcher's recent MSc in Practice-based Research (Seaman, 2016) exploring professionalism and professional identity in health visiting, and the key challenges in the workplace.

An extensive report by Dougall et al. (2018a) for The King's Fund disseminated findings from interviews aiming to understand how transformational change in the NHS had affected staff in different healthcare settings and localities. The aim of this study was similar, but focussed on one specific professional group, namely health visitors, and from one locality in England. This aligned with Dougall et al.'s (2018a) calls for further research into staff experience of change.

It is recognised that fundamental changes underpinned by greater efficiency and effectiveness are required in the NHS in England (NHS England, 2017, 2019) if it is to meet public health needs and deliver quality healthcare. This is due to escalating public demand and constrained funding and resources (Allcock et al., 2015).

In recent years there has been and continues to be a complex radical restructuring and redesign of the NHS and public health services, including the health visiting service. There has been a shift towards a private sector business style of management, with an increased focus on delivering a value for money service and encouraging competition between service providers (Page et al., 2008). More recently there has been a greater emphasis on integration and collaboration between NHS organisations in order to deliver the Five Year Forward View (2014) (Alderwick and Ham, 2017). The mission statements outlined in the NHS Long Term Plan (2019) are designed to integrate health and social care services and to invest in the prevention of ill health (Alderwick and Ham, 2017).

Following the Health and Social Care Act 2012, devolution from central government took place and Local Authorities (LAs) became responsible for the commissioning of social care services, and other public health services, including health visiting (Wenzel and Robertson, 2019). Public health services for 0–19-year-olds were put forward for tender, and NHS trusts, charities and other bodies could bid to provide these. As a result of devolution and changes to the commissioning arrangements, whereby individual LAs decide how funds are to be spent, there is a wide variation in the service

provided by HVs across the four nations, as well as within England. The changes to the system for commissioning and providing services are set to continue (Wenzel and Robertson, 2019).

The World Health Organisation (WHO) (WHO, 2017) state that a robust health workforce is required to underpin effective healthcare and that there is a 'critical mass' required for its delivery (Zodpey et al., 2018: 1). There is, however, a world-wide shortage of public health practitioners, both in developing and high-income countries (WHO, 2017). HVs, along with school nurses and occupational health nurses, constitute the public health nursing workforce in England (Brook et al., 2019). The development and sustainability of this workforce is fundamental for effective public health (Brook et al., 2019).

The Healthy Child Programme (HCP) Pregnancy and the first five years of life, published by the Department of Health (DH) (DH, 2009), sets out the key priorities for both commissioners and providers in the delivery of a universal preventive service, at the same time as focusing on vulnerable children and families. The HCP sets out national pathways which specify in detail how various professionals, including HVs, support children and families. There are a number of key performance indicators (KPIs) linked to these pathways outlined by Public Health England (PHE, 2020), to ensuring that key contacts take place within a specified time period (see Appendix A).

In 2011 the UK government launched the Health Visitor Implementation Plan 2011-2015: A Call to Action (HVIP) (DH, 2011a). This plan set out the services that families should expect from health visitors, depending on their needs, and placed an increasing emphasis on partnership working with Children's Centre staff, GP's, midwives, community nurses and other relevant services dependent on local needs. The plan also aimed to recruit over 4,000 HVs, which was achieved in 2015. Since then, funding from central government to LAs for commissioning the service has been reduced. In 2015-2016 in England, LAs reduced public health spending by £200 million as a result of government austerity measures (Vijayshankar, 2018) leading to a planned reduction of HVs in a number of areas in England. NHS Digital (2020) recorded 10,213 whole-time equivalent HVs in post in December 2015 compared with 6,672 in November 2020. The Royal College of Nursing (RCN) (2017) also highlighted that in 2016-2017 HV training commissions decreased by 22% from 2015-2016. Since the Implementation Plan (2011-2015), the Institute of Health Visiting (iHV) (iHV, 2019a), state there has been a continuous decline in the HV workforce, reducing it to pre-launch numbers (Vijayshankar, 2018). This is despite the government's previous investment in the service and training.

In response to the NHS transformational change programme, government-driven initiatives and a reduced budget, one NHS Trust in England constructed a plan to redesign the health visiting service. The LA commissioners outlined their vision for an alignment of children's community services,

integrated inter-professional working, and increased skill-mix between former Children's Centres' staff, HVs and Community Nursery Nurses. The Corporate Service¹ model was introduced in the autumn of 2018, with the associated changes planned to be phased in over a six-year period. Other organisational, as well as practice changes, were included in the service restructuring. This included the creation of more centralised work hubs and the reconfiguration of teams and work-bases. Beyond the local level, other changes had been taking place, including an increased drive towards more mobile working and performance-related auditing strategies in line with the government's performance monitoring agenda.

1.2 Validating the Investigation

This researcher was aware that in meetings, and informally amongst themselves, HVs were voicing their concerns regarding how their professional identity was being impacted by the service changes and would likely to continue to do so. In response, this researcher sought written statements from nine health visitors, with a variety of experience and from different backgrounds, to assess whether the focus of this study was of a sufficient level of significance to warrant research (see extracts in Appendix B). The prompt provided was "how does it currently feel to be a health visitor?". The word "currently" was used as this researcher found du Plock's (2008: 47) concept of the 'research trajectory' useful, informing at what point the researcher enters the inquiry and what therefore is illuminated (and what is not).

A number of key issues as a response to changes to practice were raised in the HVs' statements. All but one HV described challenging and/or troubling professional and personal concerns and feelings. These included anxiety regarding their capacity to manage the workload, frustration at a future reduction of their role and service, and the lack of consultation in the decision-making process. Overall, there was general feeling of fatigue and low morale. The HV who provided the exceptional contribution, although appearing more stoic, described her concern for her less-experienced colleagues. Their responses suggested that the changes were of great significance to them, and therefore an investigation into their lived experience of the phenomenon of change in the context of their professional identity was deemed valid. Emerging from this, the following research questions were framed:

- What was the lived experience of service change like for health visitors?
- How have service changes affected health visitors' professional identity?

¹ In the interests of anonymity, the title of the new-style service is named 'Corporate Service' throughout.

1.3 Impact of the Covid-19 Pandemic

This study extends over a period of approximately 22 months. It includes the time prior to, and immediately post the initial peak of the Covid-19 pandemic. This researcher ended her research involvement in 2020, when the changes to practice were far more radical and unexpected due to the pandemic than at the beginning of this research in 2017.

In early 2021, the pandemic became a catalyst for an even greater reform of the NHS by the government (DH, 2021). According to Adams (2020), the HV numbers in England were already down by 30% since 2015, and were further reduced during the health crisis, as around 50% were temporarily redeployed to other duties. However, Ford (2020) reported a 23.8% increase in nursing students across the UK in 2020 compared with 2019; it is suggested that this is largely as a result of the raised positive profile of nursing during the Covid-19 pandemic. Whether this will lead to a greater number of HVs in the future is yet to be seen.

Researchers have begun to ask how the pandemic has affected the working practises of NHS practitioners, including HVs. This study's findings may triangulate with others to present a broader and more holistic understanding of how these changes have affected the professional identity of HVs.

1.4 Focus on Professional Identity and Review of the Literature

This study's focus was the impact of service change on HVs' professional identity therefore, a starting point was to explore how this concept was understood in the extant literature. How this was conducted now follows and the what was gleaned from the review follows in Chapter 2 .

1.4.1 Review of the literature

The methods employed for the identification, retrieval and storage of relevant literature were as follows:

Sources and search terms:

- A variety of online data bases, including the University of Hertfordshire's Learning Resources Centre (LRC), 'Researchgate' 'Eric' and 'Sage', were mined for relevant key words, such as 'health visitor', 'identity', 'change' and 'phenomenology'. The Boolean Logic Operators, 'AND', 'NOT' and 'OR' were also applied in the search.

Inclusion/exclusion criteria:

- The relevancy and quality of the literature were assessed. For example, whether peer-reviewed, sourced from a respected journal or oft-cited by other authors. If research literature, the quality

of the work was assessed. For example, it was examined for consistency, authenticity, breadth, gaps and limitations. Opposing theories and arguments were noted.

Dates:

- Topic-specific seminal works were identified, retrieved and reviewed, as well as more current literature.

Storage system:

- For ease of access and further review the accepted literature was catalogued according to topic and stored either as hard copies or in separate online folders. Reference details were logically stored online.

Chapter 2 Identity

2.1 The Concept of Identity

According to Vignoles et al. (2011), identity in social sciences is one of the most commonly and increasingly researched constructs. The concept of identity is complex, wide-reaching, multi-layered and fragmented. There is conflicting terminology, and a vast array of seemingly opposing theories, often arising from the different disciplines, perspectives and traditions.

Vignoles et al. (2011: 2) suggest that even the seemingly fundamental identity question 'who are you?' is open to multiple interpretations. For example, the term 'you' may be interpreted as singular or plural, as in 'oneself' or 'us'. Alternatively, one's self-definition could be based on the socially accepted understanding of a particular role. Identity characteristics such as ethnicity, depend both on social as well as personal meaning. Identity could also be who one thinks oneself to be, or how one acts as being. Other questions arise such as whether one's authentic self is 'discovered' or 'constructed', personally or socially (Vignoles et al. (2011: 1).

Setting aside the myriad of theories, complexities and lack of consensus regarding what identity is and how it is formed, this researcher was interested in some of the long-standing traditional theories that appear to form a bedrock for the plethora of the more recent ones. This researcher suggests that a grasp of these identity theories was necessary because of their relationship with this study's focus on professional identity. Other theories, if pertinent to this research, will also be discussed. This is not an exhaustive account as this discussion is kept within the scope of this study.

2.2 Identity Construction and Development

Maslow's (1987/1954) hierarchy of core human needs beyond the physiological are: safety (security and protection), social needs (love and belongingness), esteem (status and recognition) and self-actualization (Anderson and Anderson 2010/2001). Lakin et al. (2003) propose that communication, and thus social interaction, was likely fostered by early man unconsciously mimicking the gestures, behaviours, postures and mannerisms of others. This was fundamental to the survival of the individual and supported human evolution. Today, this serves to strengthen affiliation, relationships and a sense of belongingness with the group (Lakin et al., 2003). There is a duality and balance between agency, individuality and oneself, and communion, collectivity and others (Adams and Marshall, 1996). One needs to feel that one matters and that one is significant to others (Erikson, 1980/1959; Rosenberg, 1979). It appears that how we develop as humans, i.e., ourselves as unique individuals ('differentiation'), and the socialization process, i.e., ourselves needing to belong to the

group ('integration'), are in opposition (Adams and Marshall, 1996: 431), however, they argue this is not the case as both are required for human growth and wellbeing.

Vondracek (1992: 130), and most theorists acknowledge that Erikson is the 'intellectual father of the construct of identity'. Erikson proposes an epigenetic development of identity which follows eight successive stages from infancy to old age (Erikson, 1980/1959). This concept of the ages of man was not in itself new, as Shakespeare reminds us:

'All the world's a stage,
And all the men and women merely players;
They have their exits and their entrances;
And one man in his time plays many parts,
His acts being seven ages.'

'As You Like It', act 11, scene 7 (Shakespeare, between 1596-1600?)

Erikson proposes that identity development is based on an interaction between sociological, historical and psychological elements, laying the foundation for how the concept of identity construction is considered today, although interpretations of it have differed (Vondracek, 1992). Erikson's work is extensive and complex, but put simply, he proposes that identity can be viewed through various lenses. There is the conscious sense of one's identity, the unconscious drive to maintain continuity of one's character, and the maintenance of inner solidarity with group ideology and identity. Further, it involves the capacity of the ego as one develops to bring together disparate functions of the personality, such as contradictory thoughts and feelings, into unity (Erikson, 1980/1959: 94). Erikson states that 'the sense of ego identity' is: '...the accrued confidence that one's ability to maintain inner sameness and continuity (one's ego in the psychological sense) is matched by the sameness and continuity of one's meaning for others.' He continues, 'The term 'identity' expresses such a mutual relation in that it connotes both a persistent sameness within oneself (selfsameness) and a persistent sharing of some kind of essential character with others.' (Erikson, 1980/1959: 109).

A discussion of two well-established theories of identity in social psychology, i.e., identity theory and social identity theory, follows.

2.3 Identity Theory

Identity theory can be traced back to the work of Mead as the creator of symbolic interactionism, a term created by Blumer, which underpins identity theory (Stryker and Burke, 2000; Geoffrion et al., 2016) (although Hogg et al. (1995) contest that it was Stryker who formulated the original theory).

Symbolic interactionism concerns role-related behaviours, and the self and society that are a product of interaction and communication. It is subjective in nature because individuals behave according to the meanings and definitions they give to aspects of the world around them, based on belief. The underlying premise of identity theory is therefore that one is not separate and alone, but 'a multifaceted social construct' borne out of the roles we take on in society (Hogg et al., 1995: 256). One's identities are both social and personal; the individual is an active player in their formation, and as social constructs they are open to change and revision (Geoffrion et al., 2016).

Carter and Bruene (2018) add further clarification. Role identity is one's perception of the occupant of a social role, and links to others' expectation of the behaviour in that role. Role identity incorporates the 'conventional' and the 'idiosyncratic'. The 'conventional' are the 'meanings or definitions' of that role shared by others and society, and the 'idiosyncratic' are one's own 'self-defined meanings' (Carter and Bruene, 2018: 430). These self-defined role identities also connect with others; for example, the role of 'tutor' connects with the meaning of 'student'. One's interactions with others then consolidate these roles and provide a sense of self-meaning. If these roles are acted out well one gains a sense of self-esteem, with the reverse having poor consequences for one's self-worth (Hogg et al., 1995; Thoits, 2013).

Stryker and Burke (2000: 284) refer to identity as diverse 'parts' of the self. These discrete multiple identities are relatively stable role identities (Hogg et al., 1995), although others like Geoffrion et al. (2016), and Carter and Bruene (2018) claim some may alter over time. Simpson and Carroll (2008: 32) extend this, claiming that role and identity are distinct but linked, and both are 'dynamic, shifting, fluid'. Personhood is made up of all of the roles one plays (Turner, 1978). Typically, individuals have multiple identities at any given time (Thoits, 2013). Examples could be that one may be a father, husband and psychologist. Again, like the ages of man the concept of multiple identities has been recognised for centuries:

'And one man in his time plays many parts'

'As You Like It', act 11, scene 7 (Shakespeare, between 1596-1600?)

Vignoles et al. (2011) highlight the apparent disparity in the literature between whether one has a singular identity, as in Erikson's theory, or multiple identities. They refer to Tajfel's social identity work in which multiple identities are considered to be simply components of one's single identity. Vignoles et al. (2011: 6) claim that multiple identities may conflict, thus unsettling the 'unitary sense of self', but suggest that individuals use their inner resources to regain harmony; for example, by creating narratives or redefining their meanings of their various identities.

The core features of identity theory are summarised by Thoits (2013) who suggests that the individual and society are enmeshed; each directly affecting the other. As discussed, individuals' self-conceptions are viewed in terms of the roles they enact in society. In enacting this social role as expected by others, the individual is provided with a meaningful sense of self - 'who I am' - within the society, and this has the potential to re-create the society itself (Thoits, 2013: 373). This is a 'reflexive process of developing shared meanings from society, person, and others' (Geoffrion et al., 2016: 274).

All of these authors have presented succinct and readable accounts, condensing very complex theories and ideas, giving just enough detail to provide a background for their arguments.

2.4 Social Identity Theory

Tajfel was influential in the development of social identity theory (Stryker and Burke, 2000). This is founded on the belief that one's social identity is created through their identification with groups. In order for individuals to make sense of their social world they categorise other people into such groups. Aligning with a group's perceptions and activities leads to a social identification with that group - the 'in-group', or 'us' (Carter and Bruene, 2018: 431). There is a sense of group cohesion which is cognitive, attitudinal and behavioural (Stets and Burke, 2000), providing a sense of belonging and self-esteem. This links with Öhlén and Segesten (1998) claim that at the core of nurses' professional identity lies self-image and self-esteem. In contrast, individuals make social comparisons, dis-identifying and discriminating against others - the 'out-group' (Carter and Bruene, 2018: 431). Carter and Bruene (2018: 431, original emphasis) add that social identity is either '*ascribed*' as in one's gender, or '*achieved*' as in one's chosen membership of a group which may be more unstable.

Stets and Burke (2000) consider the two concepts of identity theory and social identity theory. They propose that it is pragmatic not to focus on these two theories as separate, as their formation and development overlap. Social identity theory centres on the premise that the group one belongs to forms the basis for 'who one is', while the role one acts out, 'what one does', forms the basis of identity theory; these are both key features of one's identity (Stets and Burke, 2000: 234). Further, with the addition of an individual's identity, a 'complete theory of the self' is formed (Stets and Burke, 2000: 234). Hogg et al. (1995) contest this, claiming that, although both perspectives are very alike, their roots lie in different disciplines (sociology and psychology). Although both theories concern 'the socially constructed self', i.e., how we develop the 'sense of self' through our interactions with others, they 'occupy parallel but separate universes' (Hogg et al., 1995: 265). Both

articles are complex, well-researched and rich in detail, providing a sound base from which to collate further information.

2.5 Person Identity

Some theorists pay particular attention to the concept of person/personal or individual identity. Carter and Bruene (2018: 429) describe discrete 'person identities': one's unique and idiosyncratic attributes and characteristics. These 'master identities' permeate all aspects of one's life and, although unlikely to change, may do so through life experience (Carter and Bruene, 2018: 429). The authors claim that the concepts of social and role identity, and personhood, are separate but interconnected, a construct this researcher found helpful in providing some clarity in developing the concept of the complete person (which will be discussed in 3.4).

2.6 Self-concept

Carter and Bruene (2018: 429) propose that the self represents the completeness of one's feelings and thoughts about 'oneself as an object'. Further, one's identities are 'internal positional designations', defining oneself through components of the self-concept, as a 'unique person, role player, or group member' (Carter and Bruene, 2018: 429). Similarly, Johnson et al. (2012: 563) state that the definition of self-concept is 'our personal understanding of our perceived attributes', meaning seeing ourselves in terms of who we are socially, physically and cognitively. They add that the concept of self is how one thinks and feels about oneself, and includes the 'multiple selves of awareness, esteem, worth and confidence' (Johnson et al., 2012: 563).

Linked with the development of the individual, in contrast to Tajfel's social identity theory, Goffman (1971/1959) places the emphasis of identity formation primarily on the self and one's presentation of the self to others. Social identity and a 'social relationship', are a secondary product when the '...performer plays the same part to the same audience on different occasions...' (Goffman, 1971/1959: 27).

Anderson and Anderson (2010/2001: 139) outline the difference between the 'ego' and 'being'. They propose that the ego is one's mind: one's personal identity that is unique and separates one from others, encapsulating one's needs, wants, desires and ideas. The ego also fears and avoids failure which it equates with 'psychological death' (Anderson and Anderson, 2010/2001: 135). It is also known as the 'false self', as one's identity is based on the illusion of what is feared or desired (Anderson and Anderson, 2010/2001: 138). The 'being' however is the authentic self, or one's soul. The authors propose 'being' is on a higher plane of existence; it is beyond the ego's constrained limitations of cognition and judgements concerning reality. Instead, if liberated, the self can open one to new and enhanced possibilities.

At this point the term 'self' in relation to identity was explored for clarification. This researcher agrees with Leary and Tangney (2002: 3) that the term 'self' is abundantly used in identity literature, but its meaning is inconsistent. To address this semantic confusion, Leary and Tangney (2002: 9) suggest the use of 'self' in reference to the ability for 'reflexive self-thinking' only. Vignoles et al. (2011: 7, 2) add that among the numerous hyphenated 'self-' terms, many are not associated with identity, and are not self-representations that could address the 'identity question' - 'who are you?'; for example, the word 'self-efficacy'. This researcher concurs and used 'self' in a reflective sense in this dissertation, and adopted 'person', 'personhood' or 'individual' in relation to the 'total person' or personality.

2.7 Identity Salience

As discussed, it is claimed that individuals have multiple identities, and as social constructs they can be altered over time (Ibarra and Barbulescu, 2010; Geoffrion et al., 2016). Ibarra and Barbulescu (2010: 137), reflect how individuals' 'identity work' is 'forming, repairing, maintaining, strengthening, or revising their identities'.

Identity salience, i.e., the importance one attaches to a particular identity, can be flexible and hierarchical depending on one's particular setting (Stryker, 1968). Thoits (2013) proposes that identity salience can be viewed in two ways: the subjective importance individuals attach to a particular identity, or the propensity to summon a particular identity at a specific time. Identity salience can also be described in terms of its prominence dependent on the positive feedback one achieves from a particular identity. Rosenberg (1979) conceptualises concentric rings of an individual's various identities; the identities that are considered the most important to an individual are centrally placed, with the least valued radiating towards the outside.

Stryker (1968: 560) proposes that a 'commitment' to a particular identity often depends on the richness of the social network it creates. This emotional component of an individual's experience can shape the way they define it and behave as a consequence (Stryker, 1968). Rosenberg (1979) demonstrates a positive correlation between the salience of an individual's identity and their emotional and physical health. In contrast, Ibarra and Barbulescu (2010) argue that narrating one's identity supports clarity about 'who one is' (Stets and Burke, 2000: 234) and creates meaningfulness in work, although this researcher noted that their article omitted to discuss the affective and emotional role in significant work-role transitions. Turner (1978: 14) asserts that amongst other factors, individuals are more likely to choose social roles 'the more intensely and consistently significant others' identify them through their role, providing them with a positive sense of self and

strengthening the role. This may, with other factors, lead to a state of 'role-person merger' where behaviour and attitudes are taken from one's role into other areas of life (Turner, 1978: 3).

2.8 Summary

Returning to the views of Vignoles et al. (2011), this researcher concurs that no one definition of identity covers the myriad of interpretations and complexities for all disciplines. Many differing conceptualisations of identity arise from the varying theorists' perspectives. It may be more useful to think of these differences as somewhat artificial, and taking Vignoles et al.'s (2011) more integrative approach may be more enlightened. According to Vignoles et al. (2011: 5), all aspects of identity, i.e., personal, role/relational, social /collective, (even material), are both personal and social in content. How they are 'formed, maintained, and changed over time' are variously fluid and stable. This includes an individual's geographical location and personally cherished possessions. This researcher finds the unifying view of the subjective and objective nature of identity as offered by Vignoles et al. (2011: 4) inspiring in bringing together the individual, others and society:

'Viewed through the lens of an individual person, identity consists of the confluence of the person's self-chosen or ascribed commitments, personal characteristics, and beliefs about herself; roles and positions in relation to significant others; and her membership in social groups and categories (including both her status within the group and the group's status within the larger context)'.

It is noteworthy that this understanding not only brings the objective and subjective components of identity together, but also the 'emotional freight' inherent in one's identities (Geoffrion et al., 2016: 275). One's level of commitment to a particular identity is a combination of the rational and the emotional and plays a significant part in identity salience.

Chapter 3 Professional Identity

3.1 Definitions

Professional identity is a complex term (Beauchamp and Thomas, 2009; Aagaard et al., 2017). The theories and processes underpinning it are numerous, and a clear definition of professional identity in the literature proved elusive (Trede et al., 2012). In this researcher's literature review a definition was often omitted altogether. It appeared that many authors faced challenges in trying to 'pin down' a precise meaning. This experience was shared with Trede et al.'s (2012) systematic review of 20 articles pertaining to professional identity, finding only one paper offering a definition: 'the sense of being a professional' (Paterson et al., 2002, cited in Trede et al., 2012: 374). In a similar systematic review, Beijgaard et al. (2004) also remarked on a lack of definitions.

While rare, some definitions in the literature are provided. Dadich et al. (2015: 320), for example, claim 'Professional identity is the persona assumed by one who holds expertise or specialised knowledge.' Wilson et al. (2013: 370), writing on medical training, state 'Professional identity is how an individual conceives of him - or herself as a doctor...'. Ibarra (1999: 764), based on the work of Schein (1978), echoes and extends this, defining professional identity as: '...the relatively stable and enduring constellation of attributes, beliefs, values, motives and experiences in terms of which people define themselves in a professional role.' Sabanciogullari and Dogan (2015: 848) highlight the dimension of social identity: '...the attitudes, values, knowledge, beliefs and skills that are shared with others within the professional group in the work place.'

This researcher noted that even if a definition was offered, all had strengths and omissions. Some emphasised professional identity as acting a socially prescribed role, some as a shared concept within one's membership of a professional group, some only focussed on separate dimensions, such as autonomy, and others the idea of the self was centralised.

While precise definitions were sparse, various and lacking consensus, the literature offered a variety of descriptions and understandings of professional identity. As these were helpful in providing a comprehensive understanding of professional identity, a brief discussion follows.

3.2 Descriptions and Understandings

The concept of professional identity is not new. Its roots stem from the Aristotelian concept 'phronesis'. The Oxford Dictionary (2017: online) describes phronesis as:

'...ancient Greek φρόνησις thought, sense, judgement, practical wisdom, prudence from φρονεῖν to think, to have understanding, to be wise, prudent...'

According to Beauchamp and Thomas (2009), focussing on teaching, the concept of professional identity is complex because one must grapple with a variety of inter-related constructs. These include the links and connections that professional identity has with the concepts of self, emotions, agency, reflection, the strong influence of discourses, and 'identity as narrative' (Ibarra and Barbulescu, 2010: 135). In reviewing the literature this researcher became aware not only of the complexity of the inter-relationships between concepts, but also interchangeable terms.

Professional identity is sometimes used synonymously with 'occupational identity'. According to Geoffrion et al. (2016: 275), professional/occupational identity refers to 'a system of meanings associated with worker roles'. Johnson et al. (2012: 563) suggest that in addition to the term 'occupational identity', professional identity in nursing is also frequently referred to as 'vocational' or 'career' identity. This draws one's attention to the extensive work of Holland, who, building on the work of Erikson, developed the Personal Career Theory and the Vocational Identity Scale (Holland et al., 1993).

Wackerhausen (2009: 459) discusses professional identity at the levels of 'micro' and 'macro'. The 'macro' level is 'the public face' of professions, which is dynamic and evolving. It is the profession's 'official recognition' by the public, other professionals, and the 'self-image' senior members of the profession seek to portray and promote (Wackerhausen, 2009: 459). Further, he suggests that there are also a number of influential factors that combine to create a profession's identity. These include current and on-going scientific and technical advancements, the views of allied professional groups, public opinion, and a nation's climate and economy. At the 'micro' level, Wackerhausen (2009: 459), and Willetts and Clarke (2014), state that post-qualification, professionals commence the process of enculturation to acquire the necessary habits, qualities and behaviour deemed appropriate by the profession in order to be fully accepted as members of the professional group. Willetts and Clarke (2014) focus on the complex social activity involved in an individual nurse's acquisition of their professional identity and the nursing profession's historic struggle to acquire its collective professional identity. This suggests that professional identity is important and is the focus of the next discussion.

3.3 Importance of Professional Identity

The literature frequently highlights professional identity as a vital component in professional development and optimal professional efficacy (Björkström et al., 2008; Beauchamp and Thomas, 2009), particularly during times of change (Wilson et al., 2013). Sabanciogullari and Dogan (2015) propose that a key element of nursing practice is professional identity, and it provides the foundation for nursing as a profession. They claim that professionals whose identity is strong practise effectively, provide high quality patient care, become competent, develop clinical expertise

and support patient satisfaction. Johnson et al. (2012) extends this, adding the requirement for flexibility, and the positive effects professional identity had on the nurses themselves and others. Whilst this is a reasonable view, this is not developed further in their theoretical critique. Rooke (2015), writing as a Fellow of the iHV (Institute of Health Visiting), brings together both aspects of social and role identity within professional identity echoing Stets and Burke (2000). Aligning with Wilson et al. (2013), Rooke proposes that a robust sense of professional identity is necessary at a time when significant changes in health visiting are taking place.

3.4 Centrality of Personhood

The centrality of personhood is a common thread running through the literature relating to identity, social identity, role identity and professional (occupational) identity. This researcher narrowed her review of the literature to focus specifically on personhood. Acknowledging that some of the material has been included previously, a sharper focus and emphasis on the individual was required. This was to address the research question of how service changes have affected HVs' professional identity, which includes themselves as professionals and persons.

The inter-connectedness of the concepts of social, role and person identities in professional identity is clear in Merton's (1957) statement that medical education should '...transmit the culture of medicine and [...] to shape the novice into an effective practitioner of medicine, to give him the best available knowledge and skills, and to provide him with a professional identity so that he comes to think, act, and feel like a physician'. (Merton, 1957, cited in Cruess et al., 2016a: 181).

Rabow et al. (2010) echo Merton's (1957) view of the merging of one's personhood and professional identities. Based on Flexner's Report to the Carnegie Foundation in 1910, Rabow et al. (2010: 310) argue that 'professional formation' requires the integration of both personal and professional values. In their theoretical critique of professional identity in nursing and literature review, Johnson et al. (2012) acknowledge that they also found that professional identity and the concept of self were closely inter-related.

With reference to the individual, i.e., 'who one is' (Stets and Burke, 2000: 234), this researcher is reminded that personhood is dynamic, evolving and changing as one develops, grows, experiences and interacts with one's environment, society, and the world. As mentioned, Erikson (1980/1959) mapped out how human identity takes shape over a lifetime. Schein (1978), from the perspective of organisational development, addresses the life-cycle from several angles. The 'biosocial', i.e., one's natural changes in bodily states, runs concurrently with cultural and societal expectations of one's role and behaviour at any given time (Schein, 1978: 36). Linked with the 'biosocial' is the 'internal career' cycle, i.e., one's experience of the 'stages and tasks' in the workplace (Schein, 1978: 36).

Individuals enter a profession with a unique and developed sense of self which has developed from infancy (Cruess et al., 2016a), and through the process of socialisation, one belongs and matters to the group, and has significance (Rosenberg, 1979). It is broadly acknowledged that individuals possess multiple identities, personal as well as professional, which alter throughout life (Cruess et al., 2016a). Identity and professional identity are fundamentally important to individuals and professionals alike as they embody who we are; they are at the core of our individuality, extending to include groups (Hussey and Campbell-Meier, 2016). One defines and describes one's identities through the meanings given to role expectations (Geoffrion et al., 2016). One's life journey is guided by one's identities (Kroger, 2007/2000), answering both 'who you think you are' and 'who you act as being' (Vignoles et al., 2011: 2).

Cruess et al. (2016a: 183) state that 'being' a professional equates with the profession's values, and for physicians, 'competence, caring [...] compassion [...] honesty and integrity' are essential. Wackerhausen (2009: 457, original emphasis) summarises how core values embedded within a member of the 'caring and healing professions' professional identity translate into their *raison d'être*, namely, '*to do what is best for the patient*'.

Other contributors reflect the growing view that 'who one is' (Stets and Burke, 2000: 234) and being a professional are at the core of professional identity, and are of greater importance than simply one's role, i.e., 'what one does', in isolation (Stets and Burke, 2000: 234). However, this researcher is reminded of the views of Stets and Burke (2000) that these two theories are inter-related within the overall identity of the person. Other authors concur; Sabanciogullari and Dogan (2015), focussing on professional identity in nursing, incorporate identity with the profession, the individual's understanding of acting as that professional, as well as what being that professional meant to nurses. This is reiterated by Rooke (2015: 71) in defining her professional identity in the work of making a difference to 'children, families and the profession'. Rooke (2015: 71) states that a 'perfect vision' of professional identity in health visiting 'consisted of a set of values, beliefs and attitudes which resonate with standards of quality, excellence in practice and leadership behaviours'. On a personal level Rooke extends this, as through defining her professional identity and having a sense of it, she knows who she is and what she is, which is translated into action, i.e., what she can do.

Higgs (1993) (Higgs, 1993, cited in Trede et al., 2012: 374) include the notion of professional responsibility; that professional identity happens when a professional adopts the '... attitudes, beliefs and standards which support the practitioner role and the development of an identity as a member of the profession with a clear understanding of the responsibilities of being a health

professional.’ Although these authors do not explore the concept of oneself as a professional in depth, this researcher suggests that their contribution to the debate is valuable.

In summary, this researcher proposes that the concept of ‘who one is’ (Stets and Burke, 2000: 234), when discussing the nature and construction of professional identity is fundamental. A significant body of the literature suggests that it is not just about doing professional work, but also about oneself being a professional. This links with the over-arching notion of personhood in identity, and social and role identity theories.

This researcher considers that one of the most comprehensive descriptions of professional identity and its inter-relatedness to individuals’ development of personhood and group identity is put forward by Olsen (2008: 139):

‘I view identity as a label, really, for the collection of influences and effects from immediate contexts, prior constructs of self, social positionings, and meaning systems (each itself a fluid influence and all together an ever-changing construct) that become inter-twined inside the flow of activity as a teacher simultaneously reacts to and negotiates given contexts and human relationships at given moments.’

Figure 1 below depicts this researcher’s understanding of professional identity as nested amongst one’s other multiple identities in the context of the complete person and society. This figure was created by drawing together many of the views offered by key contributors from their various perspectives including Turner (1978), Hogg et al. (1995), Stets and Burke (2000), Stryker and Burke (2000), Pratt et al. (2006), Thoits (2013) and Wackerhausen (2009).

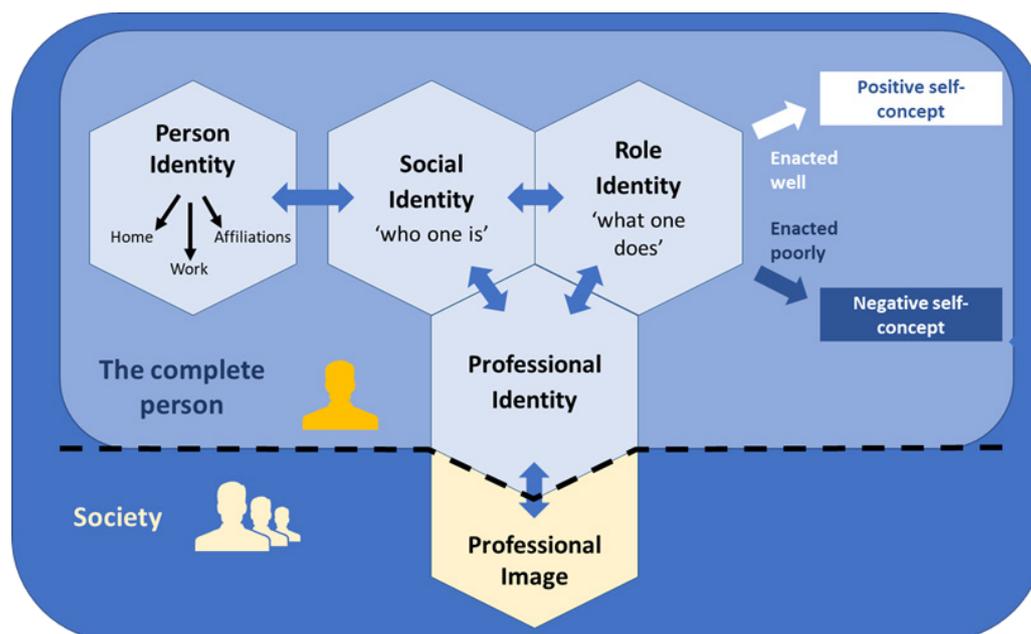


Figure 1 – The complete person

3.5 Formation and Personhood

Professional identity formation (PIF) adds further insight. The importance of professional identity formation is taking 'centre stage' in much of the literature on professionalism (Cruess et al., 2016a; Holden et al., 2015). Indeed, many authors contest that the education of professionals, such as physicians and teachers, should place the acquisition of professional identity high on the agenda in universities and teaching institutions (Beauchamp and Thomas, 2009; Irby et al., 2010; Timoštšuk and Ugaste, 2010; Johnson et al., 2012; Cruess et al., 2014; Cruess et al., 2016a). Professional identity formation has also created further debate about its nature and relationship with other elements of professionalism, such as the professional competencies and behaviours that need to be acquired by the developing professional (Cruess et al., 2016a; Barnhoorn, 2016).

Irby et al. (2010) report on the Carnegie Foundation's calls to reform medical education (2010). A proposal by the Foundation to update Carnegie's work put forward a number of key recommendations towards a comprehensive professional identity. Amongst these was that training should aim to develop excellence through 'habits of the mind and heart' (Irby et al., 2010: 225), again reflecting the inclusion of personhood. Further, the description of the socialisation process towards the desired professional identity of physicians, provided by Ewan (1988/1982: 85) combines both a positive self-image (from the feedback of enacting the role well), and what is expected of a professional in that role by society: 'The ideal outcome of the socialization process is a self-image which permits feelings of personal adequacy and satisfaction in the performance of the expected role.' Wilson et al. (2013: 370) summarise that '...the integration of personal values, morals, and attributes with the norms of the profession, that is, of the individual's personal identity with the professional self' is on-going. Wear and Castellani (2000), add that open-mindedness and reflection should be a continuing process in professional development.

Miller (1990: S 63) proposes a four-tiered hierarchical framework to offer clarity when assessing medical competence. Each level stood alone with its own assessment methods and medical students were required to develop upwards through the assessment framework from 'knows' (knowledge), through 'knows how' (competence) and 'shows how' (performance), to the highest level 'does' (action). While this has been widely adopted beyond medical education, and internationally, Cruess et al. (2016a) argue that, based on an increasing understanding of the importance of professional identity formation, a higher level of aspiration should be placed above Miller's 'does'. The authors propose that 'is' should be added, encompassing a professional's 'attitudes, values and behaviours' and moving to the higher level of 'being' above 'doing' (Cruess et al., 2016a: 180, 184). 'Is' also equates with Merton's (1957) previously discussed view that a doctor's professional identity embodies thinking, acting and feeling 'like a physician' (Merton, 1957,

cited in Cruess et al., 2016a: 181); in other words, professional identity in its most complete state is synonymous with who one 'is'. Professional behaviours emerge from 'who we are' not just 'what we do', i.e., 'what one is rather than what one does' equips doctors to manage the complex 'shades of grey' in practice (Cruess et al., 2016a: 181).

There is growing awareness and understanding of how professionals develop their professional identities alongside their competencies. Cruess et al. (2016a) describe how an individual's professional identity develops in stages, strengthened by significant new experiences, a view echoed by Pratt et al. (2006). Holden et al. (2015) concur that the process is a gradual dynamic journey of transformation as a result of an accumulated experiences, self-reflection and mentorship. Wilson et al. (2013), drawing on recent contributions, add that occupational identity construction may begin well before entry into medical school. Eventually the professional identity superimposes over the personal identity (Cruess et al., 2016a), although the latter remains as valuable. The desired result is a '...fully integrated moral self...' (Bebeau, 2006: 65).

Cruess et al.'s (2016a) article sparked a contentious debate. Barnhoorn (2016) countered that rather than place professional identity at the pinnacle of Miller's framework, it is more realistically suited to be conceptualised as part of a different type of structure, namely Korthagen and Vasalos' (2005: 54) 'layered' 'onion'. Barnhoorn (2016: 291) argues that the elements of 'knowledge, competence, performance, action, and PIF' are intertwined and inseparable, and not achieved successively. The 'layers' of the 'onion' model have mission at the core, with identity, beliefs, competences, behaviour and the environment sequentially placed towards the outside. This model was initially designed for reflective purposes, is holistic, and each 'layer' provides more of a parallel perspective rather than a hierarchy when assessing professionalism. Barnhoorn (2016: 219) claims that mission, rather than 'who one is' (Stets and Burke, 2000: 234), should be at the core of a physician's identity. Cruess et al. (2016b) in response, defended their claim that professional identity formation should remain at the pinnacle of Miller's assessment framework. They countered that this broadened professional assessment, while not decreasing the status professionalism and behaviour.

This researcher suggests that the above debate lacked clarity, and the concepts discussed were misaligned. It was not evident what Barnhoorn (2016: 291) meant by identity and 'professional identity formation'; indeed, he states that the latter concept was elusive. Although this researcher found a variety of descriptions of PIF there was a lack of consensus amongst the theorists. For this researcher, these debates demonstrate again how complex, ill-defined and variously understood the concept of professional identity is, reflecting the views of Beauchamp and Thomas (2009) and other authors, as discussed.

Simpson and Carroll (2008) offer what they claim is a contemporary perspective. Although their study was restricted to the contributions of only three managers, they contend that role is not a fixed entity or becomes an identity, but rather is dynamic, discontinuous, emerging and flexible. They argue that traditional functionalist views, such as those of Stets and Burke (2000), do not adequately address individuals' contemporary experience, such as more 'fluid' and 'shifting' job descriptions (Simpson and Carroll, 2008: 33). Professional identity formation is not a socialisation process of incremental steps with a fixed goal, but more a state of 'becoming' rather than 'being' (Simpson and Carroll, 2008: 31).

The findings of Pratt et al.'s (2006) longitudinal qualitative study of medical students add another dimension. They found that when faced with 'work-identity integrity violations', i.e., when their work did not match who the students believed themselves to be, a variable process of reconstructing their professional identity took place to accommodate for this (Pratt et al., 2006: 253). How professional identity was re-formed, however, was dependent on a number of factors centred around the individual's perspective and the 'magnitude of integrity violations' (Pratt et al., 2006: 259). These 'violations' were significantly stressful, often exacerbated by the culture and practises of those in higher authority. Given that the authors acknowledged the distress often experienced by the students, this researcher suggests that the authors' choice to omit this dimension was a missed opportunity for a more holistic understanding of professional identity formation.

For this researcher, Wenger (2017/1998) presents a very clear and holistic view on how individual identity is constructed and how one defines oneself. Although speaking of identity construction in general terms, Wenger also applies it to professional identity. His stance is based on the premise that 'we cannot become humans by ourselves' (Wenger, 2017/1998: 146). Identity is a lived experience. Oneself, and the communities one belongs to and one practises within, are inextricably interconnected - they are two sides of the same coin. One's identity is a complex, and continuously dynamic, interweaving and layering of participation in the group and a reification of oneself and others. Practice and identity are therefore bound together. This interplay between ourselves and others creates one's identities, which are in a continuous state of becoming. As well as through membership of a community, self-definition is also created by one's previous experience and future possibilities. One is also a member of various communities, and one's participation in them needs to be reconciled and negotiated, as does the global and local identity aspects of one's communities.

In reviewing the literature this researcher uncovered differing opinions as to whether a robust and stable professional identity, however described, was important for individuals and their profession, especially in times of profound change, or whether it was more pragmatic for professionals to

embrace a more fluid professional identity. As professional identity's stability or fragility was relevant to reflect upon in her study, an overview follows.

3.6 The Changing Professional Landscape

For at least 30 years seismic socio-economic changes have shaped the way the world works, and continue to do so. The advent of neoliberalism, international de-regulation, growth of capitalism, marketisation, and globalisation underpinned by dramatic advances in technology and communication, continue to have a significant impact on society. As well as affecting the citizens in society, these changes have repercussions for professionals and their associated professional identities.

Habermas (1996/1989) offers a sobering view of social evolution. He argues that contemporary capitalism and state bureaucracy's power has created de-moralisation through removing personal autonomy and distorting morality to serve a capitalist ideology and system. This has created new identities, and individuals have become amoral instruments serving the state (Stoten, 2013).

Habermas (1996/1989) calls for professionals to consider their interactions with others and the way in which they work; to ultimately bring about an ethical and moral 'inter-subjective consensus' (Stoten, 2013: 370), aligning with his theory of 'truth as consensus' (Heikkinen et al., 2001: 19).

Sachs (2001), commenting on teachers' professionalism and professional identity, draws attention to the growing commodification of the profession. Sachs (2001) speaks of the impact of government policy and restructuring in education which focusses on being effective and accountable. As a result, 'managerial professionalism' sets the agenda, rather than the profession, regarding working practises. Sachs (2001: 151, 156) points to a movement away from professional 'collaboration and collegiality' and the democratic 'activist professional identity', to an individualistic 'entrepreneurial identity'. She refers to professional 'designer teachers', whose affiliation is with management rather than their profession, and who exhibit compliance with the management's initiatives and policies Sachs (2001: 156). The possible result of individuals abandoning the in-built traditions, values and shared meaning of what being a teacher is may denigrate the 'constitution, standing, identity, autonomy and authority' of the profession as a whole (Fergusson, 1994: 106).

Evetts (2018: 52), echoing Sachs (2001), considers the notion of 'professionalism as occupational value' and the increasing changes to professionalism as more service professionals are employed by large organisations. The work-model is based on marketisation and competition, and is increasingly standardised, resulting in ways of working that move away from traditional occupational professionalism (Evetts, 2018). Evetts (2018: 53) considers the implications of this move towards the 'commodification' of professionalism, and proposes that it has both opportunities and

challenges. There may be possibilities for greater and fairer work practices via increased human resources' (HR) input, but amongst the challenges is professionals' highly-prized autonomy (Evetts, 2018). However, Alderwick and Ham (2017) acknowledge that there is some early movement away from competition towards collaboration between NHS organisations.

Employing organisations also direct and manage professional competencies, according to Clarke et al. (2000) and Deem and Brehony (2005), who warn this can create conflict when organisations attempt to manage professionals' fields of expertise. Power (1994) agrees that the principle of 'value for money' underpinning the 'audit explosion' results in performativity and the standardisation of practice, fundamentally changing the way professionals are directed to work (Power, 1994: 1, 7). Jary (2002) reflecting on Power's work, adds that the increase in audit arises from risk attitude and distrust, which includes a general lack of trust in professionals.

Bauman (2005) wrote extensively on contemporary society, conceptualising it as a state of 'liquid modernity' (Deutz, 2008: 851). Bauman (2005: 1) defines 'liquid modern' as '...a society in which the conditions under which its members act change faster than it takes the ways of acting to consolidate into habits and routines.' This 'liquid life' is precarious; there is a permanent state of change, doubt and conflict (Deutz, 2008: 351). Barnett (2008: 190, 200), drawing on Bauman's ideas, termed this 'liquid' world an age of 'supercomplexity'; a world where professional status and professional identity, i.e., 'who am I' in the world, is challenged and tested. Ever increasing demands are being made from user-groups and professional bodies, and written into state policies. According to Olesen (2001), societal changes and resulting contradictions regarding the professions has politicized professional work. There have been, and continue to be, fundamental shifts in power and relations between service providers, such as professionals, and clients/consumers/user-groups. The King's Fund (2018: 88) concur, and highlighted in their research that it was the community that had the power to 'deliver great change' in health and care.

In the 'knowledge society' (Barnett, 2008: 192), the de-mystification of knowledge is re-forming the relationship between the professional as the holder of knowledge, to just one other source of information. Professionals' knowledge can be verified or contested by the service-user's ability to speedily access so much more information than previously through advances in technology. Dent and Whitehead (2002: 1) contest that the notion of what was understood by the term 'professional' is now becoming outdated. The expectations and values of the service-user dominate, devaluing the notion of traditional professionalism. Barnett (2008: 197) extends this, claiming that the traditional professional stance of a value-driven 'ethic of service' is transforming into an 'ethic of performance' through performative measures.

For Barnett (2008), professionals today not only have multiple identities, but a wide variety of discourses pulling them in different directions. Drawing on Heidegger, Barnett (2008: 206) offers that the 'modern professional' inhabits a 'fragile world'. In order to function and thrive, he/she requires a continuous growth and practise of knowledge, and a full engagement in the re-forming of the self as a professional amidst the challenges. Wackerhausen (2009) agrees, and proposes that the new demands of a rapidly changing world mean that for professional survival and fulfilment of its *raison d'être* (in the case of the caring professions, optimum patient care), professionals must be willing to continuously search for new ways of working.

3.7 Professional Identity in Health Visiting

Since the beginnings of the profession over 150 years ago, health visiting's professional identity has been continually re-shaped. The profession has struggled to define itself, not least because the role is so complex and far-reaching (Baldwin, 2012). The role spans across 'health, education and social care' and includes a responsibility in safeguarding children (Baldwin, 2012: online). Lack of a definition has led to the description of an HV as being a 'jack of all trades' (Hunt, 1972, cited in Baldwin, 2012: online). However, more recently, Cowley et al. (2013: 11) offer an 'orientation to practice'. This describes health visiting as:

- salutogenic (health-creating) – proactively 'identifying and building strengths and resources' in order to be health-creating and solution-focussed
- human valuing – (person-centred) - positive regard for others; mindful of clients' needs, seeking strengths and unmet need, and maintaining hope
- recognises the 'person-in-situation' (human ecology) – their current needs and 'situational circumstances'.
- Cowley et al. (2013) noted from their scoping study and literature review that HVs' values and their skills are stable over time. The 'orientation to practice' describes how, initially through a universal service, HVs aspire to deliver a 'person-centred' healthcare service (Whittaker et al., 2015: 13).

Additionally, Cowley et al. (2013: 12) established three interrelated 'core practices' which function in the delivery of the HVs' universal service to all families:

- the HV-client relationship
- home visiting
- HV needs assessment

Various government agendas have been key drivers of changes to the health visiting profession.

Within the last 20 years for example, the practitioners' title, the possession of a separate

professional register and the focus of their work has changed. Around the turn of the new millennium, New Labour realised the potential of HVs to tackle health inequalities (Hoskins, 2009) and introduced a new strategy towards a greater public health role for HVs. The Hall report (revised 4th edition), *Health for All Children (2006/1989)*, underpinned this shift away from their existing role in child health surveillance (Hoskins, 2009), leading to a more targeted service (King, 2015). Following *The Nursing and Midwifery Order 2001 (UK Statutory Instruments, 2002)*, in 2004 the Health Visiting Register was closed, leaving only two parts for nursing and midwifery, thus removing the title of Health Visitor from statute. According to Hoskins (2009), this move was intended to liberate health visiting's traditional role and allow its expansion into the realm of public health. The new generic title of Specialist Community Public Health Nurse (SCPHN) followed. Alongside the vagueness of what HVs' professional identity is, the term 'public health' also lacks definition and holds ambiguity (Baldwin, 2012: 14). It is perceived variously as encompassing their entire role, or where their role takes a population-wide approach (Baldwin, 2012). Other contributors, such as Lynch (1997, cited in Baldwin, 2012), argue that the HVs' role in public health has been embedded in their role from profession's origins (Peckover, 2013). Other changes have followed that affect HVs' professional identity. The role of HVs has now been devolved and is defined locally by the four nations.

These historic and on-going changes to the health visiting role have led to a variety of commentary. Machin et al. (2012) conclude from their study of HVs' views that their professional identity needs stabilising. In contrast, Sachs (2001: 154) agrees with Wenger, claiming that professional identity is forever changing, and is 'negotiated, open, shifting, ambiguous', although this is a general statement and not applied to health visiting specifically. More recently, Baldwin (2012) agrees that professional identity is dynamic and evolving, concluding that changes in HVs' professional identity offer opportunities as well as challenges. As none of these views address professional identity as comprising of separate, but integrated components, such as social and role, it is therefore difficult to ascertain whether, which, or all areas are deemed to require stabilising or are continuously evolving. Burrell (2011: 172) extends this debate stating that, despite the challenges of relentless change, health visiting has remained 'resilient and enduring'. It is noteworthy, however, that her dissertation was completed in the same year as the government's ambitious plan to train 4,200 new HVs within four years (DH, 2011a), seemingly placing health visiting firmly back on the map. Since then, as mentioned, the numbers of HVs have reduced back to pre-plan figures (RCN, 2017; NHS Digital, 2018).

From the outset, this researcher was interested in looking beyond outward professional behaviours and into how HVs experience changes to their professional identity in the new fragile world of audit,

performativity and on-going service change, and what this means to them. Linked with this, she was curious about the nature of identity formation, especially during times of significant change. She was interested in whether identity, described as dynamic in nature (Simpson and Carroll, 2008; Beauchamp and Thomas, 2009), and in a state of 'constant becoming' and renegotiation (Wenger, 2017/1998: 154), applied to HVs' professional identity, especially in changing times (Sachs, 2001). This raises the question as to whether this dynamism applied to HVs' professional identity in its entirety, or only components of it. In contrast, Ibarra and Barbulescu's (2010: 137) claim that 'identity work' is a process of 'forming, repairing, maintaining, strengthening, or revising their identities', reflecting that there may be dimensions of HVs' professional identity that need to be maintained and strengthened. This will be discussed further in 15.3.

Towards the end of this study radical changes in health visiting were imposed by the Covid-19 pandemic. HVs' professional identity was suddenly placed in the spotlight. A plethora of research arose exploring the changes in delivering public health services and their effects on health professionals, including HVs. The participants' experiences of working through the pandemic and the radical service changes on their professional identity are analysed in Chapter 13 .

To place HVs' professional identity in the context of change, an exploration of change theory, perspectives and understandings will now follow in Chapter 4 .

Chapter 4 Change

τὰ ὄντα ἰέναι τε πάντα καὶ μένειν οὐδέν

'All things move and nothing remains still'

Attributed to Heraclitus (535 BC – 475 BC) (The Information Philosopher: online).

4.1 Change Theory and Context

There are a number of linear change theories; for example, four proposed by Lewin, Lippitt, Watson and Westley, Havelock, and Rogers, as well as nonlinear theories, such as Chaos Theory (Udod and Wagner, 2019). Amongst the broad family of change theories, there are three main types of organisational change - 'developmental', 'transitional' and 'transformational' (Anderson and Anderson, 2010/2001: 53).

Transformational change is most relevant to this study as it is this type the NHS requires to respond to, and meet, the increasing demands placed upon it² (Allcock et al., 2015; Alderwick and Ham, 2017; Dougall et al., 2018a). As discussed, reform in healthcare currently aligns to a model adapted from industry, which is designed to improve 'effectiveness and efficiency' (Dadich et al., 2015: 318). The service changes HVs in this study were experiencing were set within the wider context of a work-model based on marketisation and competition, and an early movement towards collaboration between client-facing services, as discussed in 3.6.

Anderson and Anderson (2010/2001: 60) define transformational change as '...a radical shift of strategy, structure, systems, processes, or technology, so significant that it requires a shift of culture, behaviour, and mindset to implement successfully and sustain over time.' From the NHS perspective, the McKinsey Hospital Institute's (2015: 8) report addressing change leaders³, states 'Transformation describes radical change from which there is no going back' adding, 'Transformation is a deliberate, planned process that sets out a high aspiration to make dramatic and irreversible changes for how care is delivered, what staff do (and how they behave) [...] that results in

² At the commencement of this study, planned NHS changes to meet demand with reduced budgets were already underway and the participants were directly experiencing a number of service changes. These plans were, however, abruptly disrupted by the outbreak of Covid-19 in early 2020. This necessitated a government-initiated radical re-think of the changes and what was required to respond to the health crisis (The King's Fund, 2020b). As this research began over a year prior to the pandemic, an overview of general change theory and its application in healthcare remained relevant.

³ The term 'change leaders' refer to 'positional' leaders, i.e., those with the 'formal authority to act as leader' (Woods and Roberts, 2018: preface).

substantial, measurable improvement in outcomes, patient and staff satisfaction and financial sustainability.'

Transformational change is of greater significance, and potentially more difficult to implement and sustain successfully, than developmental and transitional change (Anderson and Anderson, 2010/2001). It is more complex and nonlinear, and its clarity only emerges as the process evolves, potentially creating a sense of instability, confusion and uncertainty (Anderson and Anderson, 2010/2001). As a result, the impact on recipients can be more dramatic. Humans have a natural psychological aversion to uncertainty (Wilson, 2020: radio), and the impact is greater because of its inherent wide-reaching implications. Dougall et al. (2018a: 85) add that transformational change is 'multi-layered, messy, fluid and emergent'. Concurring with Anderson and Anderson (2010/2001), it includes shifting mindsets, changing relationships and re-distributing power, and its implementation is onerous (Dougall et al., 2018a). Transformational change may be considered successful when an organisation moves forward 'as a united whole', where the resulting 'chaos' and uncertainty is balanced by the cultural and personal stability of shared values, vision and purpose throughout the organisation (Anderson and Anderson, 2010/2001: 70).

4.2 Perspectives on Change and Change Responses

Change is a fact of life and in perpetual motion (Anderson and Anderson (2010/2001). However, as the authors point out, the two directions that change can take are either towards what is desired or away from it. From a broad perspective with reference to the ego, (Anderson and Anderson, 2010/2001: 141) claim there are six 'core human needs' which require stability if change is to be accepted by its recipients:

- 'Security
- Inclusion and Connection
- Power
- Order and Control
- Competence
- Justice and Fairness'.

There is a plethora of literature discussing resistance as a response to change, as well as what is required for change to be accepted. Schilling et al. (2012: 1230) conclude that resistance to change falls into three inter-related categories:

- ‘Natural’ emotional reactions, due to low tolerance to change, a sceptical personality trait, fear of an unknown future, or control loss, which can lead to negative psychological effects such as ‘agitation, anxiety or even depression’
- Perceived negative personal effects, such as status or security loss
- ‘Principle-based’: perceived negative consequences external to the person, such as perceived harm, or disagreeing with management’s change direction.

These various responses were of interest to this researcher to reflect upon when reviewing the reactions of the study participants to changes affecting their professional identity. A more detailed account of the possible impact on recipients of change as described in the literature will now follow.

4.3 The Impact of Change on Professional Identity and Recipients’ Responses

There are a number of aspects of professional identity and professionals’ working environment that are frequently affected by change.

4.3.1 Self-continuity and self-efficacy

Schilling et al. (2012: 1230) propose that at the core of professionals’ acceptance of change is whether they can continue to ‘enact a certain identity’ aligning with their self-concept. Additionally, professional identity and professional competence are inter-related; changes to an understanding of oneself and the role create a new identity which needs to be attractive to be accepted (Schilling et al., 2012). Similarly, Dutton et al. (1994: 7, 9) propose that for a new identity offered by an organisationally to be accepted, professionals need to feel it is compatible with their current identity, and that certain criteria are adequately met. Firstly, ‘self-continuity’, i.e., who they are, needs to be sustained to continue to feel authentic and ‘be themselves’ in work. Secondly, a need for stability of ‘self-distinctiveness’, as in belonging to their professional group (as opposed to others). Lastly, ‘self-enhancement’ is supported if the organisation offering the new identity has an attractive image. Cunningham et al. (2010) add that acceptance of change was associated with self-efficacy. Recipients who possessed positive levels of self-efficacy, in the sense of believing oneself capable of achieving goals or completing tasks for example, were more likely to commit to change.

Whether a professional identity is considered ‘local’ or ‘cosmopolitan’ (Gouldner, 1957: 281) has a bearing on how attached to an (employing) organisation a professional may be. HVs’ professional identity is ‘cosmopolitan’ in the sense that they tend to identify with, and are ‘orientated’ towards, a group external to their employing organisation, and ‘own’ ‘expert’ specialised skills (Gouldner, 1957: 288). According to Schilling et al. (2012), self-continuity has the strongest link with ‘cosmopolitan’ professionals who work within an employing organisation in order to practice, such as HVs.

März and Kelchtermans' (2013) study of teachers found that the degree to which change was accepted and implemented depended on certain factors. These include: their attitudes, beliefs and emotions, whether the change aligned with their 'task perception', values of teaching, sense of themselves as teachers, perception of what constitutes a 'proper teacher', and the reform rationale (März and Kelchtermans, 2013: 20).

Taking a broader collective view, Craig and Smith (1998) argue that role and identity confusion have led to inconsistencies in the delivery of the health visiting service. Pertinent to health visiting as currently practised across England is Collier's (2001) still relevant claim that collective identity may fragment if roles are practised differently.

4.3.2 Personality, and professional and personal values

Empson (2001: 839) highlights reactions to change include 'personal and subjective factors'. Amongst other concerns, these often centre around whether 'cherished professional values' (Schilling et al., 2012: 1230) are under threat. Sellman's (2011) view is thought-provoking: inviting practitioners to be courageous and keep a strong hold on their values despite the power of organisations. Referring to Anderson and Anderson's (2010/2001: 141) 'core human need' for 'justice and fairness', several studies found that whether or not the results of change will be perceived as fair by the recipients is associated with change acceptance or otherwise. Armenakis et al. (2007), for example, studying employees of a large company, claim recipients are likely to display resistant behaviour to change if they believe the effects of change will be unfair.

Contreras and Gonzalez (2020), studying a merger between two universities, propose that acceptance of change is also very variable depending on recipients' personalities. They report that for some employees, organisational change may be perceived as positive, but for others it may induce stress and anxiety. Oreg et al. (2011) conclude from their literature review that acceptance of change was more likely if recipients possessed a personality that was more inclined to optimism than pessimism. Conversely, they found a correlation between those who had a disposition towards negative thinking and poor job satisfaction and mental health. Ford et al. (2008) concur; some individuals may show a natural, personality-based resistance to change or display ambivalence, whereas others may have a greater openness towards it. Oreg et al. (2011) in their work with hospital staff, also found that if change outcomes are perceived as personally beneficial, they are naturally more likely to be accepted. Further, Oreg et al. (2011) propose that individuals' ways of coping also affect whether they accept or resist change. Cunningham et al. (2010), for example, claim that a more positive outcome was likely if individuals were inclined to be problem-solvers.

Hampton and Hampton's (2004) study of American nurse-midwives conclude that the relationship between professionals and a market-orientated service could be compatible. This is despite the apparent contention between the 'task-authority' professionals possess through their professional 'values, norms, ethical precepts and codes', and the external focus of management, often viewed as trying to control the work of the professionals they employ (Hampton and Hampton, 2004: 1044). An example given of compatibility is that, although work satisfaction is provided by the profession, if this aligns with customer satisfaction, enacted as a function of the organisation's market practice, the relationship between professionals and the organisation can be positive.

4.3.3 Professional autonomy and agency

Professionals are employed by organisations to carry out work that is complex and requires a mastery of specific knowledge and skills (Raelin, 1991). Evetts (2018) proposes that professional autonomy is of great worth and one of the appeals of professionalism (Evetts, 2013). Further, Finn (2001), and the European Working Conditions Observatory (EWCO) (2007) consider autonomy to be one of the key factors in job satisfaction. Professionals are affiliated to professional bodies and hold professional accountability, limiting undue risk for the employer. The HVs in this study were employed on this basis.

Autonomy is inter-related with HVs' responsibility and accountability for making assessments and decision-making through professional judgement (Nursing and Midwifery Council) (NMC, 2020). These professional characteristics are fundamental and intrinsic in their work with clients. This aligns with Pound's (2013) view that professional autonomy in health visiting is essential as practice is fundamentally relationship-centred. As professionals, Pound (2013) suggests practitioners cannot be solely directed by their employer and risk compromising their professional accountability. However, Pound (2013) proposed that HVs, like teachers in Forrester's (2000) earlier work, do need to accommodate for the contradictions between the aims of the employer (and government) and the ability to respond to the needs of individuals.

Chambers (2013) proposes that being an advocate for clients through professional autonomy takes courage, courage being one of the six 'Cs' that underpins *Compassion in Practice* (NHS England, 2016). However, in an accompanying document, the authors call for professional courage to 'do the right thing for the people we care for', ending with, 'have the personal strength and vision to innovate and embrace new ways of working' (DH and NHS Commissioning Board, 2012: 13). This researcher questions the possible ambiguity in this statement, if 'new ways of working' do not always align with what professionals believe is optimum patient/client care.

Professionals hold fast to their autonomy and self-regulation, and their tacit practice and knowledge do not lend themselves well to organisational control (Heldal, 2015). Stronach et al. (2002: 109) argue that the professional nurse and teacher are caught up in the struggle between the 'economy of performance' and the 'ecology of practice' – of particular difficulty for HVs as both apply (Burrell, 2011). Hotho's (2008: 723) literature review discusses the apparent 'great divide' between a 'top-down' managerial change agenda and its implementation, and professionals as recipients, often emphasising the conflict between professional 'autonomy and heteronomy'. Hotho (2008: 721-722) draws the conclusion that the literature is dominated by a view of locally situated professionals as often obstructive and resistant recipients, even 'victims', not as 'agents of change'.

Heldal (2015: 207) also cites autonomy as the key component in the 'battlefield between competing logics'; those of managerialism and professionalism, and thus a major challenge for employing organisations managing professionals, especially health professionals. Abernethy and Stoelwinder (1995) reflect on Raelin's (1991/1985) oft-cited work addressing the conflicts that inevitably arise when management restrict professionals' autonomy. They conclude from their study of Australian hospital staff that the degree of conflict will depend on how far the employer tries to control professional autonomy through bureaucratic processes. In contrast, Bartol (1979), Norris and Niebuhr (1984), and Rahman and Hanafiah (2002) disagree, and conclude from their studies that clashes between the two cultures did not exist, but it is note-worthy that their subjects were non-healthcare professionals, and the latter conducted in a non-western culture.

Agency, akin to autonomy, is the sense of being able to influence one's practice and professional identity. Agency may also be thought of as having the power to enable or restrict change within one's own work, even if not effective at a higher level. Vähäsantanen (2015: 10) suggests that there is as a 'balancing act' between 'transformation and maintenance'. Hotho (2008) refers to Giddens' Structuration Theory that 'to be a human being is to be a purposive agent' (Giddens, 1984: 3). As such, individuals desire involvement in transforming the organisations they belong to through their reasoned 'choices, decisions and actions' (Hotho, 2008: 726). Referring to medical professionals working as managers, it was shown that their collective 'professional legitimacy' based on their principles of selfless public service and patient care was paramount, and of a level of morality considered above that of higher management (Hotho, 2008: 731). These 'professional scripts' formed the basis of their professional identity, setting them apart from NHS managers who were deemed the 'out-group' (Hotho, 2008: 731). 'New scripts' were adopted, and existing ones adapted, in order to assert their control and autonomy, sustain salient group-membership, self-esteem and social status, and re-shape their professional identity for the future (Hotho, 2008: 731). This research focusses on doctors who arguably have greater social status and privilege than nurses

(including HVs). Nevertheless, this researcher found the discussion on professionals as agents of change, proactively engaging in re-shaping their professional identity and future profession, interesting and relevant to this study.

Agency is also linked with Anderson and Anderson's (2010/2001: 141) primary human need to retain power: '...needing to have direct influence over the outcome and process of change'. Thus, collaborative decision-making and implementation supports acceptance of change rather than resistance (Anderson and Anderson, 2010/2001). Oreg et al. (2011), from their overview of 79 quantitative studies spanning 60 years, although not limited to professional recipients, concur with Hotho (2008) and Anderson and Anderson (2010/2001). Oreg et al. (2011) state that change reactions were more likely to be positive if recipients were afforded some control over proposed changes. Further, Vähäsantanen (2015) adds that teachers were vulnerable to experiencing negative psychological and emotional consequences if their management activated a robust and persistent state of change, and teachers were not able or willing to exercise their professional agency to influence work practices or re-negotiate their professional identity. Woods and Roberts (2018: preface) propose that collaborative leadership embraces agency and supports an 'ethical good' for the development of our own and others' 'self-awareness' and 'self-determination', reflecting the human need to retain power as described by Anderson and Anderson (2010/2001).

4.3.4 Audit and accountability

Heldal (2015) claims there is movement away from autonomy towards accountability, unwelcome by professionals. This links to the aforementioned McKinsey Hospital Institute's (2015: 8) definition of transformational change and the NHS' current ethos of delivering a 'financially sustainable' service with a 'measurable improvement in outcomes'. External auditing is an obvious and integral part of such a cost-benefit exercise. However, standardising, defining and auditing 'successful' professional work outcomes is complex, difficult, and questionable, and not easily reconcilable in a market-based work model (Evetts, 2018). The rise of performative measures linked with managerialism (Power, 1997) to audit professional work is often presented in the literature as fraught with conflict.

Following many Western governments' drive for a greater auditing of public sector organisations in the 1990s, many authors have researched and written extensively over the last 20 years on the impact of performativity on professionals. Many contributors agree with Stronoch et al. (2002: 131), that 'professionalism [...] cannot thrive on performance indicators.' Evetts (2018: 53), discussing the 'commodification' of professional work, claims that 'supervision, assessment and audit' are replacing the traditional trust-relationship between professional and employer, and patients/clients have become customers/service-users.

Perhaps one of the most hard-hitting contributions is from Ball (2003). In his trilogy of papers on the impact of the culture of performativity imposed by managers on teachers and teaching, he argues that it strikes at the heart of what it is to be a professional and what it means to practice what we do. Working in order to meet targets means to '...set aside personal beliefs and commitments and live an existence of calculation' (Ball, 2003: 215). Performativity creates a professional climate of anxiety, insecurity, contradiction and disempowerment; professionals become 'ontologically insecure' and professional autonomy is removed (Ball, 2003: 220). George (2009) concurs, claiming that external auditing through target-setting and performance indicators created stress among professionals. Evetts (2018: 54) states that performative measures may 'distort work processes' and have negative effects on professionals and clients/patients alike, diverting time away from clients/patients, considered valuable by the professionals. Ethical professional codes that shape work practices may be at odds with an organisation's vision of how work should be conducted, and be compounded by limited financial resources. With reference to health visiting, these claims agree with Greenway et al. (2013) and Pound's (2013) views. They assert that HVs believed that the pressure to achieve targets weakened their professional-client relationships, undermined their autonomy and professional values, did not address clients' individual and immediate needs, or enable them to work holistically. Further, Cowley (2002) previously claims that the scope of HV practice is too diverse and complex for electronic record-keeping templates, used as auditing tools, to adequately reflect the work. This links to Southon and Braithwaite's (1998) warning that, if health service delivery is to succeed, the complexity and uncertainty of practitioners' tasks need acknowledging. Although these views were expressed some years ago, arguably, they still remain relevant.

Interestingly, Power (1997) proposes auditees may appear to comply with audit rituals, but in reality, they try to retain their autonomy as much as they can. He predicted that 'new games' of 'non-compliance compliance' would emerge in the rise of audit in society (Power, 1994: 28). Similarly, Townley (2002: 175) found that, publicly, employees often displayed acquiescence, compliance or obedience, yet 'privately [...] challenged, attacked, and dismissed performance measures'. Similarly, McGivern and Ferlie (2007: 1361) claim some professionals 'play tick-box games', demonstrating 'disguised compliance', even 'mocking bureaucracy', as a reaction against professional regulation. They comply with audit procedures just enough to be seen to be doing so, yet continue to practise as before in accordance with their professional ideology (McGivern and Ferlie, 2007). An interesting finding, however, was the reactions of newly-qualified 'post-performative' teachers in Wilkins' (2011: 389) study. Individuals that had grown up with a performative education system were

conscious of the potential contention between accountability and autonomy, but could balance these comfortably.

4.3.5 Collaborative inter-professional working

As long ago as 2007, in the document *Facing the Future: A review of the role of health visitors*, they were expected to become 'part of integrated children's team' (DH, 2007: 29). This aligns with The National Health Service Specification (2014-15) (NHS England, 2014) that directs HVs to work in partnership with a variety of other agencies and professionals. There is a well-understood value, indeed an imperative, in close inter-professional working (IPW) and collaboration in healthcare (WHO, 1978; McKinsey Hospital Institute, 2015). It is regarded as essential in the safeguarding of individuals, especially children ((Laming, 2003; (Department for Education and Skills) DfES, 2003; Chivers, 2011)). IPW is characterised by staff from different professions taking on tasks, according to competence, that were previously considered the domain of a specific profession, and requires close collaboration to be successful (Pollard, 2010).

A related area is the concept of role differentiation and role-boundary confusion with other professionals and colleagues. Although Whittaker et al. (2013) report that HVs find working in collaboration with others rewarding, identifying HVs' professional knowledge is complex and may create a threat to professional identity if the role overlaps with the work of others (Baldwin, 2012). Haldal's (2015) study findings also suggest that organisational change at local level may trigger contention between 'bounded communities' working alongside one another if professional differentiation in the form of their unique skills set and practices are perceived as under threat.

4.3.6 Centralised and corporate working

In the last few years there has been a shift within organisations for HVs (and other health professionals) to work as integrated teams, often based in large hubs. The literature highlights potential advantages in working this way. Centralising staff to work in hubs helps to reduce the costs for employers, especially at a time of financial constraints. By working corporately, more staff are available to cover work for absent colleagues and meet performance targets (Pound, 2013). Time together as a team is valuable in offering informal support between colleagues and consolidating professional identity, as well as opportunities for learning, reflecting, 'catching up' and cementing 'a shared ethic of care' (Adams et al., 2013: 422).

There are, however, disadvantages in centralised working. A physical lack of space, 'hot-desking', noise and distraction can outweigh the potential benefits of team-working, such as mutual support and the sharing of knowledge and best practice (Baldwin, 2012; Pound, 2013). Pound (2013)

questions whether centralising teams is also a way for organisations to unofficially delegate staff support to the staff themselves.

Sharing caseloads may also reduce continuity of care for clients. Whittaker et al.'s (2013) study reported HVs' frustration regarding working practices that disregarded continuity of care. Many practitioners working in this way were expressing a lack of job satisfaction, high stress levels and believed their work to be less meaningful (Pound, 2013).

Working from a central hub, rather than close to the caseload locality, may also have disadvantages. Burnham (2009) claims that positive change is most effective when it is locality-based. Williams and Sibbald (1999) propose that attachment to a smaller geographical locality has benefits, including acquiring local knowledge regarding community health concerns, and networking with the primary health care team. Although written 20 years ago, this still has resonance today. Significantly, clients' feedback consistently demonstrates the appreciation and benefits from 'being known' by their HV or small team, having a trusting professional-client relationship and continuity of care (Donetto et al., 2013; iHV, 2020a).

As part of the NHS modernisation programme, the National Mobile Health Worker Project supported the 'accelerated deployment' of mobile devices, such as laptop computers, as part of the move towards flexible working (DH, 2011b: 9). In the executive summary, 'efficiency, team-working and work-life balance' were cited as potential benefits for the use of these mobile devices (DH, 2011b: 9). Whittaker and Carter (2013) propose that there is a balance to be struck between embracing new technology, while at the same time not losing sight of the essential value of face-to face communication with clients and colleagues. They also warn against allowing mobile devices to distract from meaningful communication. At the outset of this study this researcher found very little literature specifically discussing the impact of these devices, and none regarding the impact on HVs. Since the Covid-19 pandemic, the drive to implement new technologies to improve the delivery of healthcare services has rapidly accelerated as part of the NHS' digital transformation programme (The King's Fund, 2020b). At the time of writing these innovations are yet to be fully deployed and evaluated.

4.4 Behavioural and Psychological Responses to Change

Contreras and Gonzalez (2020) propose that acceptance and tolerance to change largely depends on employees' attitudes to change and their perceptions of it. Many of the variables affecting change acceptance or resistance have been discussed. These include those relating to communication, collaboration and the professional relationships between all parties, imbalances of power and physical working conditions. Resistance to change is well-documented. Anderson and Anderson

(2010/2001) claim that emotional resistance is a natural reaction and part of the process of change; it needs to be accepted and worked through for acceptance to occur.

Withey and Cooper (1989) explored the choices individuals make if experiencing adverse working conditions. Matching against predictors, their studies found an inter-relationship between behaviours of 'loyalty/neglect', 'exit' or 'voice' which were sometimes enacted sequential over time. Withey and Cooper's (1989: 525) findings are shown below:

- 'Exiting' the job was chosen by those who had low expectations of future improvement, low commitment to the organisation, rejected voicing their concerns as 'too high a price', and attracted by better alternatives. Saari and Judge (2004) concur, highlighting a link between poor job satisfaction and high staff turnover.
- 'Loyalty/neglect' behaviours appeared as passive acceptance, but did not show authentic loyalty or commitment to the organisation. This group were also characterised by poor psychological investment, low previous job satisfaction, and pessimism for future improvement. Specifically:
 - 'Loyalty', embodied an entrapped individual who remains quietly passive, choosing to accept or adjust to working conditions, though may be psychologically resigned or resentful. They did not view voicing their concerns as a viable option.
 - Neglecting work, through demonstrating a lowering commitment, also shared the same characteristics as the 'loyalists'. Caricati et al. (2014) conclude from their study of nurses that poor work satisfaction can lead to a weak psychological contract and commitment towards the employer.
- Withey and Cooper (1989) considered the choice of voicing concerns with the aim of altering their working conditions (akin to agency). This proved too complex to draw out conclusions due to multiple variables, including whether speaking out was an individual or collective act, whether it included taking action, and whether opportunities existed to be really heard by, and responded to by managers. Further, and importantly, whether voicing concerns would be effective, or even carry a fear of negative consequences for the individual.

4.4.1 Stress and change

As discussed, organisational change is likely to evoke strong emotional reactions (Anderson and Anderson, 2010/2001) and, of these, work stress is discussed very frequently in the literature. Contreras and Gonzalez (2020) claim a correlation between organisational change and increased work stress, reduced job satisfaction and work engagement.

The term stress from the Latin 'stingere' (to draw tightly), is complex and originally used in relation to difficulties or afflictions (Cartwright and Cooper, 1997). Since Selye's (2010) description of stress

reactions in 1946, more holistic theories have been put forward to include psychological and individualistic responses. Although stress usually has negative connotations, and is frequently associated with anxiety, pressure and uncertainty in the literature (Contreras and Gonzalez, 2020), the concept is more of a continuum. Heightened levels of stress may present as very negative 'distress', or in contrast, moderate levels create positive 'eustress', which is beneficial (Aldwin, 1994).

Aldwin (1994: 261-264), proposes that there are several possible positive outcomes of eustress. These include an 'inoculation effect', whereby previous stressful situations prepare one for further stressful events, develop 'mastery' of positive character traits such as confidence, and can lead one to re-evaluate one's perspectives and values for the better. Eustress may also, 'strengthen social ties' and develop personal 'wisdom' through self-understanding (Aldwin, 1994: 261-264). Tikkamäki et al. (2016: 35) add from their study of entrepreneurs that, alongside reflective practice, eustress is useful in self-study, gaining greater perspective, 'harnessing' trust, 'regulating resources' and involving oneself in dialogue. In contrast, there are a wide number of factors associated with organisational change that can create negative stress. These include fear of job or identity loss, demotion or transfer, loss of status or power, inadequate or inconsistent information, a perception of unfairness, higher workload, decreased autonomy and loss of skills and expertise (Cartwright and Cooper, 1997; Oreg et al., 2011).

The psychological impact of negative or prolonged stress can impact on individuals' wellbeing and mental, as well as physical, health. Gelsema et al. (2006), in their study of stress in nursing, claim that the effects of work stress created by time and work pressures, and physical work demands, contributed to emotional exhaustion. Oreg et al. (2011) add that, if change outcomes were perceived as negative, this could lead to increased stress and psychological withdrawal. Conversely, job satisfaction was more likely if nurses received line manager support, felt valued and appreciated, and could exercise autonomy in their work (Gelsema et al., 2006). Oreg et al. (2011) echo this, claiming that a sense of control was a predictor of positive job satisfaction and also wellbeing. Further, Johnson et al. (2006) argue that staff collaboration in decision-making plays a significant role in decreasing work stress. Whoever holds the power and authority in the decision-making and implementation change process has a very significant part to play in whether change is accepted and successful. Therefore, a discussion of the relevant factors involved follows.

4.5 Change Leadership

4.5.1 Nature and style of leadership

The concept of leadership is complex and there are a number leadership styles, for example, the traditional linear and distributed models. The traditional model is commonly understood as hierarchical in structure, with those in power and authority above filtering down 'decisions, instructions and guidance' to others below (Woods and Roberts, 2018: 3). The distributed model fosters a less bureaucratic and more democratic or flattened style, where the leadership function resides beyond those who have the formal authority to lead, and with many 'sources of influence' in organisations (Harris, 2013: 1).

From her literature review, Harris (2013) argues that it is too simplistic to view these two models in opposition. Distributed leadership does not equate to handing over the role of leadership to all in an organisation. Instead, it is an environment where co-leadership is encouraged, cultivated and carefully orchestrated by those with the formal authority to lead in order to optimise organisational performance. Hargreaves and Harris (2015: 43) add that the most successful organisations in terms of performance were those whose formal leaders embrace 'fusion leadership', and foster well-considered collaborative strategies, such as creating 'lateral and vertical teams' within the organisation (Harris, 2013: 548). Al-Ani et al. (2011) concur, that successful distributed leadership is dependent on the active support of formal leaders.

Like Harris (2013), Woods and Roberts (2018) focus on school leadership. They propose that the nature of leadership is a process which is 'distributed, complex and emergent' (Woods and Roberts, 2018: preface). They suggest that, within and without an organisation, the 'momentum and energy' formed from the multitude of interactions at every level, and the 'intent to make a difference', together create leadership (Woods and Roberts, 2018: preface). Further, they propose that this complex process is not restricted to any particular leadership style.

Woods and Roberts (2018: preface) also ask what leadership should look like, choosing the term 'collaborative' to describe leadership that is democratic, ethical and 'value-based'. Collaborative leadership, being ethically-based, aims for 'relational freedom', i.e., for 'self-awareness and self-determination', not only for the individual, but for all. Woods and Roberts (2018: 126) propose that leadership should be a process of co-development, rather than dependence, with a commitment towards 'human flourishing'; fostering autonomy, agency, an awareness of values and leadership capabilities. It is interesting that Dougall et al. (2018a: online) argue for leadership that is both 'collaborative and distributed' to deliver successful transformational change in the NHS.

4.5.2 Leading change

Anderson and Anderson (2010/2001: 33) claim that for transformational change to succeed, attendance to 'the people components' in an organisation is as essential as the external drivers. Miller et al. (1994: 18) concur, adding that change leaders need to adopt a 'receiver-orientated' model of change which attends to staff needs for change to be accepted. Anderson and Anderson (2010/2001: 141) also argue that their six core human needs, combined with the higher human needs identified by Maslow (1987/1954), must be addressed by change leaders if change is to be successful. For example, work that is meaningful, such as '*making a difference*' (Whittaker et al., 2013: 8, original emphasis) for HVs, supports self-actualisation, thus reassuring an individual's ego that this need is secure.

Communication is key. Anderson and Anderson, (2010/2001: 157) advise change leaders to be visible to front-line staff and continuously engage with them through effective communication and to actively 'listen, listen, listen.' This is echoed by the McKinsey Hospital Institute's (2015: 12) advice: 'early, genuine engagement of frontline staff that is more 'listening' than 'telling''. Oreg et al. (2011: 492) also agree that communication regarding changes that was 'realistic, supportive and effective' fosters acceptance, although Oreg (2006) warns from an earlier study, that an excessive quantity of information can have an adverse effect and create greater resistance. Although these studies were not limited to professional recipients, they are relevant to this study.

The King's Fund (2020a: online) also propose that NHS leaders listen to staff to develop a 'shared understanding of the challenges' and replace traditional 'command-and-control' structures with distributed leadership. Acceptance can be expected if recipients feel respected by management (Oreg et al., 2011). Encouraging genuine collaboration, by drawing staff in to influence decision-making, is also commonly advised (McKinsey Hospital Institute, 2015; Dougall et al., 2018a; NHS England, 2018). Such openness and communication can thus avoid reinforcing 'top-down power dynamics' (Dougall, 2018b: online), and aligns with NHS England (2018: 21) that speaks of harnessing the energising and motivating 'sense of us'. Similarly, Evetts (2013) advises that organisations would ultimately benefit from engaging with professionals' values and ideology in order to motivate them.

The vision, core values, and mission of staff and management need to be united and shared (Anderson and Anderson, 2010/2001; NHS England, 2018). In the case of the NHS, the shared priority is to be client-focussed, i.e., 'committed to doing what is best for patients' (McKinsey Hospital Institute, 2015: 13). Specifically, it is HVs' mission to make a difference, which is recognised as a strong human desire (Dougall et al., 2018a). Viewed from another angle, Foucault (Oliver, 2010) states that as well as reducing autonomy, creating greater bureaucratic decision-making in a change

process is not optimally effective. Foucault takes a further step and proposes that decision-making power should be with the service-users if desired change was to be realised.

Schilling et al.'s. (2012: 1230) third category of resistance to change ('principle-based') may be rooted in poor communication, or employees' perception that management is untrustworthy. Oreg et al. (2011), researching recipients' reactions to organisational change argue that the degree to which recipients of change trust management as change leaders is a primary factor as to whether or not acceptance of change is likely.

There are other factors that influence whether change is likely to be accepted or resisted. It is greatly beneficial to honestly and openly raise staff awareness for the reasons behind the need for transformational change and support them to see their place in the organisation, within the context of market forces (Anderson and Anderson, 2010/2001). Time too, is a factor commonly highlighted in the literature; whilst there is a recognised need for urgency in transforming the NHS, enough time is required for change to embed (de Silva, 2015; Alderwick and Ham, 2017; Dougall et al., 2018a), and for individuals to 'work through' the change process (Anderson and Anderson, 2010/2001). A recognition that the organisation may include professionals who have other loyalties, such as to their professional bodies, is important (McKinsey Hospital Institute, 2015). Additionally, leaders need to be aware of 'powerful professional groups' who may consciously resist change (de Silva, 2015: 16), (although the author fails to give specific reasons for the resistance from their review of the extant literature).

Other advice to change leaders includes providing 'physical spaces and personal contact' (The King's Fund, 2018: 2), and peer support (Allcock et al., 2015; Dougall, 2018b). Further, Dougall's report summary (2018b: online), proposes that change leaders would be wise to 'build from the rich experience' that is already in place rather than 'starting afresh', and to particularly focus on 'lived experience', a notion particularly relevant to this study. This is echoed by others, including Dougall et al. (2018a: online), who claim that change should be led 'from within'. Successful change, Page et al. (2008: 260) argue, is dependent upon the receptiveness, 'skills, motivation and power' of the practitioners who are ultimately in charge of the change process.

Ford et al. (2008) view the outcome of change from a different angle. They claim that perceived resistance to change by recipients may be automatically viewed as negative by change leaders. Further, resistance may also be thought as the sole creation of the recipients and not influenced by the change leaders' approaches and implementation of change. Although the article is confrontational in tone, it offers useful advice. Ford et al. (2008) propose that resistance is complex, and what may appear negative could be utilised by change leaders in ways that may actually

strengthen and sustain change. Rather than change leaders absolving themselves of all responsibility, fostering a sound relationship with staff, listening to their concerns and the underlying reasons for them can be beneficial if change is to be successful.

4.6 Change During the Pandemic

The recent Covid-19 health crisis necessitated the rapid implementation of even more radical change. This has exacerbated the already onerous challenge of delivering transformational change in the NHS, and the wealth of guidance to support change leaders has become even more pertinent. Even prior to the pandemic, Anderson and Anderson (2010/2001) state that it is normal for change to evoke emotional reactions, advising that negative emotions need to be allowed to surface, be vented and explored if individuals are to move from resistance to commitment. Such processes are well-documented, such as Kübler-Ross' (1973/1969) five-stage model of loss from denial to acceptance.

Evidence of heightened work stress and mental ill health caused through living and working through the health crisis is currently emerging. Although usually associated with situations which create mass trauma, Hobfoll et al.'s (2007) five essential intervention elements can be adapted to help alleviate immediate to mid-term stress, as in the Covid-19 pandemic. These are, 'a sense of safety, calming, a sense of self and community efficacy, connectedness, and hope' (Hobfoll et al., 2007: 284). Leslie (2021) emphasises that the enormity of the consequences of change, particularly in respect of the mental health of staff, is often overlooked by change leaders. He argues that leaders need to make staff mental health a priority through therapeutic activity, including listening and actively supporting them. He also suggests that the resultant increase in motivation will also support the organisation as a business to thrive.

Chapter 5 Methodology

5.1 The Research Questions, Aims and Focus

Alvesson et al. (2008b), in their review of international literature, state that identity research matters since it covers a wide spectrum of exploration, especially in the context of organisations and how their members 'negotiate issues surrounding self in workplace settings'. Dadich et al. (2015) concur, claiming identity research can provide valuable insight into the experiences of individuals and organisations, revealing political, behavioural, and cultural issues and difficulties. Although there are numerous studies researching the effects of organisational change on professional groups and their identities (Hotho, 2008), little could be found regarding HVs, and what was found was not comprehensive.

This researcher sought to gain a deep understanding of the nature and meaning of HVs' experience of living through a time of change: specifically, what that experience was like. From the review of the literature in preceding chapters, this researcher developed a set of study aims (see Table 1).

Table 1 Study aims

1. To contribute to practice through a comprehensive understanding of health visitors' perception of their professional identity
2. To contribute to practice by identifying what, for health visitors, are the key features of externally directed changes and the resulting effects on their professional identity
3. To contribute to practice by identifying, through health visitors' experience of service changes, which dimensions of their professional identity are constant, and which are dynamic
4. To contribute to practice by understanding what is required for health visitors to practise according to their professional principles, values and mission
5. To understand health visitors' experience 'as lived through' during a time of service change: what it is like to be a health visitor at this time (van Manen, 2017b: 811)
6. To offer 'plausible insights...' into the human condition, bringing the reader into a '...more direct contact with the world' (van Manen, 2016b/2015: 9)
7. To offer insight to health visitors, other professionals and stakeholders, including change leaders, policy and decision-makers and implementers and the public whom health visitors serve

Through finding out HVs' perception of their professional identity, and their experience of the effects of service changes on it, this researcher aspired to meet the study aims and answer the following research questions described in the Introduction:

- What was the lived experience of service change like for health visitors?
- How have service changes affected health visitors' professional identity?

This researcher agrees with Wield (2002: 42) that, as this study progressed, a re-evaluation of its focus and aims were important, along with a need for pragmatism to balance up what is 'desirable' with what is 'practical'. Through continuous evaluation, the risks of over-looking important emergent issues were minimised, or conversely, of losing direction and clarity of focus by inadvertently following up every side-issue.

5.2 Choice of Methodological Approach

5.2.1 Methodological considerations

Gorard and Taylor (2004), Biggam (2011/2008), and Creswell (2014/1989) assert that the methodological approach chosen for a research investigation needs to be determined by the nature of the inquiry. This researcher's understanding of Denscombe's (2014/1998: 147) suggestion that the chosen approach should be based on 'what works best', applies on both practical and philosophical levels. The chosen approach needs to be workable and appropriate to collect the data to produce the knowledge required to meet the study's aims.

5.2.2 The Quantitative-qualitative continuum

Dilthey and Rickman (1976) distinguish between the natural and human sciences. Natural sciences, studying objects and their behaviour for example, usually lend themselves to a more quantitative approach. Human sciences study people acting consciously and purposefully, on and in the world, through creating meaning and expressions of human existence. This researcher was not testing out a theory or hypothesis through measuring and quantifying, but inquiring into real-life human experience, namely HVs' experiences in practice. Therefore, a qualitative research approach was adopted. That said, some data is presented numerically to provide the reader with clarity and a broader insight into the phenomenon under investigation.

Moving along the continuum, away from a pre-specified clear-cut quantitative structure, the qualitative approach is one that is more unfolding, flowing and flexible. It tends to be inductive and holistic, seeking questions rather than answers as the research progresses (Wolcott, 1982, cited in Punch, 2010/1998: 23). It aims to explore and understand meaning, which hold the deep subtleties and complexities of life experiences (Denscombe, 2014/1998). Stern (1980) proposes that qualitative methods can be applied to add new knowledge to that which is already known, or explore new areas where knowledge is lacking (Stern, 1980, cited in Strauss and Corbin, 1998/1990). Rich, detailed and comprehensive data can be gleaned, and deep insights revealed, concerning how individuals perceive their world, their views, feelings, attitudes, beliefs, values and opinions (Strauss and Corbin, 1998/1990).

5.2.3 Epistemology

Epistemology is the 'theory of knowledge; the branch of philosophy that inquiries into the nature and the possibility of knowledge' (Mautner, 2005/1996: 194); put simply, how do we know what we know? This researcher holds that knowledge can be a multi-layered, co-created social construct. As Yardley (2000: 217) describes, the acquisition of '...our knowledge and our experience of the world...' emerges out of our ever-evolving interaction with others, through discourse and activities. It is formed by our cultural and subjective perspectives. Knowledge is grounded in experience; as Gouldner (1970: 28) states, 'there is no knowledge of the world that is not a knowledge of our own experience of it and in relation to it'. What is understood by the terms, 'reality', 'knowledge' and 'truth' are not fixed but dynamic, as meaning is negotiated and communally constructed; as Eisner (1997: 7) claims, '...knowledge as process, a temporary state...'. Consequently, the knowledge base upon which this study is built has constantly shifted and changed in perspective as the research interacted with the world (the research environment, including the participants).

5.2.4 Ontology

Ontology is the 'inquiry into, or theory of, being' (Mautner, 2005/1996: 442); or, the question, what is real/what is reality? The philosophical stance or worldview of this researcher is from the social sciences which contend that reality is socially constructed. Reality, 'what is real', and the nature of experiences as supported by evidence from the social sciences research community, are constructed by human interaction. What she understands to be 'truth' is also predicated on authenticity and openness to other possibilities. For this researcher, naïve realism is a distortion, in that her perception of the world is not a direct and objective representation of reality, but rather subjectively constructed (Psychology Dictionary, 2013).

5.2.5 Researcher's temperament

The researcher's temperament, Silverman (2013/2000) proposes, may also affect the choice of approach. This researcher's personality, education and career background lean towards the arts and the human and social sciences. She has a great personal and professional interest in people. Qualitative research also '...has the potential to transform the very phenomenon being studied' (Finlay, 2002: 531), as interviews (for example) '...augment experience, rather than simply reflecting it' (Beer, 1997: 127). These views were an additional and attractive dimension to this researcher on a personal level, because creating new meaning felt more satisfying and dynamic than testing hypotheses.

5.2.6 Real world value

It was also important when deciding on a methodology to identify what this study intended to achieve. Leavy (2015/1975: 273) argues that 'research should illuminate, educate, transform, or emancipate'. It was this researcher's aim that this study would do many or all of these. Alvesson et al. (2008b: 8-9) review Habermas' (1972) three philosophical stances that may be employed by researchers in identity studies. The 'technical', (functionalist), aiming at insight towards positive organisational outcomes through a focus on identity, the 'emancipatory' (critical), to further understand the issues power, agency, control and resistance between organisations and workers, and the 'practical-hermeneutic'. It could be argued that the first two may have surfaced (at least in part) as a by-product of this research, although this researcher's original aim was primarily towards the last. She was interested in understanding individuals' experiences through meaning-making and description; how identities are 'crafted' through interaction with others and the world around them, and the dynamic inter-play between 'self, work and organization' (Alvesson et al., 2008b: 9).

5.2.7 Phenomenology as a research approach

In view of above considerations, phenomenology was selected as most appropriate for this researcher to answer the research questions and meet this study's aims. Phenomenology is a qualitative method concerned with human existence and how individuals interact with others and the world around them. It focusses on how human's perceive things as they 'appear to consciousness' (Langdridge, 2007: 10). The approach aims to capture lived experience through the individual's 'feelings, thoughts and perceptions' (Willig, 2013/2001: 16), which aligned with the focus of this research. It also attuned with this researcher's ontology, epistemology, temperament and personality. Considering Alvesson et al.'s (2008b: 8-9) review of Habermas' (1972) three philosophical stances, phenomenology also fitted well with the third philosophical stance, i.e., the 'practical-hermeneutic'.

Realist or social constructionist approaches (Willig, 2013/2001) were reviewed, amongst others. The realist approach aims to generate knowledge about a truth occurring in the real world irrespective of whether this is evident to the participants or researcher. The social constructionist approach aims to generate knowledge about process, focussing on how people construct reality through language (Willig, 2013/2001). These were discounted as they did not align with the kind of knowledge this researcher aimed to produce which was the subjective experience of individuals.

The choice of a phenomenological approach also came from a deeply personal desire to explore that which is the most unique, private, and intimate; 'what it means to be human' (van Manen, 2016b/2015: 12). Although human experiences are unique to the individual, they are part of what is

communally shared, touching us all (Smith et al., 2009). Furthermore, it was part of a fascinating, open and unending venture into exploring the human condition.

Although it is beyond the scope of this study to explore phenomenology in fine detail, an overview regarding its traditions, development and fundamental tenets proved useful. This researcher concurs with Zahavi and Martiny (2019) that, if a researcher adopts a (claimed) phenomenological approach, there should be a reasonable understanding of phenomenological theory and concepts that underpin the family of approaches known as phenomenological inquiry.

5.3 Phenomenology: Theory and Concepts

5.3.1 Background

Phenomenology and phenomenological inquiry are complex, and what is meant by, and constitutes a phenomenological approach is considerably diverse (Willig, 2013/2001). Caelli (2000) comments that at a US conference 20 years ago 18 varieties of phenomenology were noted. There is an ongoing, often contentious, debate amongst phenomenologists as to what constitutes phenomenology, and given the multitude of forms this is unsurprising. As a methodology, phenomenology has become widely employed by social science researchers as it focusses on an individual's conscious experience of the world, specifically, '...how the things that are perceived appear to the person' (Langdrige, 2007: 21).

Husserl is widely regarded as the 'intellectual founder of phenomenological philosophy' (van Manen, 2016a/2014: 88), and his philosophical groundwork in phenomenology has underpinned this empirical research methodological approach for over 60 years. Although Husserl's work was ground-breaking, Giorgi (1997) claimed it is also a 'murky and zigzag history...' of ambiguity and contradiction. Nevertheless, many of his ideas remain the bedrock of phenomenological inquiries.

5.3.2 Lived experience and the lifeworld

Phenomenology has its roots in philosophy. It is described as the 'philosophical name for the method of investigating or inquiring into the meanings of our experiences *as we live them*' (van Manen, 2016a/2014: 4, original emphasis). Put simply, 'phenomenological research is the study of the lifeworld' (van Manen, 2016b/2015: 9). 'Lifeworld' is translated from Husserl's original term 'lebenswelt', meaning the '...natural attitude of everyday life...' (van Manen, 2016b/2015: 7), in other words, the way one sees the world every day (Langdrige, 2007).

'Lived experience' is understood by the great exponents of phenomenology as, 'life as we live it' (van Manen, 2016a/2014: 39). This concept is from the German word for experience, 'erlebnis', which incorporates the word 'leben' meaning 'life' or 'to live', whereas the English word 'experience', does not, and therefore its meaning is more limited. Further, 'erleben' translates as 'living through

something' (van Manen, 2014/2016a: 39). Merleau-Ponty (1994/1962: xvi-xvii) claims that lived experience is that which is immediate, directly presented to one, and pre-reflective, before it has been interpreted and communicated: 'the world is not what I think, but what I live through'. Dilthey (1985) adds that 'only in thought does it [lived experience] become objective' (Dilthey, 1985, cited in van Manen, 2016b/2015: 35). Lived experiences as they are lived through are 'raw: pre-reflective, nonreflective, or atheoretic' (van Manen, 2017b).

It is noteworthy that Heidegger became very scathing of how the term 'lived experienced' entered the common everyday vernacular, stating, 'Now for the first time everything is a matter of "lived experience", and all undertakings and affairs drip with "lived experience" ...'. He argued that this overuse has subsequently diluted its true phenomenological significance (Heidegger, 2012: 98).

5.3.3 'Essence(s)' of phenomena

Husserl proposed that it is possible to extract the actual 'essence(s)', (eidos), i.e., the invariant universal properties of a phenomenon, through several complex phases. These originary⁴ meanings (van Manen (2017b), could then move from the individual experience to the universal (eidetic intuition) (Langdrige, 2007), since these meanings are at the very core of the phenomenon.

Famously, Husserl emphasised the phenomenological tenet of turning 'back to the things themselves' (Langdrige, 2007: 12), to what matters in lived experience (zu den Sachen); what 'gives itself'. As mentioned, the fundamental question in phenomenology is, 'what is this experience like?'.

5.3.4 The existential turn

Since Husserl there have been, and continue to be, many great thinkers, such as Sartre, Merleau-Ponty and Gadamer who have all contributed to what can be understood by the term 'phenomenology'. New strands of thought have created additional dimensions, bringing about the variety of phenomenological approaches.

Heidegger was a key contributor in the shift in focus away from Husserl's transcendental phenomenology to understanding existence, taking an 'existential turn' (Langdrige, 2007: 16). This was expanded further by philosophers such as Nietzsche, Sartre, de Beauvoir and Merleau-Ponty. The distinction between transcendental and existential phenomenology hinges on the relationship between noema, (the object/thing being experienced), and noesis (the subject/person experiencing the noema). Heidegger was concerned with existence itself. The word '*Da-sein*', for Heidegger meant 'a "being" itself' (Heidegger, 2012: 237), or 'there-being' (Smith et al., 2009: 16). Heidegger stated however, that '*Da-sein*' could not be translated directly in the language of a Western culture

⁴ originary: 'the origin or source of something; that gives rise to, or causes the existence of, something' (Lexico Dictionary, 2020: online).

as 'there' mistakenly indicates the concepts of 'having arrived' or 'being present' (Heidegger, 2012: 237). Smith et al. (2009: 16) clarified that '*Da-sein*' as 'there-being' means '...the uniquely situated quality of 'human being''. Heidegger also proposed that everyone is within the world, termed 'being-in-the-world' (Smith et al., 2009: 18). Persons cannot be separated from the world and are thus fundamentally part of the noema-noesis inter-relationship. Langdrige (2007: 16) states '...existence was understood to be founded on an embodied being-in the-world...', hence the existential turn in phenomenology.

Experience arguably comprises two separate, but inter-related aspects, the noema and noesis. Our perception of the world is therefore '...grounded in our body in relation to the environment in which we live' (Langdrige, 2007: 16). The phenomenological movement essentially recognises that the way to understand the world is to see it '...as it really is, through lived experience' (Langdrige, 2007: 16). Following Heideggerian thought, knowledge is co-produced by persons 'already in the world' seeking to understand others 'already in the world' (Lowes and Prowes, 2001: 474). Fundamental to phenomenological research is that it starts with the 'what', followed by 'how' it is experienced by the person. One may begin to understand the person by focussing on how they perceive the world.

Caelli (2000) discusses the differences between 'American phenomenology' and the traditional European version. She espouses that the former is interpretative and subjectivist (to a point), whereas the traditional model aligns with Husserl's objective search for the invariant, universal and essential properties of phenomena, separated from any cultural influences. The American interpretivist model seeks to understand what an individual's experience is like, as they interact with phenomena within an environmental and cultural context. Caelli (2000) states this method can describe, interpret and reflect over a recent past experience, and is a very suitable approach for research in the health sciences.

5.3.5 Descriptive and interpretative (hermeneutic) phenomenology

The main broad phenomenological approaches are descriptive and interpretative. Descriptive phenomenology remains close to Husserl's original ideas of transcendental phenomenology and a 'return to "the things themselves"' (Langdrige, 2007: 86). It focusses on capturing experience through a well-defined 'descriptive attitude' - 'precisely as it presents itself neither adding or subtracting from it' (Giorgi, 1992: 121). The researcher's interpretation is minimised, and the emphasis is to describe the phenomenon as presented by the participant in its fullness and entirety (logical reduction). There is a formal and rigidly structured set of stages to be worked through. Interpretation is viewed as a type of description. Descriptive phenomenology also adopts a maximum variation sampling method to study participants who have a common experience, but are from as many diverse backgrounds as possible. This is to attempt to isolate the essence(s), i.e.,

invariants and any variables, of phenomena. Giorgi is a strong proponent of the descriptive approach, and there are other variants, such as Ashworth's Sheffield School (Langdrige, 2007).

Heidegger moved away from striving to elucidate essence(s) from phenomena towards interpreting the meaning of 'what gives itself in lived experience' (van Manen, 2017b: 810). Interpretative phenomenology aspires to discover the quality of experience. Unlike descriptive phenomenology, it attends to the participants' sense-making of their experience, also placing the account in context, be it cultural, social or theoretical, thus illuminating the experience further (Willig, 2013/2001). When participants' accounts are viewed from this wider contextual perspective it is argued that the researcher's understanding is broadened (Willig, 2013/2001). Sampling in interpretative phenomenology is usually purposive and homogeneous, as the aim is to recruit participants who all share experience of the same phenomenon under investigation. Interpretative phenomenology also holds that all description is a form of interpretation, as pure description is impossible (Willig, 2013/2001). Interpretation also links with the notion of epoché (bracketing) which will now be discussed.

5.3.6 Epoché - 'to bracket'

Returning to Husserl, the way essence(s), meanings and phenomenological insights are elucidated from lived experience is through a series of processes including epoché. Epoché, i.e., to 'bracket', is to abstain from one's biases, judgements, assumptions, interpretations and pre-suppositions. By transcending one's own experience, one is thereby free to be fully aware of what is presented to one; to '...see the 'things in their appearing', as if for the first time' (Langdrige, 2007: 21). Epoché frees the knowledge derived from the research from any externally attributed meanings (Willig, 2013/2001). When the researcher 'stands outside the research process', remaining distant and objective, they are free to discern the essence(s), i.e., the underlying structure of an experience (Lowes and Prowes, 2001: 473).

Philosophers and psychologists debate whether epoché, even if not completely achievable, is still a fundamental component of a phenomenological method (Morley, 2019). Arguably, it may be dispensed with altogether in qualitative research, as it is really only applicable within the philosophical world (Zahavi and Martiny, 2019). Transcendental phenomenologists, followers of Husserl, claim that epoché is possible and one can transcend one's own experience and view the world as another might (Langdrige, 2007). Alternatively, whilst acknowledging that total epoché is impossible, Morley (2019) states it should be practised (presumably as far as is able) as it rests at the core of phenomenology. Conversely, influential thinkers as Schleiermacher, Heidegger and Gadamer, and exponents of Interpretative Phenomenological Analysis (IPA), hold that researchers bring their 'fore-conceptions', i.e., their 'experiences, assumptions and preconceptions' to the

research process (Smith et al., 2009: 25). Heidegger claimed that everyone, including researchers, cannot remain detached as we are all within the world, therefore, epoché, as described by Husserl, is neither attainable nor ultimately desirable. Heidegger further claimed that these fore-conceptions are to be acknowledged, as they will be revealed anyway in the research process, and in reality, the researcher's perspective is merely hidden, and therefore should be openly disclosed (Peat et al., 2019; Timulak and Elliott, 2019).

Rather than making an unrealistic attempt to set aside one's presuppositions and bracket them, these can be used as dynamic tools in the interpretative process. They enable holistic investigation, enriching meaning, and surfacing what is visible and what may be hidden. For Heidegger, these qualities, the visible and hidden, are inherently part of the 'appearance' of 'the thing itself' (Smith et al., 2009: 24). However, Heidegger warned that caution must be taken that this 'fore-structure' does not overshadow the primary focus of attending to 'the thing itself', i.e., the phenomenon under investigation (Smith et al., 2009: 24). Although van Manen (2017a: 777) holds that epoché is 'critical' to phenomenology, he also states that it is more advantageous to '...make explicit our understandings, beliefs, biases, assumptions, presuppositions and theories' in order to face them, to '...hold them deliberately at bay...' and actively challenge them (van Manen, 2016b/2015: 47), a view taken by this researcher.

5.3.7 The elusiveness and 'truth' of experience

In the reflective re-telling of an experience, something of its quality, its 'living meanings', 'depths and subtleties' will inevitably be lost as the living moment has passed (van Manen, 2016b/2015: 42).

The challenge of phenomenology is to try to (re)capture the immediacy of experience by retrospectively recalling a lived experience, and through this awareness, reflecting upon it and investigating its meanings (without objectifying them) (van Manen, 2017b). Gadamer (2013) claims that 'slippage' is inevitable when lived experience becomes objectified through study, and that 'truth' will always remain unavailable. This is summarised by Dilthey and Rickman (1976: 210): 'There never *is* a present; what we experience as present always contains memory of what has just been present.'

Denzin and Lincoln (2000/1994: 19) argue, 'that there is no clear window into the inner life of an individual' – that 'language, gender, social class, race and ethnicity' filter what is 'seen'. Further, as observations are not objective, there is no one approach that can capture the subtle and varied nature of experience (Denzin and Lincoln, 2000/1994). It follows that the 'truth' of persons' lived experience cannot be claimed, and one can only attempt to reach what is, as far as is possible, 'experience-close' through the most appropriate means (Smith et al., 2009: 204).

Habermas (Habermas, 1995, cited in Heikkinen et al., 2001: 88-89) proposed 'rules' for achieving 'truth as consensus' based on the understanding that *all* voices must be truthful, authentic and heard. Heikkinen et al. (2001: 20), speaking of action research, point out that this can rarely be achieved and researchers may need to accept a 'provisional consensus' or 'unfinished truth'.

5.4 Application of Phenomenology in this Research

5.4.1 Researcher as interviewer

In qualitative studies the researcher is central to the processes of data collection (Creswell, 2014/1989). van Manen (2016b/2015), in his discussion on the short-comings of language as a cognitive process in phenomenological research, includes nursing as one of the professions that has the ability to engage in non-cognitive forms of understanding, such as intuition. This researcher was aware that she possessed such skills and capabilities, insights, perceptiveness and understandings beyond language through her personality, and experiences as a teacher, nurse and HV. van Manen (2016b/2015: 12) describes phenomenological inquiry as '...the attentive practice of thoughtfulness' and raises the centrality of 'caring' in a desire to carry it out. Balls (2009) suggests that, although research nurses may be attracted to a phenomenological method, they may not possess the appropriate interviewing skills. Although the interviews held in this study differed from styles frequently used in her professional work, such as motivational interviewing, contrary to Balls' (2009) opinion, this researcher's lengthy professional experience and range of interviewing skills was extensive. This fully equipped her to use her transferable skills of active attentive listening, empathy and unconditional positive regard in the interviews.

5.4.2 Knowledge production

van Manen (2016b/2015: 21) proposes that phenomenology has the power to 'humanize'; through phenomenological reflection persons can become more thoughtful towards others, and more radically, it can 'humanize' '...human institutions...'. Those who are involved in hermeneutic phenomenological research are thus producing '*...action sensitive knowledge*' (van Manen, 2016b/2015: 21, original emphasis). He continues that phenomenological research also has the strength to empower persons to be less susceptible to the '...management or control of others' (van Manen, 2016b/2015: 21). Arguably, while this appears to be a very bold and extraordinary claim, this researcher considers that deep self-reflection and self-understanding may indeed have the power to free one from blindly following others by enhancing one's self-esteem and confidence. Although this study engages with historical experiences of HVs, it aims to add new knowledge and perspectives to health visiting as a profession and practice. As Gadamer reflecting on Hegel states,

'...the essential nature of the historical spirit consists not in the restoration of the past but in *thoughtful mediation with contemporary life*' (Gadamer, 2013/1975: 168, original emphasis).

This study will not lead to empirical generalisations as each participant's story and experience is unique. van Manen (2016a/2014, 2016b/2015) states that phenomenology seeks and makes explicit universal meaning, thus phenomenological understandings may be said to be 'generalised', but he is approaching this from the Husserlian perspective of elucidating essence(s) of experience. Rather, Smith et al. (2009) suggests 'theoretical transferability' instead, because as humans we are touched and enriched by each other's stories and lives. For HVs this is a fundamental part of their working lives as they are bound up with the lives of others (their clients and colleagues). Further, through reflecting on the everyday life of others however, individuals are called to respond and think about their personal perceptions (Halling, 2008, cited in Smith et al., 2009: 32). Thus, the single story moves the reader into the realm of the universal, reflecting the 'hermeneutic circle'; the relationship between the single entity and the whole. Although individual's experiences are unique, they are also based on what is communal and shared. This study's exploration of the lived experience of service change and its effects on HVs' professional identity may relate to other professionals experiencing a similar situation.

Timulak and Elliott (2019), referring to the work of Stiles (2003), spoke of transferability as '...capturing the interpretative leap of transferring the findings from a study to other people, contexts, situations, or settings'. This researcher agrees with Willig (2013/2001) that phenomenological research can contribute to improvements in practice. Although this research studies the lived experience of HVs from one organisation, it is important to situate it within the wider political context. The political agenda and reductions to public services are country-wide. The reduced funds from central government ((Harris, 2016; RCN (Royal College of Nursing), 2017; Vijayshankar, 2018; iHV, 2019)) have resulted in a significant decrease in HV numbers, thereby 'diluting' and 'eroding' the health visiting service as a consequence. More recently, towards the end of this research, the emergence of the Covid-19 pandemic has also had a radical impact on the HV profession nationally. It follows that other HVs will have their stories to tell of their lived experiences of service changes on themselves as professionals and persons, which may also resonate with others.

This researcher aimed to present a robust, compelling and 'pathic' account, i.e., having the power of empathetic relatability (van Manen, 2016a/2014: 267), to invite a response from HVs and other stakeholders. Stakeholders include educators, policy and decision-makers, managers, change leaders and implementers, NHS and other professionals, and not least the public whom HVs serve. It

invites them to engage with the data, to be curious, to wonder and reflect upon the insights gained and engage with them, both on a professional and personal level.

5.5 Interpretative Phenomenological Analysis (IPA)

5.5.1 Choice of IPA as a guiding framework

This researcher considered several phenomenological approaches out of the myriad options available (Tesch, 1990; Wolcott, 2009/1990) as an approach to steer her research. For example, narrative and template analysis were considered, and although there are similarities, IPA was chosen. It appeared to be the most appropriate guiding framework to inform this researcher's study, to form an attitude towards her work, and to underpin the structure, execution and analysis of face-to-face, one-to-one semi-structured interviews.

IPA suited this researcher's inquiry as it focusses on how persons make sense of a shared experience in a particular context. IPA commonly addresses experiences which are of special significance and above the 'everyday' for individuals (Dilthey, 1976). Smith et al. (2009) propose that IPA is appropriate for enquiries that involve questioning how individuals describe, think about, and perceive their experience, and what it means to them. Other approaches, according to Smith et al. (2009), have different emphases, such as narrative's focus on sense-making through types of story-telling, and would be appropriate for other sorts of questions.

IPA as a phenomenological approach is not without its sceptics. Critics of IPA include Giorgi (2010), van Manan (2017a) and Zahavi (2018), who all agree for various reasons that IPA does not have the credentials required to be considered 'phenomenological'. Smith et al. (2009) acknowledge that phenomenologists have diverse interests and foci, but claim that what is common is questioning 'what the experience of being human is *like*' (Smith et al., 2009: 11, original emphasis). Further, Smith (2018: 1956) proposes that due to 'phenomenological philosophy diversity' no one individual can claim ultimate authority on what is, or is not, phenomenology.

This researcher was aware of these on-going debates concerning what constitutes phenomenology. However, this is for the phenomenological researchers, philosophers and psychologists to debate. This researcher claims it is more important to explain the reason for her decision to use IPA as a fitting research design for this study. This is discussed further in 5.5.2.

According to Smith et al. (2009: 1), IPA is a valid phenomenological approach in that it explores 'experience in its own terms', aligning with Husserl's premise that phenomenology's focus should be 'back to the things themselves', i.e., the 'thing' being the lived experience in its purest form, not a 'philosophical account' of it (Smith et al., 2009: 33). IPA however, aligns more with Heidegger's

existential turn towards interpretation, rooted in the notion that persons are 'within the world' with others, and away from Husserl's transcendental focus and description.

Smith et al. (2009) propose that, from their engagement with the work of phenomenologists and philosophers, the term 'experience' is complex. From an IPA perspective, the aim of interpretation is to try to understand persons' '...embodied and situated relationship to the world'; their unique perspectives and meanings of their lived experience (Smith et al., 2009: 21). Additionally, unlike Heidegger who investigated real and fictive human experience (Heidegger, 1995, cited in van Manen, 2017b: 816), IPA's primary focus is on persons' real experiences. IPA is idiographic; it is concerned with the individual, 'the particular' (Smith et al., 2009: 37). Each participant's contribution is thoroughly explored using a flexible framework which is outlined in 9.2.

Other features of IPA include the 'hermeneutic circle', researcher reflexivity and empathetic interpretation. As described by Dilthey and Rickman (1976) the hermeneutic circle is the dynamic relationship between parts and the whole. This can be on a simple level as words and sentences, or as broad as an event and one's life. A circular, iterative, 'back and forth' movement takes place between the interpreter, their understandings and concepts, and the text, as new meanings emerge.

Researcher reflexivity, i.e., the awareness and acknowledgement as to how one cannot help but influence the research process, goes hand-in-hand with bracketing one's preconceptions of the phenomenon under investigation. The phenomenon, the researcher's preconceptions, and the interpretation may repeatedly influence each other in a cyclical form (Smith et al., 2009). If full and active attention is given to the participant to really hear what they are saying, then one's own preconceptions of the phenomenon may be placed in the background. However, both the participant and the researcher are persons making sense of their experiences. Through reflexivity in the research process, the researcher's own experiences and understandings will be revisited, reflected upon, challenged and reformed. The researcher, however, may not be fully aware of his/her preconceptions until engaging with the participants' personal accounts and is required to be continuously reflective. This is the 'double hermeneutic' in IPA; the interpreter (researcher) tries to make sense of the participant's sense-making of their lived experience (Smith et al., 2009; Pringle et al., 2011). The researcher, however, is one step away from the 'first-order' real experience. IPA requires the researcher to 'stand in the participant's shoes' as an empathetic insider, while simultaneously 'standing alongside' as a questioning outsider investigating the contribution from other angles, and exploring and interpreting varying levels of meaning (Rodham et al., 2015). Reflexivity, and this researcher's measures to address this, is discussed further in Chapter 6 and critically reviewed in Chapter 16 .

'Empathetic' interpretation (from the participants' original experience) (Willig, 2013/2001), combines with Ricoeur's 'hermeneutics of suspicion' (using external theory and perspectives) (Smith et al., 2009: 36) to offer a higher level of insight, aiming to surface more hidden meaning. IPA researchers are thus engaged in both attempting to understand what something is like for an individual, and additionally trying to make sense of this 'something' through analysis (Smith et al., 2009). The broad term 'understanding' is used to incorporate both these elements of empathy and questioning.

5.5.2 IPA: Aims, guidance and process

IPA proposes ways to collect rich, deep and detailed data about how persons experiencing a shared common phenomenon try to make sense of it, asking, "what was their lived experience like?" Participants are encouraged to answer this through their thoughts, views, feelings and emotions. This lies at the heart of how this researcher aimed to answer the study questions (see 5.1). Smith et al. (2009: 1) also claim, as mentioned, that IPA is especially suitable to study what it is like for persons who are experiencing something of 'particular significance'. Further, Peat et al. (2019: 7) propose, IPA is very suitable for topics that are 'emotionally laden'. This researcher argues that the HV participants in this study were indeed experiencing something of significance, both professionally and personally. This was based on the strength of the views and emotions expressed in the nine HVs' statements initially collected to explore the significance of the proposed focus for this research (see Appendix B).

As stated, phenomenological inquiry is complex and Smith et al. (2009) offer guidance through a research process using IPA. This guidance suggests how data can be analysed in a meaningful, consistent, nuanced and trustworthy way. Although van Manen (2017b) rejected presentation of data in any numerical form, Smith et al. (2009) suggest tables may be used, for example, to assist with the analysis or to present data clearly. As summarised by Zahavi and Martiny (2019), writing on phenomenological research in nursing, any procedure is only useful insofar that it results in a valuable outcome; a view this researcher shared. As mentioned, it was envisaged that the findings from this study will not only resonate with, and inform HVs themselves, but other stakeholders. It was therefore the intention of this researcher that the data, information and findings are made as accessible as possible, and the use of tables and/or figures can support this.

Although as Smith et al. (2009) argue, IPA is an approach grounded in phenomenological principles, it also has a degree of flexibility and creativity. As mentioned, Smith et al. (2009) claim that IPA, as well as being grounded in Husserl's 'back to the things themselves', also engages with the participants and is an interpretative rather than descriptive-orientated approach. These were additional factors that attracted this researcher to the approach.

The IPA analysis is designed to reveal the rich layers of meaning through attending to various aspects of the participants' contributions. Commonalities and differences are noted. Emergent themes, to be developed into super-ordinate themes, are drawn out of participants' spoken words after very close analysis, and in this study formed a framework for further analysis as discussed in section 14.1.2. IPA analysis includes the highlighting of descriptive, conceptual, and not least, linguistic comments. Attention is given to the words used, voice tone, emphasis, repetition and contradiction; another key reason why this researcher elected to adopt IPA. This process is further explained in section 9.2. Although it was envisaged IPA would inevitably be time-consuming because of its inherent close attention to detail, this researcher was committed to a study process that can optimally fulfil its aims (see Table 1) and answer the research questions.

5.5.3 'Methodolatry'

Timulak and Elliott (2019) state that in the last 40 years, descriptive-interpretative qualitative research has become widely adopted, and a variety of 'brand-name approaches' such as hermeneutics, thematic analysis and IPA have evolved. Within these there are a variety of data collection tools and methods that may be applied according to the research question and aims, although Timulak and Elliott (2019) contest that these methods and procedures are similar. This researcher is mindful of 'methodolatry', meaning the 'glorification' of a chosen method which risks over-riding '...the actual substance of the story being told' (Janesick, 2000/1994: 390) and other important aspects, such as ethical concerns and reflexivity (Chamberlain, 2000). This research was informed by IPA but not bound by it. Therefore, although IPA was chosen as a suitable approach to address the research questions and meet the study aims, this researcher was not blindly adhering to a 'brand-name' method (Timulak and Elliott, 2019: 1), but instead has taken a critical and thoughtful approach.

5.6 Summary

In summary, for all the reasons discussed, IPA was chosen (in combination with an art-based data collection method and participants' diaries) to understand HVs' lived experience of practice change in the context of their professional identity, and what sense and meaning they make of it. This was placed within the wider context of the current social, political and economic landscape. This researcher also concurs with Allen-Collinson's (2016: 9) view that using a phenomenological approach is beyond the simple adoption of a method; it is more of a 'whole way of thinking and being': an attitude of 'openness, curiosity and a sense of wonderment'.

Chapter 6 Reflexivity in Qualitative Research

6.1 Introduction

Researcher reflexivity was borne out of a move away from being an anonymous and unseen third person, towards being visible and responsible. Thus, the emergence of the use of the 'first person pronoun', i.e., the 'I' in researchers' work and writing (Etherington, 2004: 27).

6.2 Definitions and Understandings

'Reflexivities' encompass a variety of definitions and understandings Lynch (2000: 27). Although it is not within the scope of this study to examine all of these in depth, I concur with Etherington (2004) that in reviewing a small selection of them my understanding of reflexivity and its importance would deepen. This supported me in the challenging task of exercising and applying reflexivity throughout the research process to enhance the rigour and validity of my study (Bradbury-Jones, 2007; Bolton and Delderfield, 2018/2000).

Lincoln and Guba (2000/1994: 183) assert that researcher reflexivity is a process of 'critical subjectivity', in regards to one's role as the 'human as instrument'. Hertz (1997: vii-viii) states that it is a 'constant (and intensive) scrutiny of "what I know" and "how I know it"'; reflecting on experience, while at the same time 'living in the moment'. As opposed to reflecting, which Finlay (2002: 532) proposes means "thinking about", she defines reflexivity as, '...thoughtful, conscious self-awareness. Reflexive analysis [...] encompasses continual evaluation of subjective responses, intersubjective dynamics, and the research process itself...'. The process recognises how knowledge is purposefully constructed. Etherington (2004: 31-32) concurs, claiming that researchers who take a reflexive stance acknowledge their 'experiences and contexts', agreeing with Finlay (2002) that reflexivity is dynamic and may change as the study unfolds.

Others' contributions run along similar lines. According to Bolton and Delderfield (2018/2000: 10), the heightened researcher self-awareness required opens up questions regarding their '...attitudes, theories-in-use, values, assumptions, prejudices and habitual action', in order to understand the complex ways they interact with others. Richardson (2000/1994: 936) adds that reflexivity exposes researchers' 'complex political/ideological agendas' that lie beneath the surface. Further, Hertz (1997: viii) speaks of the necessity of focussing on the participants' 'ideology, culture and politics', as well as one's own.

Boyle (1994), Muecke (1994), Reinharz (1997) and Alvesson and Sköldberg (2009/2000) highlight the dynamic bi-directional nature of the inter-relationship between the researcher and the study, in that each are influenced and affected by the other. Importantly, Etherington (2007) calls for researchers

to take ethical responsibility for their actions towards others, through critical and sensitive self-awareness of the influences of their culture and background.

Etherington (2004), reflecting on Moustakas' (1994) viewpoint, proposes that reflexive engagement opens up questions of one's identity. Moustakas (1994: 17) focuses on the researcher's 'self' in heuristic inquiry - an approach that involves an internal enquiry to 'discover the nature and meaning of experience'. In this context the researcher is the central 'tool' in the research process and experiences a growth in knowledge and awareness of themselves (Moustakas, 1994: 17). Reinharz (1997: 5) adds that researchers' multiple identities are distinct and play out in their research. These identities include: researchers' 'research-based selves', 'brought selves' (our heritage and backgrounds) and 'situationally created selves' (our statuses and the influence of our environment).

Lynch (2000), speaking for many, states that the complex process of reflexivity is unavoidable in qualitative research. Lynch (2000) refutes the claim of reflexivity as an 'academic virtue and source of privileged knowledge', and that its 'critical potency and emancipatory potential' is a given. Instead, Lynch centralises the importance of the variables of who it is that carries it out, and in what way (Lynch, 2000: 26, 36).

All of the above definitions, understandings and dimensions of reflexivity when drawn together, resonated and provided a basis on which to approach my research.

6.3 Research Integrity, Validity and Value

Yardley (2000) and Lietz et al. (2006) amongst many, assert that the key to a valid, trustworthy and authentic qualitative study is for researchers to honestly and openly account for their influence on, and within their research. Sword (1999) proposes that, as well as enhancing the credibility of the research, fresh insights and the context of a study can be revealed through the researcher's integrity. Hertz (1997) adds that if skilfully executed there are further benefits from researchers reflecting openly on their own experience of the phenomenon being researched. Readers may be able to situate the researcher and gain insight into their perspective, helping to understand how these factors influenced the researcher's role as a filter for the participants' voices. Pillow (2003) concludes that the aim of reflexive engagement is to produce the very best and most accurate and honest account possible. Trustworthiness may be maintained by sustaining a 'curious stance and open attitude' which I upheld throughout the research process (Rodham et al., 2015: 10).

6.4 Bracketing

Ahern (1999: 410) highlights the inter-relationship between reflexivity (acknowledging 'all that one is' is brought to the study) and bracketing (the act of 'abstaining from oneself'), claiming that they

are 'fruit from the same tree'. Although reflexivity and bracketing have been explored in 5.3.6, this was from a theoretical angle, particularly in relation to my chosen phenomenological method. The following discussion considers reflexivity in concrete terms, that is, who I am and my responsibilities in my research.

I agree with Lynch's (2000) and van Manen's (2016b/2015: 47) arguments that I cannot avoid bringing to the study my '...understandings, beliefs, biases, assumptions, presuppositions, and theories' evolving out of my own experience of the phenomenon under investigation. As an HV, I also lived through service changes alongside the research participants. My culture, background, education, gender, language, political stance and values - indeed, 'all that I am' - are brought to the fore (Patton, 2002/1980). Further, as a social researcher, I agree with Porter (1993), and Lowes and Prowes (2001), that complete objectivity for researchers undertaking qualitative study is neither possible, nor more importantly, desirable. Their views align with the methodological approach chosen, i.e., interpretative phenomenological analysis (IPA), and confirms the importance of engaging in reflexivity and being mindful of bracketing, especially in practice-based enquiry.

Ahern (1999: 407) contests that to support validity, researchers should commit to bracketing their biases and presenting them openly. van Manen (2016b/2015) adds that sufficient detail should be provided on how one acknowledges, embraces and challenges one's biases, and discusses one's inner self and influence openly. This supports the trustworthiness of the research, echoing Yardley (2000), and Lowes and Prowes (2001). I acknowledge that my personal convictions are strong and therefore it was imperative that I faced my own experience, involvement and understanding of change honestly. I put these convictions aside as far as I was able, continuously challenging them through conscious and deliberate self-scrutiny. This reflects van Manen's (2016b/2015) view that as well as facing one's prior knowledge of the phenomenon, one can deliberately challenge one's biases to expose weaknesses. I agree with Finlay (2002) that reflexivity and bracketing must run as sustained threads throughout my study, from the pre-research phase to its conclusion, for it to be of true value.

6.5 Questions, Limitations and Caution

Whilst I strongly agree that engaging in reflexive practice is fundamental for the many reasons discussed, there are a number of related aspects that required careful thought and consideration.

6.5.1 The researcher's voice

Reflecting on Alvesson and Skoldberg's (2009/2000: 1) view, I agree that an interpretivist approach such as IPA is 'perspectival', raising the important question of whether my researcher voice is legitimate or useful. Jeffcutt (Jeffcutt, 1993, cited in Alvesson and Kärreman, 2011: 50), speaks of

the researcher's '...dominant authorial voice'. However, I contest that the researcher's authorial voice is necessarily 'dominant'. In reality my voice and influence cannot be hidden or denied as my voice is the filter for the voices of the participants (Richardson, 2000/1994). It is how, and in what way, my voice is heard that is crucial if my study is to be deemed credible, dependable and valid.

6.5.2 Maintaining balance

Conscious of the views of a number of contributors to the discussion on reflexivity, I have tried to maintain a balanced attitude in how far I examine my subjectivity in my research journey. Patai (1994), discussing feminist research, is profoundly critical of what she views as an excessive preoccupation with reflexivity, in that it can be misused by misguided researchers. Patai (1994: 64) argues that reflexive activity has become overly egocentric and self-indulgent, summarising that '...we are spending much too much time wading in the morass of our own positionings', warning that if practiced beyond reason, its value is limited. Others such as Reinharz (1997) agree, and that instead of researchers presenting the various participating voices in the study, they may be justly criticised if offering only an introspective 'narcissistic display' (Reinharz, 1997: 18). Likewise, van Maanen (2011/1988: 99), discussing the 'fieldwork confessionals' of (ethnographic) researchers, also warns that 'confessions, endlessly replayed, begin to lose their novelty and power to inform'. He warns that in the extreme, a greater knowledge about the researcher is surfaced than the phenomenon under investigation (van Maanen, 2011/1988).

Patai (1994: 68) questions the boundaries of reflexivity and researchers' motives for an '...insistence on interminable analysis' and 'breast-beating'. Patai (1994: 70) suggests that one may be deluding oneself into how far reflexive self-disclosure can overcome the 'messiness of reality', and instead it inadvertently only serves to become a methodological show of power. Ironically, reflexivity overplayed then appears to echo the unfortunate inequalities of power in bygone anthropological studies (Pillow, 2003).

Further, Patai (1994: 70) alludes to researchers' underlying motives to remove their situatedness in their research, paradoxically by overly discussing it, and instead calls for 'intellectual independence'. While I acknowledge Patai's (1994) viewpoint, I agree with Fine (1994: 30) that 'intellectual independence' in social research is neither attainable nor desirable as one's politics and biography are deeply embedded in academic enquiry. Practising reflexivity was not to remove myself from this study, indeed, quite the opposite. I found Finlay's (2002) view helpful in that reflexivity must remain purposeful. The risks of self-indulgent 'wallowing' in subjectivity are minimised if the focus always remains on the participant. This focus also helps address Pillow's (2003) question of how far one delves into one's background, culture or political stance to decipher one's sense of power or prejudices.

6.6 Ethics and Authenticity

Ethical mindfulness underpinned my study at every level. Beyond strictly complying with the procedures set out by the university's ethics committee, I needed to consider a multitude of ethical questions that presented themselves as the research progressed. This proved to be a complex and onerous task.

In considering these ethical questions I found it useful to consider the four principles of medical ethics with which I was familiar, which are 'respect for autonomy, nonmaleficence, beneficence and justice' (Beauchamp and Childress, 2019/1977: 13). Although Holm (2002) argues that there are difficulties in the authors' discussion of these and in their intention to provide a comprehensive account, the principles proved to be a fit guide for the purposes of my research. My research aimed 'to do good', 'to do no harm', and 'be just and fair', but this surfaced many difficult questions. I considered what does 'fair' mean? To whom am I aiming 'to do good'? What measures can I put in place to ensure no harm? In conclusion, I took the view that some questions may be intractable, but that throughout the study I needed to consider how to think and act as ethically as possible. These questions will be explored further in 16.2.

Following on from the views of Yardley (2000), Pillow (2003) and Lietz et al. (2006) regarding researcher honesty and integrity, I explored what is meant by 'authenticity'. Several notable philosophers and existentialists such as Heidegger, Sartre and de Beauvoir wrote extensively on this subject, each with differing, often contentious interpretations. From a complex range of ideas debated on the BBC radio programme, 'In Our Time' (2019), I concur with the view that to 'live authentically' is to continuously and actively turn one's attention to oneself and take responsibility for one's actions. One strives to be the best person one can be in all our roles, rather than live in passive anonymity led by others. I agree with contributor McMullin (2019: podcast) that fundamentally, as "socially embedded creatures", who we are is formed by our relationships. This echoes Heidegger's 'being-in-world' (Smith et al., 2009: 18), and as such not living in a "moral desert" but having an ethical responsibility towards others.

A discussion of how these theories, understandings and factors underlying reflexivity were applied in my research will now follow.

Chapter 7 Applying Reflexivity in My Research

7.1 Myself as Researcher

7.1.1 Myself in the study

Insight into my background, education and life experiences may be useful to furnish the reader with an understanding of my motives for undertaking the research, and for my methodological choices and decisions. My positionality to the participants is also valuable information if the phenomenon under investigation is to be situated and understood (Reinharz, 1997; Rojas, 2012).

The depth of my vocational commitment to the mission, values and worth of the health visiting profession underpins the choice of my research focus, and it '...arises from a passion that calls...' (Smythe et al., 2008). This can be traced back to my decision in my late 20s to leave teaching and pursue a nursing career. As a long-standing practising HV at the beginning of the study, I was, according to Tietze (2013), an 'insider', already conversant with how the employing organisation functioned, the processes and politics, and the staff and their practices. More specifically I was at the outset also immersed in the early externally-directed changes to practice.

I was deeply troubled by the early service changes, such as the health visiting and former Children Centre services merger. Firstly, I experienced my personal and professional identities as 'merged' (Turner, 1978), thus, any perceived threat to my professional values, sense of agency and integrity, was also personally felt to be unjust and unfair. Secondly, my troubled feelings were exacerbated by witnessing anxiety, frustration, low morale and a sense of powerlessness amongst many of my HV colleagues, affronting my values of care and concern for others. Thirdly, on a more personal level, I have an acute sense of how it feels to be in a marginalised and disadvantaged position as, growing up, I experienced a relatively impoverished background, both materially, culturally, and educationally. Lastly, but as importantly, my conviction is that the health visiting profession is a powerful contributor to the health and wellbeing of society, especially for the vulnerable.

Therefore, any reduction or significant changes to the health visiting role which may threaten service quality or provision, was thought to be worthy of investigation. These factors led to a determination to investigate how other HVs experienced their professional identity during service changes. This led to the focus of this study's research title: Health visitors' professional identity and their lived experience of service change.

Acknowledging and reflecting on the above raised some deeply ethical questions. I considered my positive intension 'to do good' through this study, but to whom and how? It was clear that my primary focus was on HVs and the profession. Through reflecting on the initial nine HVs' statements

(see Appendix B), I endeavoured to give HVs a voice in the interests of fairness and to explore what mattered to them to provide knowledge and insight for the profession, employers, policy and decision-makers. Many HVs were expressing they felt that they were not being listened to or treated fairly as respected professionals. But what of others? I cannot claim to do good for all, but for change leaders, decision-makers and other interested parties, insight into HVs' experience may foster change that also supports organisations to thrive.

My long-standing prejudice against those who wield misplaced or oppressive power was a persistent bias that I worked hard to set aside throughout the study, so I did not influence the participants or the analysis of their accounts. Similarly, it was ethical to include the 'lone voices' of a few participants who disagreed with the majority, and those whose views did not fit with my own views and values, or the emergent themes.

Knowing oneself is not straightforward. I propose the Cartesian premise that as a unified whole one is knowable is overly simplistic. Instead, I concur with Luft's (1969) image of the 'Johari window' (Luft, 1969, cited in Cutcliffe, 2003: 139), that one cannot fully know oneself. Although I practised reflexivity throughout this study, it had its limitations because my own blind-spots of self-awareness may have been beyond my ability to reflect upon. Cutcliffe (2003) offers techniques such as peer feedback to illuminate what I may not 'see' for myself, which although sometimes difficult to hear, were enlightening. I was also aware that my tacit knowledge might lead me to know, without being able to explain how (Cutcliffe, 2003). Similarly, Gouldner's 'domain assumptions' may be easily over-looked and left unchallenged, for example 'all cats hate water' (Gouldner, 1970: 31-33).

7.1.2 The 'insider-outsider' debate and making the 'familiar strange'

An important area of reflexive engagement was to try to understand my position as an 'insider' or 'outsider' researcher. I concluded from a literature review that the commonly-held understanding that an 'insider' is one who researches their own organisation, and an 'outsider' is not, is too simplistic. Therefore, as a new starting point, I reviewed Merton's (1972) early contribution to the 'insider - outsider' debate.

Merton argues that 'insider doctrine - one must be one in order to understand one - is deceptively simple and sociologically fallacious [...as...] is the case with the total Outsider doctrine' as persons have many statuses and identities (Merton, 1972: 24). Merton considers a researcher's position as within or without 'groups', 'collectives' and 'organisations', widening this to include '...statuses, cultures, and societies' (Merton, 1972: 15). He also questions the boundaries of affiliation within these groups; logically, how far do one's 'credentials' need to match those of the group to be an insider? For example, taking the 'insider doctrine' '...you have to be one in order to understand one'

(Merton, 1972: 15). If, as a woman you are specifically researching women's issues, then what of the variables within that group such as age, ethnicity, cultural background – where is the 'insider line' drawn? This is also a question posed by Song and Parker (1995) and Mannay (2010). More importantly, it is Merton's (1972) assertions arising from this debate that is of greatest significance and interest to me. It is not, Merton claims, whether one is an insider or an outsider, but the level of academic rigour and autonomy transcending '...other loyalties...', '...craftsmanship and integrity...' that is of ultimate importance in the pursuance of truth (Merton, 1972: 44, 42). Whilst acknowledging the greater significance of academic integrity above whether one considers oneself as insider or an outsider, I continued to seek further definitions, as much of the literature contains these terms, and clarity was important to further my understanding.

It could be claimed that I was a 'true' insider researcher when I began interviewing HVs whilst in practice myself, and an outsider when my employment status altered. I argue that this is too simplistic, and that having been an HV during the early implementation of the changes I am more of an insider researcher. I am also aware of the possible significance of my other statuses. As Merton (1972) highlighted, I am also a woman and mother interviewing women, most of whom are mothers or have family commitments and responsibilities as women outside of their employment. This has a potential influence on their experience of change, and was therefore reflected upon in the research.

Hellawell's (2006) notion of multiple, parallel 'insider-outsider continua', from '...complete observer...' to '...complete participant...' (Hellawell, 2006: 488) has further resonance for me. He proposes that it is not simply whether the researcher possesses a priori of knowledge of the participants and their world that is useful. Instead, it is the researcher's awareness of their dynamic perceptions 'stepping in and out' of the sense of familiarity or otherwise through reflexivity as the study progresses, that adds depth. Hellawell's (2006) view is interesting; that one may be both an insider and outsider researcher simultaneously or alternating at various times during the study.

Burns et al. (2012) favour a centralised researcher position, not dissimilar to Hellawell's (2006) notion of the continuum. Burns et al. (2012: 59) refer to the utility of the researcher's 'multi-layered identity' in order to balance familiarity with 'analytical distance'. However, as van Maanen (2011/1988: 77) points out in his discussion on 'confessional tales', 'as both vessels and vehicles of knowledge', the 'to and fro' movement between being both a 'passionate' insider and 'dispassionate' outsider maybe the most problematic of all forms of reflexivity to manage.

Through reflexive engagement, I was aware of the positions I held at various times along the insider-outsider continuum throughout the study. This led me to consider the relationships and dynamics between myself and the participants. For example, early on I recognised that there were some

differences in participants' responses to me, as presented through their behaviour, either as a colleague they felt they knew well or vice-versa. In this sense, I may have been viewed by the participants either as an insider or an outsider. Once aware of these responses I was able to reflect upon my influence in the study. This led me to understand the necessity of presenting myself more as a researcher than a colleague to the participants, irrespective of any familiarity.

From the early days of anthropological inquiry, the debate over the advantages and disadvantages of being either an insider or outsider researcher has played out (Hellawell, 2006). One of the issues for an insider who has knowledge and an understanding of the organisation, and may have experience of the same phenomenon as the participants such as myself, is how to make the 'familiar' become 'strange' (Tietze, 2013: 60). It may be an advantage to have a shared experience with the participants, in so far that I may be able to relate and understand their interpretation of their experience more than if I had not, but as Berger (2013: 12) proposes, this is a 'double sword'. The shared phenomenon needs to be viewed with 'fresh eyes', so that it may be understood more deeply (Tietze, 2013). Every attempt was made through various methods (such as keeping a reflexive journal) that my familiarity with it did not become the lens by which I viewed the participants' perceptions and experience (Berger, 2013).

A very different stance is put forward by others such as Agar (Agar, 1980, cited in Tietze, 2013: 56) claiming that researchers should assume the role of 'professional strangers'. By this it is presumed that as an outsider, a researcher has the advantage of remaining impartial. I disagree, even if this were possible in this study. Instead, I concur with Mann (2016) that there may be advantages and disadvantages of both insider and outsider positions. Hammersley (1993: 219) adds that the combination of both 'involvement and estrangement' may assist in the validating research findings. The researcher's position as being an outsider or insider is fluid, and will depend on their relationship with the particular participant and the setting.

I contend that my knowledge and experience of the service changes was an advantage. I could empathise with my participants and their experiences, and had some insight into their interpretations, even though their experiences were 'lived through' and only 'displayed' to me (Merleau-Ponty, 1994/1962: 356). 'Stepping back' into an insider role I was also able to strive for a warm rapport, as I was not standing at a distance, 'cold' and objective. I care greatly about my colleagues' (and clients') interests and welfare, which sparked my original interest in the phenomenon under investigation. At the same time, I understood the need to continually scrutinise my influence in this study process; where I 'began and ended' (Pillow, 2003), and engaged wholeheartedly in on-going reflexive practice. Through a realistic level of bracketing of my

assumptions and biases, I endeavoured to make the 'familiar' 'strange'; to have 'opened my eyes and ears' to the participants' contributions as if experiencing the phenomenon for the first time.

7.1.3 The reflexive journal

The importance of keeping a reflexive journal in qualitative research is well-documented. Bradbury-Jones (2007) argues that credibility can be made explicit through an audit trail, such as writing a reflexive journal. The practice also enhances study credibility and rigour (Creswell, 2014/1989), and can support learning (Etherington, 2004: 127). The researcher, as bricoleur, can reflect on the options that arise, question their choices and make thoughtful decisions as the study unfolds (Bolton and Delderfield, 2018/2000). They are acting as their own 'internal supervisor' through a process of self-scrutiny (Casement, 1985/2014: 25). As discussed, there was a need to bracket my assumptions, biases and pre-understandings of the phenomenon. Through writing, reading and re-reading my journal these were continuously illuminated, kept ever-present and 'visible', and thus open to challenge (van Manen, 2016b/2015). I agree with Peshkin (1988), that the process of being aware of one's subjectivity, i.e., the impact of one's quality as a researcher on the study, should be systematic and continuous. Reflexivity is a state of mind, and exploring my subjectivity was a continuous process as this study progressed. My reflexive journal entries were contemporaneous and timely.

I valued the sense of privacy and freedom to record my experiences without inhibitions that journal writing brings, although agree with Bolton and Delderfield (2018/2000) that this can be uncomfortable. My feelings, thoughts, assumptions, aspirations and ideas were logged, as were my anxieties, hopes, disappointments and achievements. I learned from my errors and felt empowered by my successes. Journals may record anything of note, and may take any form; prose, poetry, doodles and drawings, (Bolton and Delderfield, 2018/2000). Writing is my intuitive learning style so I naturally gravitated towards this in my journal. As a 'documentary tool' (Janesick, 2000/1994: 392), art can be used by researchers and participants alike, as in this study. Alongside my journal writing I also created a series of collages which I found enlightening and motivating, especially at challenging times (see Appendix G).

Finlay (2002), drawing on the work of Moustakas (1994), suggests that one begins with the self to engage with reflexive activity. I agree that one needs to untangle one's own interpretations and pre-understandings of the phenomenon from those of the participants. This was not an easy task. Pillow (2003) questions how far reflexivity can really claim to have revealed 'truth' in capturing the participants' voices. She suggests that researchers' own agendas and desire for what is believed to be 'truth' may still remain subjective under the surface. I understood this to mean that to simply carry out a set of reflexive procedures will not in itself automatically reveal 'truth'. Researchers

must delve deeper and 'lay bare' what may be hidden, prepared to face the reality and discomfort of 'messy' research (Pillow, 2003: 193). Even though objectivity may only arise through subjectivity, through personal reflection, thinking and intuiting (Moustakas, 1994), by continuously re-focussing on the participants rather than myself, I tried to ensure that the correct balance was maintained. Through my journal writing I was able to keep in focus that it was the lifeworlds of the participants that I was investigating, not my own.

Reflecting on the views of Patai (1994) and van Maanen (2011/1988), Etherington's (2004: 189) claim resonated; that journal keeping may also help lower the risk of self-analysis becoming self-indulgence. Knowing oneself as far as one is able, however, underpins the reflexive process (Pillow, 2003). I found Bradbury-Jones' (2007) adaption of Peshkin's (1988) 'I's inspiring. Even though I came to this knowledge quite late in my research, I noted in my journal how many of my entries could be grouped together, revealing much about myself as an individual and researcher. Like Bradbury-Jones (2007: 293), I aligned myself with 'the paladin I' – the desire to act as a champion for the health visiting profession and provide a forum for HVs' voices to be heard. Another 'I' that surfaced strongly and continuously was 'the empathetic I'. I often struggled and felt burdened by the negative emotions deeply felt by many of the participants, requiring me to find emotional support for myself. A personal revelation was my 'cautious I', an anxiety to tread carefully through the research process lest I make unnecessary ethical errors.

Keeping a reflexive journal was particularly useful in facing the many ethical dilemmas and struggles that surfaced during the research. Writing about these complex issues gave space for healing and learning. The process of writing can bring focus, clarity and future structure to the study when one feels 'lost' 'in the 'swampy lowland' (Schön, 1987: 3) and when finding it difficult to 'see' beyond the immediate 'landscape'. This has been my personal experience. I also concur with (Schön, 1987: 3) that, as opposed to the relative 'safety' and clarity of vision on the 'high ground', the more important human issues may be found and addressed in the 'swamp'. I have also experienced '...sharp, sunlit moments of clarity or insight - little conceptual epiphanies', especially on waking (Miles et al., 2014/1994: 99). I have noted what spontaneously struck me as fresh and relevant; the 'ah ha' moments (Smythe et al., 2008: 1390). Journaling also helped shape my future research plans.

A discussion to explore reflexivity further, its inter-relatedness with the inter-woven dimensions of embodiment, empathy and intersubjectivity, power and relationships will now follow.

7.2 Myself and the Participants

7.2.1 Intersubjectivity, embodiment and empathy

Zahavi (2001) investigated a range of key phenomenological approaches to intersubjectivity held by eminent philosophers such as Scheler, Husserl, Sartre, Merleau-Ponty and Heidegger. These approaches are complex and often contradictory. Zahavi (2001: 166) claims that the 'self', 'others', and the 'world' co-exist, and 'reciprocally illuminate' each other; any understanding of them comes from their interconnectedness. This view reflects Merleau-Ponty's (1994/1962) phenomenology of perception and his reflections on intersubjectivity. Merleau-Ponty gives the example of a shared experience of viewing a landscape with a companion; rather than '...each incarcerated in our separate perspectives'. He continues, 'I believe, on the contrary, that my gestures invade Paul's world and guide his gaze', and vice-versa (Merleau-Ponty, 1994/1962: 405). I agree with both of these views on intersubjectivity.

Although embodiment is discussed in the context of visual art creation in section 8.1.2, the inter-relationship between embodiment, intersubjectivity and empathy in the context of reflexivity, requires further discussion and a re-focussing from another angle, i.e., the part embodiment plays in the interview setting.

Aligning with Dewey (1958), Merleau-Ponty (1994/1962: 181, 82) understands the body and mind as interconnected, stating 'the body is a power of natural expression' and 'the body is the vehicle of being in the world', an interpretation shared by Halling and Goldfarb (1991), Levin (2000) and Finlay (2005). I agree with Merleau-Ponty's interpretation and share Halling and Goldfarb's (1991: 319, 328) view that 'human activities of meaning-giving and meaning-creation are rooted in the body' and 'language comes from the body, and that speaking deepens and completes experience'.

As I have taken a broadly Heideggerian phenomenological approach, I concur with Finlay (2002: 533) that the participant and I were '...enmeshed in pre-reflective existence'. This study is a human encounter, and as such we were bound together in an interactive and dynamic process. The data were a co-constituted and co-created enterprise between us (Lowe and Prowse, 2001; Rapley, 2001; Finlay, 2002). Understandings and meanings were surfaced and shared, and new realities and knowledge formed.

Finlay (2005) offers an inter-connecting, co-existing and fluid set of reflexive dimensions, claiming them to be valuable in phenomenological research. These are based on how '...intersubjective corporal commonality...' can engender empathy potentially leading to a rich understanding of the participant, and the self (Finlay, 2005: 290). Stein (Stein, 1989/1916, cited in Finlay, 2005: 284)

however, argues that rather than a 'feeling of oneness' with another, it is the surfacing of the differences that engenders understanding.

Finlay's (2005: 272, original emphasis) proposes three reflexive empathetic dimensions:

- '*connecting-of* the Other's embodiment to our own' - The researcher can empathise with the participant's embodied experience through a conscious awareness of their own bodily experience. Empathy is possible because we are paradoxically different, yet alike. There is a recognition of familiarity.
- '*acting-into* the Other's bodily experience' - The researcher creatively and imaginatively projects themselves 'into' the Other, to imagine *and feel* the participant's experience bodily, as if it were their own.
- '*merging-with* the Other's bodily experience' - The researcher experiences complete, if transient, immersion into the experience of the participant. This is a fluid 'to and fro' movement between the participant and researcher. It does not however, fall into the trap of a shift of focus towards the subjectivity of the researcher (Stein, 1989/1916, cited in Finlay, 2005: 284).

I found Finlay's (2005) dimensions useful to reflect upon during the interviews and when engaging in my own reflexive practice. In the interviews, I paid conscious and deliberate attention to my own bodily responses, and of how I appeared to affect the participants, and vice-versa. Through our bodily responses to one another, whether face-to-face or remotely through audio and transcription, together we were engaged in a bidirectional 'dance' of reciprocity (Halling and Goldfarb, 1991: 328).

Embodied reflexivity therefore creates the potential to establish a deep understanding of the participants through empathy, which is of greater depth and meaning than simply 'standing in the shoes' of another. However, Pillow (2003) questions how far can we ever really know another? Through language, Merleau-Ponty (1994/1962) proposes that persons 'intertwine', each collaborating in 'consummate reciprocity' as a 'dual being'; '...our perspectives merge into each other, and we co-exist through a common world' (Merleau-Ponty, 1994/1962: 354). However, he also proposes that we cannot completely share another's experience as our embodied perspectives of the world are personal and always our own; a view I share. While I acknowledged that could not entirely share my participants experiences, I tried to '*capture the essence*' of them by ensuring they 'speak for themselves' (Trinh, 1991: 57, cited in Pillow, 2003: 184, original emphasis), and was honest in really trying to hear and faithfully record what they communicated, whether verbally or non-verbally.

7.2.2 The interview relationship

One of the first ethical concerns I encountered was inviting HVs for interviews who had already expressed that they were stressed by their heavy workloads, and I thought that I could be exacerbating this. Although keen to recruit, I remained mindful that no potential participants felt obliged to consent. I also felt an ethical duty to ensure that this study's aims would be met, and the outcomes would be worthwhile. It was heartening that, post interview, so many participants expressed a keen interest in reading the finished dissertation and found the interview experience valuable, motivating and for some, even joyful.

The interview is a complex and challenging task and requires careful planning to yield valuable data (Kvale, 2007). I was aware this research was an inter-personal enterprise and the quality of the knowledge produced was dependent upon the relationship between myself and the participants. The interview needed to be 'up close and personal' to be effective (Tietze, 2013: 58), with the essential ingredients of trust, openness, and honesty. Conscious, close attention was paid as to how I co-created knowledge through embodiment; how I was experiencing my interaction with the participant at a bodily level (Halling and Goldfarb, 1991). My choice of words, tone, facial expressions and body language were carefully considered as they would impact upon the participant (and vice-versa). It was crucial to remain attentive and vigilant, actively listening to the participant's spoken and unspoken words, and their silences. How I was receiving the participants' contribution, whether it was a shared understanding, or a divergence from my own was also important (Finlay, 2002). I tried to ensure that my expressions, tone and body language remained neutral and quietly receptive.

I was keenly aware that the interview was likely to affect the participants. As Holt (2012: 104) reminds us, research methods make '...an incision into the world' and claims that those involved will inevitably be affected. Mann (2016) describes several sobering accounts of negative emotional 'fall-out' experienced by participants in past studies. Considering the content of the HVs' statements in Appendix B, I was aware that for many of the study participants, the interviews were likely to stir up deep emotions. For the majority, the time offered to reflect was highly valued. For some, the reasons why they became HVs, or reflecting on the positive outcomes of their work, cheered and motivated them. For others however, deep reflection surfaced unsettling questions as to whether their personal struggles with poor mental health needed to be faced. While I ensured that, if required, participants were accessing or had access to further support, for me the ethical dilemma of my research unintentionally surfacing HVs' personal struggles remained. Participants' strong emotions also affected me. Writing about my interview experiences in my reflexive journal and

creating collages helped me to come to terms with the challenging emotions that surfaced, as well as being uplifted by the joys, which were motivating.

Spradley's (1979: 36) discussion of the researcher's responsibility is sobering; they have a safeguarding responsibility to protect participants' 'rights', 'interests' and 'sensitivities', especially as they may be unaware of the extent of how they may be affected. My role was to create a safe environment for participants to offer contributions about their private world that would be made public (Kvale, 2007). This was an onerous task for which I took full responsibility, for example by providing a detailed explanation of the process and ensuring that participants fully understood their role through a clear 'task understanding' (Silverman, 2014/1993: 199).

As discussed, when interacting with some participants I may have been viewed as insider researcher as I was known as a fellow HV. While this afforded the advantage of having some understanding of the shared experience, I ensured that boundaries did not become blurred; familiarity was not an excuse for any ethical 'line to be crossed'. For example, only contributions offered in the interview, or within the limits of the consent to share information entered the study (Spradley, 1979; Tietze, 2013). The interview transcriptions were shared for verification (see 8.3.1.4) and any request to remove material, honoured.

The participants trusted me to ensure that their contributions remained anonymous. A few appeared uneasy in that, if they could be identified by their employer, they may somehow be placed in a vulnerable and compromised position. Beyond taking care to ensure that participants' anonymity was protected in the dissertation, further practical measures were taken. For example, participants chose the interview venue with options away from their work-base. This choice was not disclosed to their managers or their identity disclosed. Whether or not to offer participants the choice of being identified in the study acknowledgements was considered. As there was in some cases a link between their contributions and their stage of service in the study for analytical purposes, regretfully I chose not to identify them individually for ethical reasons.

I trusted that what participants revealed to me was the truth as they perceived it. Likewise, participants needed to be able to trust that I would faithfully represent what they contributed, and that their voices when heard would be considered authentic by the reader. If participants held different views from my own, as discussed, I set mine aside and ensured that their contributions were represented.

7.2.3 Power in research relationships

Although I was keen to consider and uphold my ethical duties towards the participants as far as able, I acknowledge there was an 'asymmetry of power' (Kvale, 1996: 126). Pillow (2003) claims that

reflexivity exists because of this inequality of power. I acknowledged my power, in as much as I decided the choice of research focus, and the design and execution of the process. Acknowledging there is always a power imbalance, I carefully considered how, and in what ways, it could be ethically distributed between myself and the participants. I attempted this by giving ownership to the participants where possible. For example, although I acknowledge that it is I who provided the prompts for their collages, they created them, and were a given free choice as to whether to participate or otherwise. Although my choice of interview style was semi-structured, it was also designed to provide space for participants to share their stories freely and to choose what they wished to disclose, or not. From early on in the initial interviews, I tried to pick up cues from participants' responses as to what this experience may be like for them and if and how it could be improved. For example, I noted that I was required to be very flexible as to what time of day they felt most comfortable to be interviewed.

7.3 Summary

I acknowledge the complexity, challenges and limitations inherent in reflexive engagement, but did not view it as a burden, as could be inferred from the tone of Ahern's (1999) suggestions for reflexive bracketing. Instead, I embraced Finlay's (2002: 544) view that one's reflexive awareness of the self may be thought of as positive, fruitful and worth-while: 'Done well, it has the potential to enliven, teach, and spur readers towards a more radical consciousness. Voicing the unspoken can empower both researcher and participant' (Finlay, 2002: 544). Likewise, my aspiration as an ethical researcher engaging with participants is summarised in the following quote:

'I want to understand the world from your point of view. I want to know what you know in the way you know it. I want understand the meaning of your experience, to walk in your shoes, to feel things as you feel them, to explain things as you explain them. Will you become my teacher and help me understand?' (Spradley, 1979: 34).

Chapter 8 Data Collection

8.1 Data Collection Methods: Interviews, Visual Art and Diaries

8.1.1 Interviews

Interviews are central to IPA and formed this researcher's primary source of data, complemented by visual art and the participants' diaries.

Interviews have been utilised in 90 percent of social science studies for over 20 years (Holstein and Gubrium, 1995, cited in Denzin, 2001: 23). King (2012/2004) claims that they are useful in studying the identities of individuals and groups in large and complex organisations such as the NHS, which is relevant in this research. However, Alvesson et al. (2008b), in their review of identity literature, claim that although interviews are commonly used, their validity as providing a truthful and realistic account of one's identity is increasingly doubted, although the authors are describing interviews where the interviewer holds pre-assumptions. For this study, this researcher strove to carry out interviews reflexively, and setting aside her pre-assumptions as far as possible.

Interviews are much more than simply a data gathering tool. This researcher concurs with Kvale (2007: 9) that interviews can give '...a unique access to the lived world of the subjects, who in their own words describe their activities, experiences and opinions'. Interviews are performative events which connect persons through shared experience underpinned by human concern, respect and affection for others. Denzin (2001) claims the reflexive interview also has a potentially transformative power. Denzin's (2001: 24) 'utopian' vision proposes that the reflexive interview has the power to surface social inequalities and injustice, pointing to an ethical way forward for a more humane society.

In practical terms, interviews are reasonably cost-effective, require minimal equipment, and potentially have a high response rate as they can be arranged at the participant's convenience (Denscombe, 2014/1998), all of which were relevant in this research. That said, this is balanced with the notion that interviews require skill to be performed well (Kvale and Brinkmann, 2009/1996).

This researcher concurs with Wolcott (2002) that observing participants is at the heart of all qualitative research. Berger and Luckmann (1967: 43) claim that if face-to-face, it is '...the most important experience of others'. Additionally, this interview style supports rapport, helping to create a relaxed atmosphere and a positive co-partnership between the researcher and the participant, who is 'the experiential expert' (Smith et al., 2009: 64). One-to-one interviews may be easier to arrange, manage 'live' and transcribe, than focus groups. Having participated in a focus group, this researcher's experience was that in trying to give space for others, her own voice was not

fully heard. HVs are also familiar and comfortable with communicating on a one-to-one basis in their work setting.

In the Lindsay Memorial Lectures in 1958, Polanyi (1959: 60) stated 'human thought grows only within language'. Language is powerful; 'words matter', and can deeply affect us (Denzin, 2001: 24). Language can give access to the lifeworld of others, not through 'transposing oneself into another person [...] and relive his experiences (Erlebnisse)' (Gadamer, 2013/1975: 401), but through dialogue persons can come to an understanding about the world they share (Gadamer, 2013/1975). That said, van Manen (2016b/2015) adds that words are inadequate to fully describe experience, as language is fundamentally a social phenomenon and will inevitably 'miss the mark'. Willig (2013/2001) claims that using of a variety of data collection tools within a study can create a deep, more enriched understanding of a phenomenon. For these reasons this researcher sought a holistic approach that combined interviews, where there was an attention to embodiment, with additional data collection through visual art and reflective diaries.

8.1.2 Visual art

This researcher aimed to uncover HVs' understanding of their lived experience of change in a deep, meaningful and nuanced way through a variety of data collection methods. She recognised that the participants' thoughts, feelings and tacit knowledge of their professional identity in the context of change could not be elicited through a conventional interview method alone, as it would not surface the depth of understanding sought. Through understanding that '...not only does knowledge come in different forms, the forms of its creation differ', a further approach was required (Eisner, 2008: 5). Arts-based research is becoming a widely-respected and rapidly expanding form of inquiry (Gerstenblatt, 2013). Collaging was chosen as its value as an experiential sense-making approach aligned well with this researcher's choice of a phenomenological method (IPA) to understand the lifeworlds of the participants (Noë, 2000; Mannay, 2016). Perry (2013: radio) in his fourth Reith Lecture adds, "art's most important role is probably meaning-making".

Visual art is a form of communication and expression beyond verbal language (Mannay, 2016). Tacit knowledge situated within the pre-conscious may be hidden beyond words, but may be aroused and expressed through the creation of a visual image (Halprin, 2003). Janesick (2000/1994: 392) adds that creativity can expand individuals' thoughts by placing their thinking '...in an artistic frame and stretching that part of their brains'. Through art we also '...tap into emotions...' (Leavy, 2015/1975: 12). Feelings and thoughts about experience may be verbalised which could otherwise have stayed dormant (Spouse, 2000).

Like Mannay (2016), this researcher became interested in using visual art as a research tool by unexpected exposure to it herself. As a doctoral student she was offered the opportunity of expressing how she saw herself in the research process through collage. During the creation of the collage the depth of emotion engendered surprised this researcher. A personal encounter with the artist collective Project Art Works and its neurodiverse creators has also inspired this researcher to choose a tool that is spontaneous and communicates beyond words. As with Outsider Art, the art communicates what is 'otherwise unsayable' (Rhodes, 2000: 7). Jarvis and Trodd (2008) investigated a variety of approaches, including collaging, to explore professional identity. This article resonated, and further supported the use of visual art as a data collection method.

A characteristic of art in social research is active and embodied participation (Chilton and Scotti, 2014). The psychologist, philosopher and educator Dewey postulated the 'principle of continuity' (Leitan and Murray, 2014: 472/4), linking the words 'body-mind' (Dewey, 1958: 77). He claims that the body and mind are inseparable in how one experiences 'consciousness, self, and meaning in life' (Anderson, 2018: 73) and having 'unity and connection' with nature (Dewey, 1958: 296-7). Evidence from neuroscience suggests that embodied learning can take place as the nervous system throughout the body makes 'the whole body a brain' (Payne, 2019: online). Wiebe and Snowber (2011: 111) add that 'embodied knowing' is sited in the senses and the 'sensuous'. As a researcher one must seek ways to access 'enfleshed knowledge' (Spry, 2001: 724), which is the body's 'storehouse' of experience and memory and the 'repository' for all that is known to us (Stinson, 2004: 160).

Imagination used as a creative tool offers the possibility for participants to explore their professional identity in a safe and novel way, the perspectives of colleagues, different ways of working, and new professional identities for themselves (Jarvis and Trodd, 2008). Warnock (1989/1987) makes links between imagination, memory, experience, emotions, and education. Through memory, individuals have a knowledge of themselves; of who they are, '...a person...*over time*' (Warnock, 1989/1987: 74, original emphasis). This reflects the postmodern view of identity as not static, but dynamic (Akkerman and Meijer, 2011). Imagination ascribes meanings to the things around us and, if applied freely and creatively, can enlighten us to what is significant in our experiences as well as '...sporadically, we may also use it to render our experience unfamiliar and mysterious' (Warnock, 1976: 207-208). Leavy (2015/1975: 12) concurs, that art '...may jar us into seeing or thinking differently'. Mannay (2016: 6) agrees, stating that through creative art participants can make the 'familiar strange', gaining 'new perspectives on their subjective understandings of their worlds' and offering fresh perspectives (Eisner, 2008).

Leavy (2015/1975: 26, original emphasis) considered that using art as a tool can ‘...*promote dialogue*, which is critical to cultivating understanding’ and connects individuals on ‘...emotional and visceral levels’. This researcher concurs with Mannay (2016), who asserts that the potential benefits of using visual tools can only occur if embedded in narrative. The art created was not an end in itself, but the participants, if willing, were invited to interpret what they had created. Elicitation interviews followed to discover further what participants wished to communicate in their art.

Collage, (from the French ‘collé’, meaning ‘to stick’), with its 1,000-year-old roots, embraces metaphor and metonymy to capture ideas. Materials are inexpensive and readily available. It is also led by the participants and fosters a greater distribution of power than other, more researcher-led, methods. This researcher fully endorses Finley’s view that ‘...arts-based researchers renounce the role of expert...’ and instead participants are valued as ‘...coequal collaborators’ in the research process (Finley, 2008: 75). The creative process can also be enjoyable and playful (Roberts and Woods, 2018).

Butler-Kisber and Poldma (2010) describe three ways in which collage can be used in research: reflection, for elicitation and to conceptualise ideas. In this research, the process of reflection began with the participants’ choice of materials in response to the art prompt. Feelings about their experience then surfaced through the creation of the art, which disrupted linear thought and helped to illuminate tacit understandings. The elicitation and conceptualisation of ideas followed through the subsequent discussion and interpretation of their artwork, providing a rich and nuanced understanding of the participants’ experiences.

The physicality of collaging is important as it can unlock deeper levels of knowledge, understanding and experience and develop fresh ideas (Roberts and Woods, 2018). Fuchs and Koch (2014: 1, original emphasis) state, ‘motion and emotion are [...] intrinsically connected: one is *moved by movement*’. Halprin (2003: 20) echoes this, speaking of a ‘...relationship and interplay between the physical body, emotions, and thinking’. By inviting participants to create a collage whereby materials are chosen, moved, arranged and rearranged, their bodily movements act as ‘a medium of emotional perception’ (Sheets-Johnstone, 1999; Fuchs and Koch, 2014: 1). Through this slow-paced reflective and expressive activity, participants’ thoughts can develop (Roberts and Woods, 2018). Examples of this were noted when participant P1 H described her initial collage (see Figure 6), and participant P3 S, her second collage (see Figure 25). As they described these, they moved the materials around, pausing to reflect further. The materials were not glued down to allow for this movement of placing and replacing to occur.

As discussed, the analytical process of a double hermeneutic in IPA also involved this researcher in trying to interpret the participants' own interpretation. Combining both the visual and narrative, the interpretation of the art is embedded and contextualised. The said and unsaid, the intended and unintended open up to '...new ways of knowing' (Butler-Kisber, 2008: 268). The researcher can 'visually listen' to the art and note what appears striking. The analysis involves looking at the 'wholeness' of the collages in their entirety (Jongeward, 2015/1975: 255; Roberts and Woods, 2018: 13). The characteristics, form, shape, colour and juxtaposition of the materials selected are analysed and, through this, the individual collages can reveal rich insights. Viewed collectively, a deep understanding of the HVs' lived experiences can be gained through attention to contrasts, comparisons and similarities.

8.1.3 Diaries

Participants were offered diaries to note thoughts about their experience of service changes between interviews as an additional data collection tool, primarily with a view to discussing this material during a second interview, if held, to compare data. It was considered that contemporaneous diaries would add phenomenological value as the entries would be made in 'real time' (Willig, 2013; van Manen, 2016b/2015) and in the case of this study, changes to practice were continuously unfolding. This reflects van Manen's view (2016b/2015) that recalling experience retrospectively cannot capture the immediacy of experience. The rawness or intimacy of very personal emotions that may not surface in interviews may be captured in diaries.

8.1.4 Testing the approach

A small-scale study involving three HVs was carried out to test out the proposed approach using interviews and visual art. This proved invaluable in the final design of the interviews and approach to art creation.

8.2 Sample and Recruitment

A purposive homogeneous sample of qualified, practising HVs was sought. They all shared the phenomenon under investigation, namely service change. Initially, information regarding the study was circulated in two ways. An email was sent to several large teams of HVs introducing the study, and this researcher also presented it at team meetings to invite participation. Following a poor response, a selection of HVs considered as suitable candidates were approached personally by email, text and face-to-face. Although this was a purposive sample, to avoid sample bias this researcher did not intentionally seek out those who were likely to have a particular viewpoint. A few HVs who were particularly interested however, self-selected.

The sample was all female as the researcher was not in contact with any male HVs, reflecting the gender distribution in the profession. Effort was made to select from those who had a range of nursing and health visiting experience, and from different working localities, ages and ethnic backgrounds. At the time of the initial interview (Stage 1, n=20) four HVs were newly qualified HVs (NQHV), two had been qualified for less than one year, and two for between one and two years. Seven HVs were trained as part of the Health Visitor Implementation Plan (HVIP) (2011-2015), therefore with a range of experience from three to seven years. Two HVs had returned to practice between five to ten years previously, three had between ten-20 years' experience, and four had between 20-25 or more years' experience. In addition, one HV was unable to attend any face-to-face interviews and responded in writing; her comments were only included in the first analysis (Stage 1).

There were several criteria for exclusion. At the time of recruitment, participants expressing an intention to retire or leave the profession imminently were excluded; this was an extended study and it was intended to request a second interview approximately 12 to 14 months following the first to compare data. This prolonged engagement also supported the validity and credibility of the findings (Creswell, 2014/1989) and validity is discussed further 16.2. Only HVs in routine practice were included, not those with team-leader status or above. It was thought that managers' positions might be compromised and also the practice changes did not affect them directly in the same way. Those HVs who participated in the previous small-scale study and close personal friends were also excluded to reduce the risk of bias from previous knowledge or assumptions.

The sample size (n=20) was larger than in most IPA studies according to Smith et al. (2009). Although 'larger' does not necessarily equate to 'better' (Smith et al., 2009: 52), there was the time available to interview a greater number of participants. The aim was to gather a wide spectrum of information about HVs' experiences, enabling the emergent themes to be more substantiated and thus produce a comprehensive study. Although there will always be new data with every contribution, saturation was considered complete when no new themes emerged. Following the 20 Stage 1 interviews, no new participants were invited since a point of saturation had been reached.

8.3 Procedure for Data Collection: Interview Stages 1-3

The three interview stages are shown in Table 2 below.

Table 2 Stages and structure of the interviews

Approach	Interview Stage		
	Stage 1	Stage 2	Stage 3
Timing	Initial interviews held within the first few months of the introduction of the 'Corporate Service'	Follow-up interviews commenced approximately 1 year after Stage 1 (prior to Covid-19)	Follow-up interviews held approximately 15 months after Stage 1 (post-initial peak Covid-19)
Number of participants interviewed	n=20/20 (Only n=19/20 ⁵ accounts could be fully analysed in relation to the research questions)	n=8/20	n=7/20
Information sought	<ul style="list-style-type: none"> HVs' perception of their professional identity What it is like to be an HV What it is like to be an HV living through change The effects of service change on HVs' professional identity 	<ul style="list-style-type: none"> What it is like to be an HV living through change HVs' lived experience of service changes mapped against core dimensions of their professional identity 	<ul style="list-style-type: none"> What it is like to be an HV living through change HVs' lived experience of service changes mapped against core dimensions of their professional identity
Methods used	<ul style="list-style-type: none"> One-to-one semi-structured interviews Collage 	<ul style="list-style-type: none"> One-to-one semi-structured interviews Collage Diaries 	<ul style="list-style-type: none"> One-to-one semi-structured interviews Collage Diaries

8.3.1 Stage 1 interviews

8.3.1.1 Preparation

One-to-one semi-structured interviews, combined with an art-based activity, were conducted at a mutually agreed time and venue, lasting about one hour. An atmosphere conducive for interviews was created, with a quiet, comfortable and informal room setting (Oppenheim, 1992). Outside distractions and interruptions were anticipated and managed. The art-making materials and related prompt were set out, initially unseen, and the recording device set up prior to the participant's

⁵ One participant had no exposure to the service changes as she was new in post, and therefore could not contribute to the discussion on service change, only on her perception of her HV professional identity and what it was like to be an HV.

arrival. Participants were warmly welcomed, thanked for attending and liquid refreshment offered. An Information Sheet provided before the interview was discussed, and the Consent and Art Release Forms shared and signed.

8.3.1.2 Art creation

The participants were invited to create a collage and introduced to the art-making materials (see Appendix C). These comprised coloured A2 sugar paper, tissue paper, magazines and scissors, textiles, natural materials such as shells, stones, seaweed and feathers, ribbons and string, metal objects, such as nuts and bolts, and an assortment of small plastic objects, such as buttons.

In the previous small-scale study participants had been invited to choose from paper with a drawn outline on one side. This either symbolised a female figure based on the simplistic design used as universal signage to indicate an area designated for women (inspired by the work of Richardson, 2015), or a more androgynous figure. The reverse side was left blank for freer expression. On reflection this was considered to be possibly restricting or leading, so the figure was omitted. Also, in the small-scale study more drawing implements were provided; however, the number was subsequently reduced to deter participants from defaulting to only writing about their experiences (writing being a familiar, routine daily activity in health visiting).

By providing a choice of materials, the aim was to reduce the risk of self-consciousness, embarrassment or understandable, but misplaced concern about artistic ability. If mentioned, it was made clear that this was not about artistic merit, as, in a similar way, no answer to the interview questions would be deemed correct or incorrect.

The art prompt provided was “who are you as a health visitor?”. This aligned with the study’s aim to explore the HVs’ lived experience of changes in the context of their professional identity. Vignoles et al. (2011) highlighted the various interpretations in identity theories regarding the basic question of identity - ‘who are you?’ (see 2.1). The phenomenological approach attempts to understand ‘individuals’ personal, subjective experiences of their identities’ Vignoles et al. (2011: 12), therefore the art prompt was left open for free interpretation.

Spouse (2000) comments that the time allowance for art production may alter the richness of the data. Pauwels (2010) adds that participants’ contributions tend to be more representative if they have sufficient time to absorb the focus of the research. However, after reflecting on the small-scale study when the collage prompt was provided prior to the interview, it was thought that this did not align with eliciting embodied felt response. Nor did it fit with the aim to capture participants’ experience spontaneously and relatively pre-reflectively. This pre-reflection is the initial layer of reflection inherent in phenomenological enquiry, before the researcher interacts with the

participant and enters into the research process (Smith et al., 2009). Therefore, it was decided to provide the prompt only during the interview.

8.3.1.3 Face to face interviews

The participants were left alone for sufficient time to complete their art creations, typically 10 to 20 minutes, after which they were re-joined by the researcher. A recording device was then activated and the participants, if willing, were encouraged to reflect on their art, prompted by this researcher asking, “would you like to tell me about it?”. Attention was given to the characteristics of the materials chosen for the collage, such as shape, texture and colour, as possible metaphors for their experience. Key ideas surfacing from their verbal account were noted.

The participants were then asked a small number of paced open questions (see Appendix D and summarised below) unless some were answered spontaneously through their story-telling.

Table 3 Stage 1 Interview questions

- | |
|---|
| <ol style="list-style-type: none"> 1. Can you describe your experience of being a health visitor? 2. Can you describe a recent event or situation where you felt affirmed as a health visitor; when being a health visitor mattered to you? When you felt like a <i>'fish in water'</i>? 3. Can you describe the person you are at home, and at work? 4. Thinking about the new Corporate Service and proposed changes: <ul style="list-style-type: none"> - Can you describe your experience of being a health visitor <i>now</i>? - ...your thoughts as an HV in the <i>future</i>? 5. Can you describe your experience of support through this time of change? |
|---|

The first question was purposely open and broad. As mentioned, this researcher’s use of the term ‘being’ does not equate with Anderson and Anderson’s (2010/2001) definition as synonymous with ‘soul’; it is used throughout this study to mean ‘oneself’ as an HV. More delving questions and prompts to deepen reflection were also employed, such as “can you tell me more about...?”, as the interview progressed. Careful attention was paid to the wording of the questions to try to surface what the participants’ experience was really like; their thoughts, views, feelings and perceptions (Willig, 2013). This contrasts with Wood’s (1991) unstructured approach where only one initial question is asked, and from which data is expected to flow.

A balance was sought between encouraging the participants to talk expansively (a fundamental aspect of phenomenological inquiry) and asking anchoring questions. Smith et al. (2009) suggest adopting a flexible approach, as there may be occasions when the interview schedule is largely abandoned in response to participants’ contributions. van Manen (2016b/2015) advises that more direct questions should only be asked if it is to follow up what participants have already referred to.

This researcher departed from these suggestions in an attempt to investigate and hold fast to the aims and focus of the study. When topics were not addressed spontaneously by the participants during the course of the interview, further questions were asked.

Although all accounts will fall short of the true pre-reflective lived experience itself, care was taken in the interview to try to access the meanings within the participants' description of the phenomenon. For example, the wording of the questions was crafted to encourage participants to 'speak' the experience, rather than 'speaking *about* it'.

The research questions which were:

- What was the lived experience of service change like for health visitors?
- How have service changes affected health visitors' professional identity?

For the purposes of the later analysis and in order to answer these questions, the initial interviews were structured as follows:

- Stage 1a
 - Capture the HVs' perception of their professional identity, namely who they believed themselves to be, and their perception of their role. This was because a definition of what constitutes health visiting professional identity continued to be vague and defied consensus. To understand how HVs perceived their professional identity as nested within their multiple identities.
 - Understand what being an HV is like. This was partly achieved through initial questions aligning with the collage prompt. A further device was used where participants were invited to tell their story of their experiences of being an HV in concrete terms. They were asked to describe an event or situation where they felt affirmed as an HV; when they felt like a 'fish in water', when one feels at ease and 'at one' with, and in, a social setting (Maton, 2014/2008: 56). This device was inspired by Bourdieu's somewhat abstruse concept of 'habitus', i.e., 'one's dispositions', resources and 'capital', and that of 'field', i.e., one's 'social arena'/social context (Maton, 2014/2008: 50).
- Stage 1b:
 - Funnel down and explore the participants' lived experience of the service changes, and if, and how, it affected their professional identity through subsequent questions (see Table 3). A question concerning support was designed to find out about their experience of being part of a wider team at this time acknowledging that transformational change requires support (Anderson and Anderson, 2010; Dougall, 2018b)

Although theories underpinned the questions, such as the notions of 'being and doing' in professional identity (social and role identity) (Cruess et al., 2016), these were not theories a priori to prove or disprove. This researcher agrees with van Manen (2016b/2015) that phenomenology does not prove or disprove theories, nor problem-solve.

At the close of the interview participants were asked if they thought they had said all they desired to before the recording device was deactivated (to avoid the scenario of significant contributions offered after the recording ends). Occasionally participants wished to add to their contribution and, with their permission, the recording device was reactivated. With the participants' permission a photograph was taken of their art creations for further analysis, prior to the artefact being dismantled. Participants were offered reflective diaries to use between interviews.

8.3.1.4 After the interview

Note-taking is a recommended and useful step in IPA, as it can capture immediate impressions, atmosphere, and nuances, and supports study validity. Immediately following the interview, this researcher's assumptions, thoughts and impressions were documented in her reflexive journal for further reflection. A verbatim transcription was made from the interview recording and a copy promptly sent to the participants for verification and comment.

This researcher was very aware of the ethical implications of the participants' contributions. Besides ensuring confidentiality and anonymity, it was important to make certain that the participants had sufficient follow-up support if required following the interviews.

8.3.2 Stage 2 interviews

The second interviews commenced approximately 12 months later to further understand participants' experience of their professional identity during the ongoing practice changes and compare data over time. The Covid-19 pandemic outbreak occurred approximately half-way through Stage 2 and the government's nationwide initial lockdown procedures enacted from March 2020 meant that only eight interviews could be completed.

The participants were invited to create another collage with the new prompt "thinking of this time of change, who are you as a health visitor now?". The collage materials provided were the same as before. Participants were again provided with time alone to create their collages as this worked well in the first interviews.

An interview conversation followed, taking a similar approach to Stage 1, and with a discussion of the participants' diary entries if kept, with their consent. The questions are summarised below:

Table 4 Stage 2 Interview questions

1. Reflecting on your collage and diary entries, can you describe your experience as a health visitor during the service changes?
2. Thinking about the Corporate Service, can you describe your experience as a health visitor *now*?
3. Can you describe your experience of support through these changes?
4. In respect of the changes:
 - do you have any thoughts regarding the future of your role?
 - how do you see health visiting, as a profession, in the future?

The first questions were slightly amended to specifically focus on the HVs' experience of change '*as lived through*' (van Manen, 2017b: 811, researcher's italics). Further questions continued to explore participants' experience of being part of a wider team, and of themselves and the profession in the future. At this stage, this researcher thought it was beneficial to continue to ask these questions to further ascertain the HVs' perception of their professional identity and address the third study aim regarding its stability or otherwise (see Table 1). The question regarding the participants' views of themselves as persons in or out of the work context had been answered in Stage 1 and did not require further investigation.

8.3.3 Stage 3 interviews

The pandemic necessitated some alterations to the plan of the original two-part extended study. After the lockdown restrictions were eased, contact was made with the remainder of the original sample of 20 participants. They were offered a range of interview options, including online, and seven agreed to meet face-to-face with strict 'covid-safe' precautions in place. Two participants (P3 J and P3 T) were unable to attend and put their comments in writing; these data were included where appropriate. The other remaining member of this cohort declined a follow-up interview (reason undisclosed).

The health crisis had necessitated health visiting service changes far beyond those that were the focus at the outset of this research, exposing the remaining HVs to far greater challenges than those interviewed previously. It was over 15 months since the Stage 3 participants' Stage 1 interviews had been held. These HVs had been directed to operate a 'partial-stop service' (iHV, 2020d: online), pared down to focus primarily on ante-natal and new birth contacts, vulnerable families and safeguarding.

The general format of the interview was similar to previously. The participants were invited to create a collage with the same prompt as provided in the pre-pandemic Stage 2 interviews, i.e., "thinking of this time of change, who are you as a health visitor now?". The impact of the pandemic, combined with this researcher's on-going learning and reflection also prompted a review of the

interview questions and a few were re-formed. A pared down interview schedule was created (see Appendix D and summary of questions shown below).

Table 5 Stage 3 Interview questions

1. Reflecting on your collage and diary entries, can you describe your experience as a health visitor during this time of change particularly in respect of being a health visitor working through the Covid-19 pandemic?
2. What matters to you as a health visitor at this time?
3. Can you describe your experience of being part of a wider team during these changes?

The first question remained relevant but was redesigned to reflect the HVs' widened experience of working during the health crisis. The subsequent questions were phrased to find out what they understood was at the core of health visiting practice and to revisit working as a wider team, which had surfaced in the previous interviews.

This researcher questioned the relevance of directly asking about the participants' experience of support. Although it could be argued that the question of support was, on the surface, opening another area of experience altogether, previously it was designed to find out about HVs' experience of being part of a wider team, acknowledging again that transformational change requires support (Anderson and Anderson, 2010; Dougall, 2018b). It had in fact provided relevant information regarding the HVs' sense of collegiality, which is embedded in their social identity; social identity being a facet of their overall professional identity. The question was re-phrased to encourage a broader interpretation of the lived experience of being part of a team and to reduce any distraction or limitation by the direct use of the word 'support'.

A further amendment was the removal of questions pertaining to participants' future as HVs, or the profession, as these questions had already been addressed. More importantly, on further reflection it did not directly pertain to the participants' experience 'as lived', even though some useful insights regarding what HVs understood was at the core of health visiting had been gained.

Chapter 9 Data Analysis Overview

9.1 Exploring the Study Questions through Staged Interviews

The study questions were:

- What was the lived experience of service change like for health visitors?
- How have service changes affected health visitors' professional identity?

To answer these questions, three stages of interviews were held, as described in Chapter 8, and three sets of data collected. The methods used to analyse the data are described below. The analysis of Stage 1 interviews was split into two inter-connected parts, namely, 1a and 1b. Stage 1a established the HVs' perception of their professional identity and what it was like to be an HV. Stage 1b analysed what it was like to be an HV living through service change. The effects of these changes were mapped onto HVs' perception of their professional identity.

9.2 Data Interpretation

9.2.1 Application of IPA

Aligning with IPA's idiographic approach, each participants' contribution was respected as unique and valuable, and was examined in depth and fullness. Smith et al. (2009) make useful suggestions for analysing a larger corpus of data than the handful usual for IPA studies. The primary aim underlying the IPA process is to attend to, and capture, how persons try to make sense of what they have experienced, as outlined in section 5.5.1. To do this, the suggested steps in IPA thematic analysis were followed (Smith et al., 2009) as described in this chapter.

9.2.2 Reflexive journal

This researcher's reflexive journal was also drawn into the analysis and reviewed for its post-interview impressions, insights and critical thinking. Aligning with IPA, this researcher drew on her own understandings and experience to engage deeply with the data. As mentioned, this researcher was engaged in the double hermeneutic, i.e., interpreting the participants' interpretation (Smith et al., 2009). However, the focus always remained centred on the participants' experience and account of their lifeworlds.

9.2.3 Participants' contribution

Soon after each interview, the audio recording was listened to carefully several times to try to really hear what the participants were saying. Notes were made referring to what might be significant. Photographs of the collages were reviewed alongside the participants' verbal interpretation of them

(see examples in Appendix E). The colours and characteristics of the materials chosen offered further insight.

The audio recordings were transcribed. Each verbatim transcription was scrutinised line by line to explore the semantics and language used by the participants. The comments were divided into 'descriptive', 'linguistic' and 'conceptual', and colour-coded for clarity. Initial exploratory comments were made, commonalities and differences noted, and emerging themes were highlighted from each contribution. Sections of the transcriptions were highlighted, aiming to capture the most meaningful and essential understandings of what the participants had presented. Although these sections were extracted from the original, they were still in the context of the whole. A back-and-forth movement between the whole and the development of the emerging themes took place, reflecting the hermeneutic circle. Participants' quotes were chosen which encapsulated and reflected essential meanings.

9.2.4 Core dimensions of professional identity

The participants' collective perception of their professional identity was established by extracting core dimensions from the Stage 1 interview accounts, combining these with the most common aspects proposed by theorists in the literature. This provided a foundation made up of the interconnected core dimensions of the HVs' social identity (the group they belong to), their role identity (how they enact their professionalism) and the public face of their professional identity. As mentioned, separating social and role identities is to some degree artificial as they overlap (Stets and Burke, 2000), but this approach was chosen to provide clarity.

9.2.5 Emergent themes

Emergent themes were also drawn out of the Stage 1 interview accounts. These were listed separately in chronological order, then grouped together in clusters depending on commonalities. These were ordered then re-ordered after returning to the transcriptions, again exemplifying the hermeneutic circle; the original transcriptions were worked in parts then drawn back together. This process transformed emergent themes into a super-ordinate theme by collecting together related themes (see 11.6). As this was a large sample in IPA terms, following the advice of Smith et al. (2009) the process of drawing together patterns and common themes to develop into super-ordinate themes was left until all the accounts had been analysed. This was because the focus was to surface the key themes for the whole sample, while still subscribing to the IPA principle of idiography and valuing all contributions.

Following a further suggestion from Smith et al. (2009), a decision was required as to what measure of recurrence was to be accepted as a theme at 'group level'. It was decided that recurrence of a

theme would be classified as such if shown in 50% or above, across all accounts in the initial interviews, irrespective of frequency (see Appendix F). The themes were not necessarily only linked to one dimension of professional identity. For example, the super-ordinate theme of 'time' related to both *collegiality* (having sufficient time with colleagues) and *uniqueness and complexity* of the role (having sufficient time with clients). The themes were also linked to other concerns evident somewhere within the participants' accounts. For example, having insufficient time to complete tasks within contracted working hours.

These themes were then documented with reference to the research questions, and illustrated using participants' quotes and collages in the analysis of the Stage 2 and 3 interviews.

9.2.6 Feelings and emotions

As well as considering the core dimensions and emergent themes discussed above, it was important to understand what living through the service changes was like for the HVs through exploring their feelings and emotions. Smith et al. (2009: 199) state, 'emotions are absolutely central to our human understanding of experience'. The feelings/emotions of the participants were presented both spontaneously and embedded within their accounts rather than sought directly through interview questions. The transcriptions were mined for the occurrence of key words; for example, 'feel', 'feeling' and 'felt', 'confuse/confused', using a computer word-search facility and recorded only once per participant, irrespective of frequency. This was enhanced by this researcher adding value to the spoken words by searching for feelings/emotions that may not have been spoken directly but embedded within what was said. For example, P1 A presented feelings of confusion in, "...we've no clue about what we are doing" (S20 L9-10). This was further augmented by this researcher's interpretation based on participants' body language, facial expressions, voice tones and gestures. Additionally, feelings/emotions presented ambivalently (as partial, qualified or contradicted) within individual accounts were also initially recorded. It was decided to present the findings as a list of the 30 feelings/emotions that emerged from the data (see Table 10) and the occurrence of each these as a simple block graph (see Figure 14). As it was unclear why some feelings/emotions were sometimes presented ambivalently, these were subsequently set aside and removed as their overall reliability was questionable (see Figure 15).

As this is a comparatively large IPA study, Smith et al. (2009) recommend that the analysis should primarily focus on majority views. However, 'lone voices' should also be heard, as well as contradictory or dissenting views if pertinent, as IPA is an idiographic ('particular') approach (Smith et al., 2009: 3). Some comments, views and feelings less commonly experienced are of no lesser importance, as many were expressed with gravitas and powerful emotions, and thus are of

significance. For example, unlike the majority of her colleagues who felt a strong sense of collegiality, P1 T commented:

“I think I feel pretty insignificant as part of a massive team.” (S5 L38-39).

Within the interview time available, participants appeared to choose to speak about those matters and aspects of their professional identity that most mattered to them at that time. This researcher, however, does not interpret this to mean that matters left unspoken are necessarily issues of no importance to them. The constraints of time, the flow and direction of thoughts and emotions, and their mood on the day, are factors to be taken into account. In the participants' accounts these themes were often far-reaching. For the purposes of this study, this researcher has only included data concerning themes that have had the most direct or significant effect on HVs' professional identity (encompassing their social and role identities, and their personhood).

9.3 Presentation of Participants' Contributions

A number of conventions and abbreviations have been used in presenting the participants' contributions:

- The number following the letter 'P' (participant) '1', indicates that the quote came from a Stage 1 interview. This was replaced by '2' or '3' indicating a Stage 2 or 3 interview with the same participant. The subsequent letter is a randomly assigned identifier unique to each participant, for example P1 T.
- Quotations. S = section and L = line/lines in the transcriptions. All italics within the quotations represent tonal emphasis heard in the audio recordings.
- This researcher has occasionally added words to the participants' quotes in parentheses to assist clarification.
- Participants' quotes may be linked to their collages as these were often rich with metaphors expressing further their thoughts and feelings. The collages presented within the body of the text will only have the relevant part of the participants' verbal interpretation attached. For examples of collages with the full interpretations see Appendix E.
- The figure number of a participant's collage is attached to their quote.
- The abbreviation 'NQHV' denotes a newly qualified HV of less than 2 years.
- The abbreviation 'HVIP' HV denotes an HV who was trained as part of the government's recruitment drive to increase the number of HVs as outlined in the Health Visitor Implementation Plan 2011-2015: A Call to Action (DH, 2011a).

- In the interests of anonymity, the new-style Children's Centres and staff have been entitled 'Family Bases' and 'Family Base' staff. The new umbrella service combining the services of HVs, Nursery Nurses and Family Base staff is entitled the 'Corporate Service'.

Chapter 10 Analysis - Stage 1a Interviews: Being a Health Visitor - Professional Identity

10.1 Introduction

Through the methods discussed in section 8.3, the Stage 1 interviews aimed to identify HVs' perception of their professional identity and what it was like to be an HV. Twenty participants were interviewed face-to-face and 19 of these created collages. As discussed, the analysis of the Stage 1 interviews was split into two inter-connected parts, and the focus of the first of these, Stage 1a, is shown in Table 6.

Table 6 Summary of Stage 1a analysis

Timing	Stage 1 interviews held within the first few months of the introduction of the Corporate Service. Stages 1a and 1b were carried out during the same session
Number of participants interviewed	n=20 (+1 written response, P1 V)
Information sought	<ul style="list-style-type: none"> • HVs' perception of their professional identity • What it is like to be an HV
Methods of analysis	<ul style="list-style-type: none"> • Audio recordings listened to and initial post-interview notes read • Line-by-line analysis of the transcriptions • Initial exploratory comments made • Commonalities and differences identified • Common core dimensions of HV professional identity identified • Started to identify emergent themes

10.2 Core Dimensions of Professional Identity

The participants' collective perception of their professional identity was established by extracting core dimensions from the interview accounts (see 9.2.4). These were arranged under the three key components of professional identity (see Table 7), and reflect Figure 1. These core dimensions have been used to organise the contents of the remainder of this and subsequent analysis chapters.

Table 7 Being a health visitor – core dimensions of professional identity

<p><i>Social identity - 'who they are'</i></p> <p>Core dimensions:</p> <ol style="list-style-type: none"> 1. Self-identification with health visiting as a professional group 2. The sense of collegiality 3. Identity affiliation with the NHS (linked with 4) 4. Identity as a healthcare professional 5. Registered professional with a professional code and accountability 6. Professional status and expertise through training and qualifications
<p><i>Role identity - 'what they do'</i></p> <p>Core dimensions:</p> <ol style="list-style-type: none"> 7. Professional autonomy, agency and caseload ownership (linked with 8) 8. Uniqueness and complexity of the HV role 9. Enact professional values/personal values 10. Emotional and personal commitment, investment and attachment 11. Inter-professional working (IPW) 12. Public worth and value
<p><i>The public face of health visitors' professional identity</i></p> <p>Core dimensions:</p> <ol style="list-style-type: none"> 13. Status and role as public health nurses (linked with 14) 14. Public understanding and recognition of the HV role

10.3 Sense of Self

The centrality of the self runs as a common thread through professional identity and the concept of the complete person (see Figure 1). This is evidenced through participants describing who they felt they were as HVs, and how their personal values, commitment, investment and attachment were central to their work. All (20/20) (and P1 V) showed evidence of their sense of self embedded into their professional identity (or vice-versa), variously, and to different degrees. This was clear in many of their collages, in the objects chosen, and often in their background colour choice. For example:

P1 T "...the [professional] experience...makes *me* who I am...personally and professionally entwined" (S4 L4-5, 10).

10.4 Social Identity – ‘Who They Are’

The majority (17/20) referred to themselves as professionals, and/or their professional identity in broad terms beyond just a description of their role.

The three remaining participants who did not define their HV professional identity in terms that were separate and beyond a description of their role were NQHVs; two within one year of qualifying and the other within two years. These three appeared to be psychologically oscillating between their previous roles in nursing and midwifery. As HVs, two felt a loss of public recognition, status and universal appreciation:

P1 M “...I go to quite a lot of houses and they don’t really know what a health visitor does and I think that’s also quite difficult, going from a job where you think everyone knows what you do, everyone thinks, ‘oh, that’s a great job’” (S1 L30-34).

P1 M was trying to adjust to the value of her new preventative role over time, “the long-game” (S20 L33), which contrasted her ward-based role where outcomes were more immediate, and also feared becoming clinically de-skilled. Another commented:

P1 N “...parents don’t always value the input of a health visitor as much as they would a midwife. I find that a little bit *hard* to adjust to” (S26 L5-7) “I don’t feel as *proud* by saying I’m a health visitor as I would by saying a midwife.” (S27 L13-14),

but then contradicted this:

“I *am* proud to be a health visitor, but yeah.” (S28 L8)

The third NQHV used the metaphor of a flower growing to describe herself as an HV: her HV identity was still embryonic:

P1 O “I feel like sort of the flower is growing” (S2 L3-4) (Figure 2)



Figure 2 Collage by participant O – Stage 1 interview

This gradual development of professional identity aligns with the views of Pratt, (2006), Cruess et al., (2016) and others.

10.4.1 Core dimension: Self-identification with health visiting as a professional group

Although very few participants commented upon their sense of an HV professional group identity directly, all (20/20) participants self-identified as HVs through evidence of a shared professional ‘orientation to practice’ (Cowley et al., 2013: 11) (see 3.7), values, principles, attitudes and behaviours and ideology (mission). Evidence of these is addressed in the following sections and in discussing the HVs’ role. There was the sense of belonging to an ‘in group’ with ‘shared meanings of togetherness...[and]...common expectations’ (Carter and Bruene, 2018: 431).

Professional values

The professional Code (NMC, 2018: 4, 7, 11, 15) sets out four broad standards which the participants embraced as their practice values. These are to:

- prioritise people

- practise effectively
- preserve safety
- promote professionalism and trust.

The HVs also showed evidence of upholding the four over-arching ‘workforce values’ outlined by Whittaker et al. (2015: 13):

- sense of privilege to connect with families
- using knowledge, skills and experience
- working with others
- professional autonomy.

All (20/20) participants showed evidence of these shared values in the way they worked. These values were either addressed directly, were evident when re-telling those experiences with clients when they felt ‘most affirmed’ as HVs, or as underpinning several of the core dimensions of their professional identity. For example, ‘working with others’ (Whittaker et al., 2015: 13) was embedded in inter-professional working, and the value of autonomy was another core dimension.

Principles

All 20/20 showed evidence of a commitment to the four principles in health visiting⁶ outlined by (Cowley, 2007: 757). These were variously presented in their contributions.

Orientation to practice

Embedded within the ‘orientation to practice’ (Cowley et al., 2013: 11) (see 3.7) were many shared objectives, such as empowering clients, fostering hope, supporting and being alongside clients and building strong professional-client relationships to enable positive outcomes. All (20/20) spoke or showed evidence of these concepts in the way they worked. Examples are:

P1 D “...through the service, I hope to provide, I’m a ‘shining kind of a bit of light’...a little bit of a ‘beacon of hope’ in the situation and embracing a space – kind of creating a bit of safe space” (S1 L20-23) (Figure 3)

⁶ Principles of health visiting that underpin training and practice (Cowley, 2007: 757):

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



Figure 3 Collage by participant D – Stage 1 interview

P1 I "...we're trying to help them in from the 'dark times' to the 'good times', and *my* aim as a health visitor I think is mostly to empower women" (S1 L20-23) (Figure 4)



Figure 4 Collage by participant I – Stage 1 interview

Core components of health visiting practice

As discussed, Cowley et al. (2013) established that there are three core components embedded in the universal service offered by HVs to all families, which acts as a gateway to other levels of HV intervention (see 3.7). All (20/20) spoke of or showed evidence of these three core components being central to their practices.

Shared attitudes and behaviours

The majority evidenced that they shared very similar attitudes and behaviours towards health visiting and health visiting practice. The service changes did, however, affect some relationships and collegiality between colleagues at a local level (see 11.2.2).

Ideology of practice

All (20/20) reported that their professional and personal aspiration was to be effective; to make a positive difference to clients' lives, aligning with the findings of Whittaker et al. (2013). Twelve participants spoke the words '*make a difference*' (Whittaker et al., 2013: 8, original emphasis), or used similar words:

P1 S "I've been in nursing a long time...you want to make a difference, you come in to make a difference" (S29 L9-13).

10.4.2 Core dimension: The sense of collegiality

Collegiality is described as 'the cooperative relationship of colleagues' (Merriam-Webster Dictionary, 2020: online). The participants presented this as a more localised sense of belonging than the broader concept of being part of a professional group.

Three-quarters (15/20) remarked on their positive experience and/or desired need for collegiality with their immediate HV colleagues:

P1 N "I have a very good team of colleagues and we can support one another" (S3 L11-12).

A small number mentioned that working alongside colleagues supported their on-going learning. A very experienced participant stated:

P1 H "...I was at the breastfeeding group...with a colleague of mine and she's very skilled at supporting breastfeeding...I'm trying to ...do that group with her sometimes so that I'm improving my skills...that was all really, really positive and I was learning as well" (S10 L20-26, 61-62).

Of those who did not experience a positive sense of collegiality, in all but one of the 5/20 cases, this was attributed to the service changes.

10.4.3 Core dimension: Identity affiliation with the NHS

(Linked with '*Identity as a healthcare professional*')

A quarter (5/20) commented directly and positively about their affiliation with the NHS:

P1 F "It's my identity. When I'm in the community, very *proud* to work for the NHS [...] *it's very very fundamentally* important. It's *everything* really..." (S11 L1-2, 7-9)

P1 N "I feel proud to work for the NHS...for *me*, that is *centre* to my role." (S1 L11-13).

In contrast, one participant reported that she did not identify as an NHS worker, rather that client care was her priority:

P1 Q "...if it works well for the clients that we're serving then I don't care who I work for." (S18 L11-12)

Affiliation with the NHS was also linked with identification as healthcare professionals.

10.4.4 Core dimension: Identity as a healthcare professional

Over a quarter (7/20) identified themselves as healthcare professionals (four of whom had also identified as NHS workers). Further, over a quarter (6/20) also made reference to their nursing and / or midwifery background (two of whom had also identified as healthcare professionals):

P1 F (*regarding clients*) "I want them to be very very clear that I'm a health professional, a public health *nurse*" (S11 L18-20).

10.4.5 Core dimension: Registered professional with a professional code and accountability

As professionals HVs are accountable for the decisions that they make through their professional judgement (NMC, 2020). The Nursing and Midwifery Council (NMC) professional Code sets out 'the professional standards that registered nurses, midwives and nursing associates must uphold' (NMC., 2018: 3). The Code outlines HVs' accountability for their actions and behaviours.

A quarter (5/20) commented about their accountability directly or it was embedded within their accounts, summarised thus:

P1 Q "...you have to pay for it by registering, doing your NMC registration and re-validating every year, so that's done *outside* of work time, so that's much more something about you as a person that you are actually identifying as a professional" (S30 L3-8)

"You can't be a health visitor if you don't maintain that professional identity on paper and actually pay your fee and be registered and have, you know, a body that you're registered with and keep to their rules and guidance, the NMC Guidelines and Code of Conduct" (S30 L17-22).

10.4.6 Core dimension: Professional status and expertise through training and qualifications

With this dimension there is a cross-over between social and role identities.

HVs are a 'highly skilled workforce' (iHV, 2019: 4). They are qualified nurses or midwives who have undertaken further training to qualify as Specialist Community Public Health Nurses (HV) (iHV, 2021). They are registered fit for practice by the Nursing and Midwifery Council (NMC) through their training, qualification, skills and accountability. Half (10/20) evidenced their belief in themselves as professionals through their training and qualifications:

P1 B "You're a *highly-trained* professional." (S21 L25)

P1 Q "...you have to have previous qualifications, you have to have done, had a certain amount of experience, you have to have a training, you have to pass a certain level, so there's so much more hanging on it to make you identify as that person..." (S30 L32-37)

One NQHV recognised that she was in the very early stages of this process.

Health visiting has its professional roots in nursing (and/or midwifery). Several participants referred to their previous professional history in nursing as evidenced in some of the quotes. An experienced HV spoke of herself as an HV and nurse:

P1 K "I love health visiting; I love my nursing" (S2 L3).

10.5 Role Identity - 'What They Do'

As discussed in 3.7, the HV role lacks a clear and consensual definition. From the 20 accounts from the Stage 1 interviews a complex picture emerged as to what their role comprised.

The participants were not asked to define their role directly. Instead, the art prompt "who are you as a health visitor?" was left open to interpretation. Some HVs focussed more on how the changes were affecting them and their practice, rather than summarising the content of their role. The responses revealed:

- Almost all (18/20) highlighted their core work with children and families
- Almost half (8/20) mentioned safeguarding children and 2 more (4 in total/20), vulnerable families and targeted work
- Almost a quarter (4/20) had, or desired to have a specialist role
- Almost half (9/20) spoke of their belief in effective interprofessional working (IPW)
- Almost half (8/20) regretted the loss of traditional work, such as facilitating group and child health surveillance
- Less than a quarter (3/20) described themselves as public health nurses (one of whom did so as she thought the term 'health visitor' would not be recognised by all). This researcher concurs with Lynch (1997, cited in Baldwin, 2012) that the public health role was embedded in their work, more within health advice and education to individuals than as a population-wide message, as described by Billingham (Billingham, 1994, cited in Baldwin, 2012).

Although their role appeared multi-dimensional, it was underpinned by fundamental principles and values which were commented upon or suggested through evidence by all or most of the participants.

As discussed in 10.4.1, considering the four principles of health visiting (Adams, 2012), HVs enacted many professional and personal skills and attributes in their work. Alongside the aforementioned aims, such as client support and empowerment, participants highlighted others including: active and attentive listening, maintaining positivity and containment through difficult times, and collaborative health planning when possible. Many of these will be evident in the following sections.

10.5.1 Core dimension: Professional autonomy, agency and caseload ownership (Linked with '*Uniqueness and complexity of the HV role*')

In simple terms the meaning of autonomy is the 'state of being self-governing' and the freedom to be self-directing (Merriam-Webster Dictionary, 2020: online). Agency, in terms of professional identity, is having the power to act, or being able to exert power, for example, to effect change (Merriam-Webster Dictionary, 2020). Caseload ownership in this context is a client caseload that is predominantly managed by an individual HV rather than a corporate caseload which is shared amongst two or more HVs.

The majority spoke or evidenced their belief in autonomy, agency and caseload ownership in two ways. These were either in the sense of continuity of care and professional accountability as integral to safe and effective practice, or in their re-telling of a client contact experience. This was particularly linked to the health visiting principle of 'the search for health needs', holistic assessment, planning interventions and follow-up care and support (Adams, 2012: online).

10.5.2 Core dimension: Uniqueness and complexity of the HV role

Health visiting practice is unique in that practitioners are 'the only professional group who visit every family in England' (iHV, 2019: 3) and are 'uniquely placed to work with parents and families' (RCN, 2011: online). HVs have skills that encompass 'a philosophy and way of working' to 'understand the interplay of complex contextual issues' (iHV, 2019: 3). This uniqueness and complexity of the health visiting role was addressed directly by several participants, summarised by two very experienced HVs:

P1 T "I think our job is very, very *unique*: we see so much more than anybody else." (S15 L4-5).

The other commented that HV work is too complex to capture and demonstrated this on her collage. She created a three-dimensional art-work to represent this as far as she was able (see Figure 6):

P1 H "...I let it be 'dirty' on purpose, because life is like, 'dirty', so I let the bits of 'dust' go everywhere and make 'dirt'" (S7 L8-10).

Additionally, the majority evidenced these aspects of their role in their accounts of their work with clients.

10.5.3 Core dimension: Enact professional values/personal values

Loman (2019), claims that one's own beliefs are inter-related with one's professional values. Almost half (9/20) spoke specifically about their personal values that they bring to the role. Amongst the most frequently expressed were fairness, justice and equity, honesty, trustworthiness and loyalty, care, compassion, kindness and empathy, high expectations of oneself, and working hard:

P1 H "...I do think about what is, what's *right* and what's *just* and what's *fair* for people and I try to act in accordance with *that*." (S30 L19-21)

P1 I "the NHS values...caring, compassion, quality [...] I think they are my core values..." (S22 L7-9)

and:

"...I want to be an advocate for, you know, people who don't have that advantage [...] I want everyone to be treated equally." (S22 L13-15, 20-21)

P1 J "...*honesty* I think, *quality* [...] *fairness, teamwork, loyalty, support*". (S22 L10-12)

"So that's me, I'm not different. I can't be different in one place to another place." (S23 L1-2)

P1 C "I like loyalty, that's very important to me; and honesty [...] good morals [...] trust, honesty." "It's important at both" (work and home) (S21 L1-7).

P1 R "...I just feel like, as a person, I feel kind and compassionate, and that's what I want to be able to bring to the role of a health visitor; that's why I went into a caring profession" (S12 L10-16).

As discussed in 10.4.1, many of the professional values outlined as standards by the NMC (2018), and Whittaker et al.'s (2015: 13) 'workforce values' that the HVs' shared, underpinned a number of the core dimensions of the HVs' perceived professional identity. Combined with the participants' expressed personal values, four common themes emerged:

- Individualised client-centred care
- Primacy of client care
- Holistic assessment (over time)
- Aspiring to make a difference (linked with 'practise effectively' (NMC, 2018: 7)).

Individualised client-centred care

All (20/20) either commented directly about their commitment to prioritising the shared value of individualised client-centred care, or evidenced this in their re-telling of a client contact that

affirmed them as HVs. This was 'across the board', from very newly qualified staff to those with over 20+ years' HV experience:

P1 F "...you can train anybody to give a *message*, but as health visitors, we don't just give a message: we assess health needs, we identify the needs and we give a message in a way that's going to work for the family [...] its adapted" (S7 L14-20) (HVIP HV)

P1 B (very experienced HV) "... 'one size does not fit all', not by any stretch of *anybody's* imagination" (S7 L9-10).

Primacy of client care

Over half (11/20) spoke directly about how they prioritise client needs and care above all else, and this aligns directly with the Code (NMC, 2018: 6) in 'prioritising people'; putting '... the interests of people using or needing nursing or midwifery services first. You make their care and safety your main concern...'. This reflected the difference between 'tick-box' care (standardised record templates and forms to capture KPI data, see Appendix A) and individualised, client-led care.

Two very experienced participants commented:

P1 K "I take *on* the changes as *much* as I can so that I am 'ticking boxes' but I always, because of my training as a general nurse, will *always* put the client first whether it meets a target or not." (S5 L10-14).

A newly-qualified HV (NQHV), found herself in a situation that required her to abandon her routine visiting plan and thus was unable complete the forms required of her. She commented:

P1 O "It was supposed to be just an antenatal visit...it ended up being very different from what I imagined, but I will go back and try and actually do the antenatal visit this time; I never really got around to it last time" (S6 L9-13)

adding:

"...you seem to get a much better response than going in, you know, with your own agenda... 'ticking boxes' and things." (S18 L16-19) (NQHV)

In addition to client care prioritised over 'tick-boxes', one experienced participant reported client care prioritised even above collegiality:

P1 K "I've always had *really* high morals [...] I can be outspoken and I will pick people up if I feel they've not treated someone correctly [...] if a patient didn't get good care" (S9 L4, 9-13).

Holistic assessment (over time)

Holistic assessment and client-centred care was either commented upon and/or evidenced by all (20/20) in the re-telling of a scenario where they felt most affirmed as HVs. This was summarised by one very experienced HV:

P1 T “We look at the whole family situation; we, we almost *experience* what they experience. And I think we see the whole *scope* and the *depth* and *breadth* of every family dynamics.” (S15 L5-9).

As with all aspects of client contact, assessment is built on fostering strong professional-client relationships:

P1 L “...because we’ve built that great relationship, and I had time yesterday to do that and spend that time with her, she is more forthcoming to text me and give me updates regularly” (S8 L21-25).

Ideology of practice (aspiring to ‘make a difference’, Whittaker et al., 2013b: 8, original emphasis)

All (20/20) evidenced that they had contributed to making a positive difference for clients in their retelling of an experience when they felt most affirmed as HVs. An example is:

P1 L “...one of my clients I was keeping in contact with because she had previous mental health issues...she contacted me...and you could see it was difficult for her to talk about what she was experiencing – a lot of intrusive thoughts and it was impacting on her day-to-day life...we agreed to do an urgent referral to the appropriate mental health team... you could just hear the kind of relief in her voice that something was being done and she was going to get the appropriate support” (S21 L3-5, 20, 22-25, 38-41).

10.5.4 Core dimension: Emotional and personal commitment, investment and attachment

All (20/20) reported a very strong personal commitment to health visiting. For example:

P1 O “...I would try and invest everything... [in the HV role]” (S15 L17-18) (NQHV).

Almost all (17/20) evidenced attachment towards health visiting and directly expressed positive feelings about being an HV, especially in their direct contact with clients, as summarised by:

P1 T “Feeling very positive and worthwhile...” (S10 L16)

P1 E “...hand on heart I absolutely love my job; absolutely love it” (S9 L1).

However, 15/17 of these were conflicted; their love of the work was based on the principles of health visiting as they thought it should be practised, or had been before the changes. The two participants who did not comment negatively were both newly qualified between one-two years, and presumably did not have much knowledge of the previous model of HV practice with which to compare.

Three very experienced HVs expressed an attachment to health visiting beyond positive feelings: they felt that their professional identity was part of who they were as persons:

P1 Q “Your personal life and your health visiting life; they very much intermingle...” (S28 L2-3)

P1 T “...the experience with families, professional [...] it makes *me* who I am [...] entwined” (S4 L4-5, 10)

“Part of me thinks I just want to retire and not work anymore, but then I don’t want to lose my identity because I *do* enjoy my job...” (S4 L16-18) (Figure 5).

Seven out of the eight areas on P1 T’s collage and the background colour represented dimensions of her personality embedded within her identity as an HV:



Figure 5 Collage by participant T – Stage 1 interview

P1 H’s collage (Figure 6) reflected the interconnection of her personal and professional life:

P1 H “...so pretty much you’re the same *person*, you *bring* yourself to work and you use yourself to be *effective*...” (S32 L14-18)



Figure 6 Collage by participant H – Stage 1 interview

P1 H verbally interpreted her collage (Figure 6):

Tower built of various components reflected her sense of self and her 'layers' of life, "how you've kind of *built on your life...your qualifications and everything*" (S1 L13-14).

A quarter (5/20) reported how their life experiences influenced their role. This concurs with Appleton and Cowley's (2008) finding that life experience as well as personal values influence HV assessments.

The following quotes are all from very experienced HVs:

P1 H "When you *are* a health visitor you are using *yourself* as a tool..." (S32 L2-3)

"...so pretty much you're the same *person*, you *bring* yourself to work and you *use* yourself to be *effective*...improving people's health...doing what needs doing..." (S32 L14-18)

P1 T "I think you kind of relate a lot to people and their situations and you try to make *sense* of it [...] your own life stories kind of almost, part of what you're seeing as well, and you just try and make sense of it" (S17 L5-12).

A fourth HV reported that she used her experience of being a parent herself in her role with families. Another reported that her professional identity/role as an HV came from her experience of being a mother and previous service-user. Conversely, one reported that the HV role had positively influenced the way she now parented.

The positive psychological rewards of health visiting appeared to be directly linked with the ideology of practice – to '*make a difference*' to clients' lives (Whittaker et al., 2013: 8, original emphasis).

Participants felt most affirmed as HVs when they could practice in a way that enabled making a positive change in clients' lives. 17/20 participants directly reported positive feelings of emotional reward when they had effected change:

P1 R "...supporting the families [...] actually seeing them make a difference and turn their life round...is so, so rewarding as a health visitor and that's what I feel my role should be..." (S7 L7-13)

P1 F "I'm full of pride...there's so many families where I've worked with, that's what stimulates me; that's what I *enjoy* and that's what we're here *for* because the difference that we've made [...] you can't measure that outcome; we've made a massive difference." (S5 L1-7)

P1 G "I felt affirmed, I felt *yes*, look what I've *done*, look what I've *achieved* and I felt very happy." (S7 L42-44)

P1 L "I did her a *really good service*, a *really good service*, that will I hope be so much more beneficial for her than what she's experienced already". This HV added she felt "elated" (S23 L2-5, 7).

Two of the three remaining contributions contained very positive comments concerning the ideology and worth of the health visiting service, but took a more pragmatic stance. The other spoke of her current tiredness and the stress due to work pressures she felt, thus possibly over-riding any report of emotional rewards:

P1 J "You've probably not caught me at a very good time" (S30 L22)

"Just I'm tired." (S30 L26).

10.5.5 Core dimension: Inter-professional working

Inter-professional working (IPW) is a key aspect of HVs' professional identity, in that it is recognised as essential for clients' safety, welfare, and their best interests (Laming, 2003; Wackerhausen, 2009). The participants mainly commented upon working with the former Children's Centre staff (within the newly formed Corporate Service), rather than other professionals such as GPs. This is discussed further in 11.3.5.

10.5.6 Core dimension: Public worth and value

All participants (20/20) reported the aspiration as HVs to make a positive difference to the lives of their clients, with several specifically commenting on the public value of the HV role. Reflecting Barnett's discussion concerning the 'new world' availability of sources of information beyond professionals alone (Barnett, 2008), P1 M (NQHV) stated:

"...I've realised that people still like that human contact and want to be validated [...] they'll still ask, even though they might have read it on the internet [...] they want to know from a health professional" (S9 L18-24)

"...I think that kind of validates our role" (S9 L24-25)

“...they respect the knowledge and you know, and *want* it, want the information.” (S9 L33-35).

10.6 The Public Face of Health Visitors' Professional Identity

This core dimension was developed from the review of the literature on professional identity. It is, as mentioned, the profession's 'official recognition' by the public, other professionals, and the 'self-image' senior members of the profession seek to portray and promote (Wackerhausen, 2009: 459). This study only included the perceptions of HVs and therefore it is unknown how the public, including HVs' clients and others view the professional identity of HVs. However, a few participants mentioned the public face of their professional identity in terms of their what they understood was their status and recognition by the public, this core dimension was referred to more in the context of the experience of service change in 11.4.

Chapter 11 Analysis – Stage 1b Interviews: Health Visitors' Lived Experience of Service Changes on their Professional Identity

11.1 Introduction

This chapter describes the effects of the changes mapped onto the foundation framework encompassing the core dimensions of HVs' professional identity from the Stage 1a analysis (see Table 7), noting commonalities, differences and emerging themes. This chapter also explores the HVs' professional identity in the broader context of change and what living through the changes was like for the HVs, i.e., their feelings and emotions.

Table 8 Summary of Stage 1b analysis

Timing	Stage 1 interviews held within the first few months of the introduction of the Corporate Service. Stages 1a and 1b were carried out during the same session
Number of participants interviewed	n=19 (+1 written response, P1 V) ⁷
Information sought	<ul style="list-style-type: none"> • What it is like to be an HV living through change • The effects of service change on HVs' professional identity
Methods of analysis	<ul style="list-style-type: none"> • Audio recordings listened to and initial post-interview notes read • Line-by-line analysis of the transcriptions • Initial exploratory comments made • Commonalities and differences identified • Emergent themes identified and developed into super-ordinate themes

11.2 Social Identity: The Effects of Service Changes

As evidenced and discussed, during the Stage 1 interviews the majority of participants referred to themselves as professionals, and/or their professional identity, in terms that were beyond a description of their role, i.e., their social identity. The strength of many of the participants' allegiance to their social identity was emphasised, often vehemently and robustly in the face of the changes. Their comments also revealed the centrality of their sense of self.

⁷ In Stage 1b 19/20 participants' contributions from the interviews were analysed with regard to the changes, as one participant had no exposure to these as she was new in post. Participant P1 V responded in writing and her contributions were included where appropriate.

11.2.1 Core dimension: Self-identification with health visiting as a professional group

Although all (19/19⁸) showed evidence of commitment to the health visiting profession's 'orientation to practice' (Cowley et al., 2013: 11) (see 3.7), values, principles, and ideology, the changes had negatively affected the social identity of all in some way. Considering the four principles of health visiting (see 10.4.1), all had been affected to a certain degree. The changes had especially curtailed the HVs' ability to 'influence policies affecting health' which will be discussed in 11.5.2.

None thought that the changes had negatively affected their personal sense of being an HV. However, one participant commented that, although she believed strongly in her professional identity as an HV, what was expected of her now threatened to confound this:

P1 F "...who I am as a health visitor? At the moment that's a bit of a mystery" (*ironic, sad tone*) (S1 L1-3).

11.2.2 Core dimension: The sense of collegiality

Communication, time and support were all important factors for participants' sense of collegiality. Over three-quarters (14/19) remarked on their positive experience of, and/or desired need for, collegiality with their immediate HV colleagues, as summarised by:

P1 J "...it's a *great team*...and I find my colleagues very supportive, otherwise I would have left by now." (S18 L10-12)

Of these 14, four specifically commented on the sense of a shared experience of the changes amongst colleagues, including:

P1 L "...everyone's under pressure [...] they're going through exactly the same thing" (*comment included her immediate managers*) (S14 L21, 25-26)

P1 E "...the most support I've got is from my colleagues, because they're in the same boat" (S6 L1-3).

However, some relationships with HV colleagues were considered strained, attributed to the effects of the changes. For over a quarter (5/19), the changes were reported to have had a negative effect on shared values and behaviour, fracturing the sense of shared social identity and collegiality. Three out of these five participants referred to an 'out-group': colleagues with whom they dis-identified from or whom they disassociated (Carter and Bruene, 2018). P1 K hinted that some colleagues leaned towards an 'entrepreneurial' identity that was 'externally defined' (Sachs, 2001: 156-157):

⁸ Only 19/20 (n=19) participants' contributions from the interviews were analysed with regard to the changes, as one participant had no exposure to these as she was new in post. P1 V responded in writing and her contributions were included where appropriate.

"...some colleagues I've noticed can make the changes because they're not 'client-centred'; they have a different outlook on their nursing, health visiting role. ...so, if they're not 'client-centred', they can 'tick the boxes' [...] it's task-driven whereas I'm 'old school'" (S6 L2-9)

P1 T stated:

"I accept that change happens and it's not *always* for the best. I've seen changes *in* people as well. Sometimes not so nice ones." (S5 L8-12)

"...sometimes I feel that I can talk to colleagues, but I don't really know if I can always trust everybody" (S6 L7-9).

A third commented that division, ill-feeling and discontent were present between colleagues who chose to work in their own time to manage their workload and those who did not, as a result of the changes and resultant increased workload:

P1 I "...I very much think of them as martyrs, and actually people sometimes wear it as a 'badge of honour'" (S32 L2-4).

Of the 14/19 who spoke about the importance of collegiality, half (7/14) evidenced specifically that by colleague contact they meant face-to-face communication, for example:

P1 C "...a good day at work is when...I've been able to *speak* to somebody in the office...because I think it's important to have that contact." (S22 L1, 4-7)

P1 S "If I see a person [colleague] face-to-face, I see that as a positive [...] that's terrible, isn't it?" (S5 L2, 3-5)

and commenting on attending meetings:

"I haven't got *time* to go [...] so I just 'bob' in [...] you don't really see people [...] so I will *make sure* I go to the 'hub' meetings to have face-to-face with people [...] I see that as a *positive* because that's important for me to have that little bit of support" (S5 L18-25).

P1 S also reported that she and her colleagues had an additional way to communicate:

"...we're all in a 'WhatsApp' group [...] that's a *really* good way – quick way of getting together"

but added:

"...I think you [...] glean more out of support from face-to-face human contact - is better, and you have a *richer* communication" (S25 L5-6, 10-14).

Of the remainder that commented on the importance of collegiality, one very experienced HV felt it was her role as a senior team member was to support others rather than receive support herself:

P1 K "When I look at my colleagues, they're all very stressed and I'm trying to hold it all together" (S1 L17-19) (Figure 7)



Figure 7 Collage by participant K – Stage 1 interview

P1 K verbally interpreted her collage:

Plug represented “I’m trying to ‘put a plug’ on everything at work [...] containment, professionalism, everything...so many changes that I feel it’s out of control” (*sad, stressed tone*) (S1 L5-10)

Safety pin represented “...being very fragile holding everything together in a fragile manner.” (S1 L15-17).

One other presented as duty-bound to try to prioritise the changes over collegiality, another as not requiring collegiate support, and two others only spoke of the how their colleagues had been negatively impacted by the changes.

Over half (11/19) highlighted other specific factors that were having a detrimental impact on the sense of collegiality. A significant number mentioned a mixture of these:

- Team restructuring and relocation of smaller teams into larger teams with a central base (hub)
- Increased focus on mobile working
- Format of team meetings.

The two characteristics that appeared to be key for a positive sense of collegiality, and yet were most affected by the changes, were face-to-face contact with colleagues and adequate time for this.

The restructuring of teams

The practicalities of the reconfigured team bases were summarised thus:

P1 S "...there's always a need to meet *more* with the hub and have *longer*" (S25 L31-32)

P1 B "I value my colleagues *hugely*. Don't see them often enough because of the team structure; so, it doesn't actually function as a team...because of mobile working and limited space in the office and our limited car parking." (S2 L7-12)

commenting further:

"...the team at times can almost be dysfunctional [...] that's to do with the structure; it's not to do with the people in the team *at all*." (S22 L3-6).

Another very experienced participant reported:

P1 T "What I think my job lacks very much is the feeling of being part of a team [...] we're just so fragmented: we don't have the opportunity to come together [...] to *reflect* with each other; we don't get a chance to actually focus on how somebody might be feeling. So, we're working very much in isolation and I don't think that's good for a person as a professional [...] you don't feel *nurtured* at all." (S5 L19-28)

adding:

"...I feel pretty insignificant as part of a massive team." (S5 L38-39)

suggesting that the lack of time was a key factor

"...people [colleagues] will often hear you but they don't actually listen to you. Maybe it's just because they haven't got the capacity to." (S6 L12-14).

This was echoed again:

P1 A "We are so alone" (S15 L7-8)

"I feel like I'm with strangers" (S20 L37).

P1 A felt that even being part of a bigger team with more staff was ironically more isolating due to lack of time. She referred to a previous nursing role, in a different locality and in a smaller team with regular 'de-briefing' time built in, and compared this with her current experience:

"...just need time together" (S20 L13)

"Just to know that somebody really understands and cares..." (S22 L7-8).

These and other accounts evidence the restrictions of time, particularly due to the increasing volume of work, as well as practicalities such as parking issues.

One experienced participant however, after reporting a substantial number of recent resignations, stated philosophically:

P1 G "I still need my colleagues [...] but we're having to work more efficiently [...] and it doesn't allow for an awful lot of interaction, but there are times when you need to discuss things." (S10 L12-16)

followed by:

"...you just take the opportunities when they arise, so unfortunately whenever we see everyone we...(rushed tone)... 'get it out of our system' and then you move on!" (S10 L17-21).

Mobile working

Increased mobile working was also cited as a barrier to effective communication for support between colleagues, as summarised by one experienced participant:

P1 D "...there's been a real *push* towards mobile working and I feel that the kind of work we do, it's *really* important to feel part of a team...for so many reasons" (S6 L9-11)

followed up with:

"...it's driving everybody away from the office and not seeing one another" (S6 L24-25).

Team meeting format

The change in the team meeting format was also cited as a barrier for communication and support between colleagues. It also appeared to negatively affect HVs' sense of professional worth and recognition by management:

P1 I "Team meetings I don't feel are a support anymore. I think the agenda's completely changed" (S15 L3-5)

clarifying:

"I think we need to be kept up to date but [...] we have to do 'any other business' at the *beginning* and I feel that's to keep us quiet [...] I don't think we have the opportunity to speak a lot, or to speak as a united front." (S15 L5-6, 9-11,16-17).

Another experienced participant reported the emphasis in team meetings was now about information-giving and allocation of work, not as an opportunity for face-to-face collegiate support:

P1 J "There's too many meetings. But part of it was that we'd get together and *support* each other. It's not really... that isn't because obviously we're all saying, 'oh, well I can do that or I can't do' - not exactly a *forum* for support really, is it?" (*sarcastic tone*) (S15 L25-27).

One team, recognising the unfulfilled need to be in closer face-to-face contact, had shown enterprise and formed a communal 'knitting group'. One newly qualified HV (NQHV) participant, pointing to a cotton reel on her collage, cheerfully reported:

P1 N "...the little cotton reel represents knitting." (S6 L10-11) "So, our team...have been stressed recently, so somebody suggested a bit of mindfulness; we could do a bit of knitting after the team meeting" (S7 L2-5)

however, she added:

"...I've not been part of that yet because I've always had to go and do visits or whatever..." (S7 L6-8).

This researcher was aware that HVs and their colleagues also arranged their own 'unofficial' 'away-days' which were popular and successful.

11.2.3 Core dimension: Identity affiliation with the NHS

(Linked with '*Identity as a healthcare professional*')

Over a quarter (5/19) commented directly that the service changes negatively affected their identity with the NHS denigrating their professional worth and recognition, as summarised:

P1 P "I feel quite a lot that, that our NHS identity's been completely taken away" (S10 L1-2)

"...I do think we've completely lost the NHS identity." (S10 L8-10)

"People don't know that we're NHS." (S10 L11) "...people don't really know that we're anything to do with healthcare really anymore...and that's my job!" (S11 L10-14).

One very experienced participant disagreed:

P1 Q "...if it works well for the clients that we're serving then I don't care who I work for." (S18 L11-12).

11.2.4 Core dimension: Identity as a healthcare professional

Of the five participants discussed in section 11.2.3, four commented that their identity as a healthcare professional had been 'hidden' or diminished through being required to wear a Corporate Service lanyard:

P1 F "I want them [clients] to be very, very, clear that I'm a healthcare professional, a public health *nurse*" (S11 L18-20)

and commenting on the directive not to wear the NHS lanyard:

"There was no *warning* given that this was going to happen [...] someone just came in and *took* the lanyard, confiscated it [...] I just felt stripped of my identity; I felt *absolutely heartbroken*." (S19 L13, 16-19)

P1 N "I think it's really important that families know [...] that you're a *health professional* and with this (*indicates to Corporate Service lanyard*) it doesn't feel like I'm a health professional" (S10 L15-18).

A further two went against the directive to wear the corporate lanyard; one boldly, but the other hesitantly, although she purposely placed a picture of a lanyard at the centre of her collage to represent her pride in working in the NHS:

P1 N "I don't want to draw attention to myself for not wearing...this one (*indicates to lanyard*) and wearing my NHS one, but sometimes on visits I put my NHS one on" (S10 L11-14) (Figure 8)



Figure 8 Collage by participant N – Stage 1 interview

Another very experienced HV remarked that they thought the debate around wearing the corporate lanyard was a relatively minor issue compared to the more major changes:

P1 H "...I know it represented identity, but for me [...] I've got 'bigger fish to fry'" (*confident tone*) (S25 L6, 8).

Echoing this, another also commented that her colleagues' concerns around the corporate lanyard had added to an already stressful situation, and that there were more major changes to be concerned with:

P1 A "I think our jobs are quite stressful enough...I don't think the families care who wear it...if we're all coming up working as one team, we're with this one team...if it's not the big thing like reducing staff numbers, moving from (*names locality*)" (S5 L5-9, 14-16)

P1 C commented that her identity remained stable:

"I still...see myself very much as an NHS worker" (S18 L2)

"...I don't see myself as a 'new person'; as a new role either." (S18 L10-11).

11.2.5 Core dimension: Registered professional with a professional code and accountability

Professional worth and recognition also underpinned the comments made by almost a quarter (4/19), who reported that they were concerned about the safety and welfare of their clients during the changes, especially with regard to reduced staff numbers:

P1 L "...if things don't change, the support's not there for families, things are gonna go wrong, drastically wrong, to jeopardise people's safety and wellbeing" (S7 L14-17) (Figure 9)



Figure 9 Collage by participant L – Stage1 interview

P1 L verbally interpreted her collage:

'Fireworks' represented the inevitability of "...something serious is going to happen" (S7 L20-21) due to reduced funding staff and how health visiting is being managed.

Over a quarter (5/19) presented concern about their accountability. Two of these commented:

P1 F "...there's a *genuine fear, daily*, that something bad will happen and somehow I will be *blamed* for it" (S18 L25-27)

P1 H "...*you* and good practice is not *protected*" (S18 L14).

11.2.6 Core dimension: Professional status and expertise through training and qualifications

Again, there is a cross-over here between social and role identities. Professional worth and recognition were surfaced by over half (10/19), who commented that their expertise and status as HVs was under threat from the changes, for example:

P1 R "...you could employ anyone with no qualifications and say 'all you've got to do is go into a visit – ask these questions, 'tick the boxes' and your job's done'" (S11 L21-25)

"I just feel I'm very easily replaced now." (S12 L5-6)

P1 K "People... [HVs] they're just counted as numbers" (S4 L22).

One very experienced HV, however, had a contrasting view and did not feel her professional identity was in any way threatened by the changes:

P1 Q "...the changes people probably talk a lot about, but it doesn't bother me at all, because, done it all so many times, it's just more of the same." (S5 L5-8).

Similarly, three more very experienced HVs commented that they had 'seen it all before' as regards service changes, and that they believed change went around in cycles. Two appeared to have a more relaxed, philosophical, almost blasé attitude towards the process compared with most of the other participants. One, however, felt powerless to effect change.

11.3 Role Identity: The Effects of Service Changes

Analysis of the interviews showed that overall, participants remained steadfast in what they perceived their professional role to be. However, almost all reported that the changes threatened, restricted, or compromised their ability to carry out their HV role effectively, in a way that aligned with their perception of 'best practice' and adherence to the Code (NMC, 2018).

11.3.1 Core dimension: Professional autonomy, agency and caseload ownership

(Linked with *'Uniqueness and complexity of the HV role'*)

Almost all participants spoke, or showed evidence of their belief that autonomy, agency and caseload ownership (in the sense of continuity of care and professional accountability) were fundamental to safe and effective practice. All (19/19) referred to a sense of limitation regarding what they could, or were directed by management to, provide for clients in practice. This was either because of the way the work was now managed (especially work allocation), the increasing culture of performativity, and/or staff shortages. There was a sense that HVs' professional worth and status was not recognised by management and decision-makers. For example, one very experienced HV spoke directly of how less contact with her team, the changes to practice guidelines, and the new style of work allocation had removed her sense of professional autonomy and caseload ownership:

P1 B "That [lack of team contact] also makes it difficult to take ownership of the caseload as a whole compared to previously when we were more autonomous practitioners, that we really are not anymore." (S2 L13-16)

adding:

"Guidelines have become fact, whereas in fact to just have it as a guideline and use your own judgement." (S21 L21-23)

also:

"...you're getting work on a really...basically a 'taxi-cab' principle...you're being allocated work" (S22 L1-3).

Another commonly held view was expressed by two experienced HVs:

P1 R "I don't feel there's scope now, as a health visitor to be able to delve deeper into some of the things you identify [...] because we're not commissioned to go any further" (S11 L25-29)

P1 S "Because of the changes, and because of what we are not allowed to do [...] I'm not *allowed* to do baby massage, I'm not *allowed* to do the groups" (S10 L2-6).

However, most participants continued to show evidence of autonomy, agency and ownership in their practice in their accounts, particularly with clients identified as requiring a more on-going service beyond the 'universal offer' (five statutory contacts/visits). One experienced participant commented:

P1 D "...you've still got a bit of autonomy" (S6 L34-35).

This sense of professional autonomy, agency and ownership appeared to over-ride the service changes imposed upon the participants, all of them evidencing their commitment to the professional value of the *primacy of client care* and prioritising their needs. The theme of time underpinned two experienced participants exercising autonomy in providing further support to clients and being client-led:

P1 S "...she had a lot *longer* than she *should've* had with the team" (S42 L25-26)

P1 B "I probably couldn't 'tick too many boxes' on the outcome, but it felt like a very valuable visit, and mum and dad both, I felt I'd got positive feedback from them." (S13 L15-18)

and in describing group child development checks:

"They all took an hour, not forty-five minutes that's allocated, but *that's* fine because it was their time and that's what they felt was needed." (S13 L64-67).

Interestingly, the NQHV who had joined the service after the commencement of the service changes (and thus whose overall contribution was not appropriate to analyse in this section), evidenced an awareness that what she felt she was directed to do sometimes needed over-riding in order to meet clients' needs, thus showing autonomy in her thinking:

P1 O "I'm going back [...] to do the visit I was *supposed* to be doing." (S6 L3-5)

"...you seem to get a much better response than going in [...] with your own agenda [rather than] ... 'tick-boxes'" (S18 L16-18).

Deeply concerning was the contribution of one experienced HV in describing a serious incident she was involved in:

P1 K "...it was *all* what I had chosen to do for that client protected me. None of the changes or target-driven things [...] would have saved me from this situation happening recently..."

adding:

"...that worries me professionally" (S6 L29-35).

Her feeling of vulnerability was clear. It appeared that if she had not practised autonomously, she could have been placed in a very challenging position, both professionally and personally.

11.3.2 Core dimension: Uniqueness and complexity of the HV role

The 'human element' of practice, especially the importance of face-to-face client contact in order to build strong professional-client relationships, holistically assess need, provide support and guidance, was evidenced by all (19/19) as essential for effective working. The complex and diverse nature of the role was also evidenced by the majority in their accounts.

There were several aspects of the uniqueness and complexity of HV practice that were reported to be negatively affected, at least in part, by the changes, in particular those relating to standardisation and administrative practices. Changes to practice included the increasing use of forms, such as questionnaires for use with clients and record-keeping templates ('tick-boxes'), designed to standardise practice and as an audit tool for measuring key performance indicators (KPIs). Two main issues cited were the excessive time taken to complete the forms, and the underlying rationale for using them, either for assessing clients' needs or to audit health visiting practice.

Negative effects of service change

Over half (12/19), commented directly that at least one area of their practice was negatively affected by these changes. Of those who did not (7/19), other concerns were focussed upon. Also, 2/7 were NQHVs of less than a year and therefore had little experience of the role, or the role as practised before the changes. One very experienced and confident participant commented about how she placed her experience above audit processes, completing 'tick-boxes' just enough to demonstrate compliance.

Five out of 12 referred to excessive administration duties, two stating that these took time away from client care, for example:

P1 T "Now you spend probably seventy percent of your time on the computer which is *ridiculous*." (S13 L27-29)

P1 P "...trying to get everything done...not so much what's best for clients...worrying because there's things you haven't done...all the admin." (S6 L6-8, 13-14).

The use of questionnaires/audit tools to assess client need, above HVs' skills and expertise, was referred to by 3/12. One very experienced participant spoke at length about how HV practice was

becoming increasingly “process-driven”, threatening to remove the “person’s side” from the work (P1 B, S25 L2-4). Face-to-face client contact, using her professional skills of intuition, perception, inquisitiveness and experience could not be replaced by a standardised form to make an assessment. Speaking about the government’s drive for the “digitalisation of everything” (S25 L6), P1 B reported:

“Which would *possibly* meet a lot of need, but it’s never going to be able to measure people’s feelings...you could send people a mental health assessment form in the post or ask them to complete it online; that’s not the same as looking at somebody and reading their non-verbal communication.” (S25 L7-14)

P1 F, commenting on the directive to use assessment questionnaires:

“I feel I’m expected to be more robotic in what I do and I *cannot* do that; it goes against everything that I am” (S17 L24-27).

Three out of 12 were concerned about the misuse of record template tools (‘tick-boxes’) to audit HV complex practice. Power (1997: 95) posed the question of how ‘...this world of accounts and related forms of audit’ can relate to more diverse and complex activities such as ‘...curing the sick’. Power (1997: 143) questions whether audit is in danger of subsuming ‘performance and quality’, and that it should always be asked ‘...whether the tail may be wagging the dog’. One experienced participant echoed Power’s (1997) exact words, when questioning the volume of administration and meetings over practice:

P1 J “...the amount of record-keeping and form-filling and meetings and *obviously* you *do* need those things [...] but somehow it feels like ‘the tail wagging the dog’.” (S12 L10-13).

Seven out of 12 considered that the sense that productivity was taking priority over the ‘human element’, for example:

P1 K “People...they’re just counted as numbers” (S4 L22)

P1 R “...the way things are now it’s all about meeting KPIs and ‘ticking boxes’ and pleasing commissioners. It’s no longer about what people that you’re visiting want from a health visitor” (S3 L6-11).

The uniqueness and complexity of health visiting was not recognised in the changes by 4/12, for example:

P1 B “...there’s a lot of ‘boxes to tick’, around, ‘did you do this, this, this’; ‘have you done that, that, that?’ All good and necessary stuff. But it can *feel* now quite ‘process-driven’, whereas the visit ...was more about sitting back and listening to those parents and what their needs were [...] *really, really, really* active listening.” (S16 L4-12)

Another, reporting on changes increasing the amount of what was directed to be covered in a new birth visit, spoke of the reality of practice:

P1 K “And that doesn’t take into account if you turn up at the home, the mum’s crying [...] needs help with breast feeding [...] toddlers running around [...] things going on in the home, baby crying, baby needs nappy changed...” (S7 L26-29, 32-34)

and:

“...you’ve got this eighteen ‘tick-box’ list [...] as well as getting all the health promotion over and at what point will the mother ‘switch off’ anyway?” (S7 L35-38).

Reflecting on practice

Reflection is essential in health visiting, especially as its practise is so complex.

Over a quarter (6/19) spoke directly of a lack of time to reflect on their work and themselves as HVs:

P1 M (NQHV) “...the day is so busy [...] you’re *meant* to reflect and have time to reflect in your day, especially it’s important with this job [...] the *time* and the ‘head space’ to do that is quite difficult as you’re constantly ‘on the go’...” (S27 L3-8)

adding:

“...especially for me being newly qualified – I’ve got all this *new* information, *new* job role, *lots* of changes” (S27 L15-17)

P1 C “.... A good day at work is when...I have time to sit down and reflect on my day” (S22 L1-3).

Regular attendance at ‘restorative supervision’ sessions was mandated by the employing organisation. The primary focus was to discuss specific cases presented by HVs for reflection and discussion. Of the 4/19 who mentioned supervision, all experienced difficulties with it. A very experienced participant viewed it as not helpful, as the time between sessions was too lengthy for any guidance from colleagues to be of use for current client cases. An NQHV found it helpful, but the negative emotions amongst colleagues attending had had a detrimental emotional effect on her. Another found the practicalities of time taken to travel to a distant location and clashes with other commitments difficult. The fourth participant viewed it cynically as put in place primarily for the image of the organisation in fulfilling its duty of care.

11.3.3 Core dimension: Enact professional values/personal values

There was no evidence that the changes had any significant impact on the professional values HVs held as described in 10.4.1. However, the impact of the changes did affect how these values were realised in practice due to constraints such as time. HVs’ sense of their professional worth and recognition as professionals was undermined.

Time with clients

The increasing time taken up with administration duties, compounded by staff shortages, directly impacted upon client care as it reduced the time spent with them. This was summarised by P1 B describing the unmet needs of families as not considered high priority by the service generally:

"...those families that could do with a little bit of support but are not high level of need just don't get a 'look-in' at the moment." (S2 L3-6).

Almost all (17/19) spoke directly about the lack of time to work effectively. Five commented on excessive administration duties, of which two stated directly that this took time away from client care. P1 I, responding to a client's request for support commented:

"I made an appointment for a couple of weeks later because that's when I could *actually* fit her in, which is awful [...] but that's how it is at the moment" (S5 L8, 10-13).

Regarding the lack of time to be effective, P1 E stated:

"I don't feel we've got the time to give them what they [clients] need, because it's all about 'you have to do this, 'you have to do that', 'to complete that', 'so, tick-box' that'" (S4 L3-6)

P1 L added that time pressures were distracting:

"...even though I'm there with families [...] I'm still thinking, what else have I got to do [...] and I kind of don't feel I've got the mental capacity to give myself to them a hundred per cent." (S2 L15-20).

This links directly with supporting clients and being optimally effective as an HV.

However, a few very experienced and confident participants worked in a way that enabled them to give as much time as they could to their clients, exercising a degree of autonomy in managing their own time:

P1 B "...they're one of those families that maybe just need a little bit of time. Not very often, once every three months or something" (S13 L22-25)

P1 T "...you spend so much time with them compared with other professionals" (S18 L5-7).

Communication with clients

The service changes had also impacted upon communication with clients according to almost all participants. As aforementioned, client contacts were now more prescribed and directed so that they could be audited to monitor KPIs. The sense of the 'human element' was diminishing not only in the health visiting service but more widely in society, as previously discussed. Another means of communication with clients and the general public that was affected by the changes was the mandatory wearing of the corporate lanyard as discussed in 11.2.4.

Support as central to client care

In reviewing the participants' experiences of the impact of the service changes on their time and communication with clients, it became obvious that their ability to optimally support clients and provide a universal service was being negatively impacted. Almost all the participants (and P1 V) felt they could not provide the service to clients that they aspired to. However, there were exceptions

as most of the experienced HVs seemed to manage their time in a way that overcame the time-restrictions, enabling them to come closer to providing the level of client care.

One specific group of HVs shared a concern that they could not provide an optimum service to their clients. These were the seven HVs trained between 2011 and 2015 as part of the government's drive to increase HV numbers through the HVIP ((Health Visitor Implementation Plan (DH, 2011a)).

Summarising for all, P1 R stated:

"I just feel that *this* isn't the job that I signed up to do. I feel like there's a 'big cloud' hanging over me; I feel I'm working desperately *hard* [...] feeling 'weighed down' [...] 'squeezed'." (S2 L12-19 (Figure 10)



Figure 10 Collage by participant R – Stage 1 interview

P1 E, commenting on the contrast between when she qualified and now:

"...it was completely different; it was very focussed [...] all these extra health visitors [...] and then completely opposite six years 'down the line'." (S12 L10-12, 14-15)

Another from HVIP cohort stated:

P1 P "The Health Visitor Implementation Programme was a *great* thing, and then they stopped that and just pretty much forgot about us" (S31 L14-17).

11.3.4 Core dimension: Emotional and personal commitment, investment and attachment

All (20/20) (including the participant newly in post) reported a very strong personal attachment to health visiting and showed evidence of the psychological rewards of practice. However, over one-

third (8/19) reported that the overall effects of the changes on their professional identity had resulted in them contemplating or desiring to resign from post.

11.3.5 Core dimension: Inter-professional working

The Corporate Service plan introduced corporate working between HVs, Community Nursery Nurses and former Children's Centre staff (now known as Family Base staff). This raised a mixture of comments and/or concerns from almost all (17/19) participants. The two who did not comment directly, presented as overwhelmed with other issues. Difficulties with communication, time, IPW support, and professional worth and recognition surfaced, as summarised below:

'Promised' improvements

The positive impact that HVs reported that the organisation had 'promised' was not being realised, for example:

P1 T "I think they [management for the Corporate Service] made a lot of promises of putting in a lot of support but we're finding, you know, that they're not actually equipped or staffed...we're kind of left doing all that part as well." (S7 L2-4, 6-7)

Four out of 19 also reported that the new arrangements were creating a heavier HV workload:

P1 N "I think at the beginning [...] it was all *really, really* positive." (S11 L6-10) "I thought the whole point of the [corporate] service was to *improve* things, but if they're not taking referral then that's obviously going to increase *our* caseload" (S13 L3-7).

De-skilling

The traditional work carried out by HVs now transferred to other interprofessional working (IPW) colleagues:

P1 D "I'm actually feeling increasingly de-skilled, actually, so it's almost making me doubt what am I?" (S9 L11-14)

P1 L "...health visitor roles are being depleted" (S12 L20-21).

Appropriate skill level

There could be risks attached to employing less qualified staff to do 'HV work', such as health assessments as observed by P1 I:

"I think one of the concerns that health visitors have is that we just don't know what people's skills are who work for the [Family Base]. They seem to come from a range of backgrounds" (S36 L5-9)

"...we don't know what their level of assessment is, their level of risk" (S36 L14-15).

Role definition

Two participants commented:

P1 C "...it wasn't very clear what *exactly* their roles [Family Base staff] are going to be, and how and what difference our roles are going to be." (S17 L2-5)

"...some of the roles are quite ambiguous" (S18 L23)

P1 B "I think we need to be quite clear about what roles people are doing." (S10 L8-10).

A further participant thought that the time to develop a realistic and effective service plan was grossly inadequate:

P1 H "...oh, you've got half an hour to have a 'bunfight' about obesity [...] review this data"; well, I can't look at it properly; don't expect me to come up with something sensible" (*cynical, humorous tone*) (S20 L25-29).

Effects of re-structuring

The previous positive working relationship and practice with the original Children's Centre staff was thought to have been lost through restructuring. Commenting on working alongside the Children's Centres previously, over a quarter (5/19) felt a sense of loss, as summarised:

P1 K "...it worked brilliantly" (S15 L13)

Out of these five, three felt that due to the restructuring of the work and the reduction in Family Base staff (compared to the original Children's Centre staff numbers) the working relationship between HVs and the new Family Base staff had weakened. For example:

P1 N "...the working relationship was different, but now it feels very – almost like prescribed" (S11 L16-18)

"I don't feel as now...you could just pop in and talk to a member of the [Family Base] staff like you could do before, because they're not always there" "...I feel that that relationship has been lost along the way...don't get me wrong; the staff are *lovely*, but [...] it doesn't feel how it used to feel" (S12 L5-8, 11-14).

Another very experienced HV stated:

P1 H "...everything from what went on before was being *destroyed*, so everything was being *thrown away*" (S20 L38-39)

adding:

"...that's been presented as something that's somehow going to cause an *efficiency* within health visiting, but...that's not true; we were all working very closely together *before*" (S22 L6-10).

Potential benefits from the Corporate Service plan

Almost half (8/19) acknowledged that the Corporate Service plan was still in an embryonic phase and its full impact on HVs was yet to be experienced:

P1 J "I suppose it's a bit early to tell with the [Family Bases]" (S5 L19-20)

P1 G "Well, hopefully it's going to be a lot more 'joined-up' and seamless...we're just kind of trying to understand it." (S13 L3-6).

A few participants showed hope and positivity. Two very experienced HVs commented:

P1 Q "...in theory it's *absolutely brilliant* [...] there are *huge* possibilities for us all working together, once they [Family Bases] get staffed" (S17 L5, 11-12)

P1 B "I think actually a lot of it will be good (S10 L6-7).

One NQHV, although not having had previous experience of working with local Children's Centres, also commented on the potential benefits of IPW:

P1 M "...we've got ...more *clinical* things to think about in clinic [...] so I think actually it probably works quite well having health visitors, nursery nurses and the [Family Base] workers all together" (S16 L8-11).

Working with other professional colleagues:

IPW with other staff such as GPs was mentioned, but comments were in the minority. Reflecting on now being placed in bigger teams, one participant commented that they were regrettably losing contact with local GPs, who no longer understood the role of the HV. She felt that this affected her sense of professional worth and recognition:

P1 D "I enjoyed being GP-attached. I enjoyed being part of a *small-ish* team in a community with several small-ish teams and [...] regular meet-ups" (S12 L1-4)

"I kind of feel like links to GP surgeries are...in *my* experience kind of being lost, and so they're losing sight of what service we offer *now*." (S12 L6-9).

11.3.6 Core dimension: Public worth and value

All (19/19) commented that clients generally valued the health visiting service. However, over half (12/19) evidenced that the impact of being on the front-line interfacing directly with clients during the changes was challenging both professionally and personally. This was for reasons previously discussed, for example staff shortages and difficulties in implementing the Corporate Service plan. HVs also felt that their professional worth was not being sufficiently recognised by the organisation, policy and decision-makers:

P1 E "I think...slowly, we're losing our identity and I think it's just down to cost" (S19 L1-3) adding:

"...because...shortages of staff [...] I feel at the moment, as a health visitor and as a health visiting team, we *are letting down our families*" (S3 L11-12, 16-18).

However, one very confident and experienced participant spoke of the resilience of the health visiting profession and themselves despite on-going changes:

P1 H "...people still *need* us. We're 'pitched and tossed' around a little...by how our organisations respond to whatever the political agenda is...but were still 'floating'! (*laughs*)" (S33 L11-16).

This linked to several who spoke philosophically about changes that go in cycles, indicating that the profession was ultimately resilient.

11.4 The Public Face of Health Visitors' Professional Identity: The Effects of Service Changes

11.4.1 Core dimension: Status and role as public health nurses

(Linked with '*Public understanding and recognition of the HV role*')

As stated, only HVs' views were sought, therefore it is unknown how the public viewed HVs' professional identity.

HVs' sense of professional worth and recognition was also highlighted when reflecting on their public identity. Many spoke about the impact of the service changes on clients, and several commented upon the impact on the public from their perspective. A few others spoke broadly of how the possible future changes to their traditional HV role, for example if the universal service remit is lost, would, in their opinion, have a negative impact on the public. Two NQHVs felt that their status had diminished when compared with their previous recent nursing roles.

Linked with the collective identity of the profession as viewed by the public, one participant said:

P1 L "...speaking to clients who've been really disappointed with what has changed, with the previous provisions that have been on offer for them [...] you still have to put a 'brave face' on because you don't want to, obviously, bring a bad reputation [...] to the [employing organisation]" (S7 L36-43).

11.4.2 Core dimension: Public understanding and recognition of the HV role

This centred around HVs' identity and ability to present themselves as NHS workers so that the public would know who they were and that they could be trusted.

Over a quarter (5/19) commented directly that the changes negatively affected their identity as belonging to the NHS, and four of these recognised that, as healthcare professionals, working for the NHS was very important. As previously discussed, the importance of wearing the NHS lanyard was referred to:

P1 F "...we *don't* wear a uniform [...] but the visual lanyard is very obvious for *families* to recognise [...] I go into families where they've come from all different parts of the world and they *recognise* that lanyard and therefore they *recognise* I'm a safe person to be coming into their home." (S11 L20, 23-24, 29-33).

11.5 Health Visitors' Professional Identity in the Context of Change Implementation

The HVs' views and feelings towards the nature of the changes, how the change decisions were made, by whom, and in the way that they were implemented were analysed.

A number of implications of the changes, such as a change of 'branding', i.e., moving away from a clear NHS identity, the increasing amount of administration, and arrangements record-keeping and audit tools, have been previously discussed. Participants frequently commented on further aspects of the management of change, namely:

- Rate of change
- Communication between HVs and management
- HVs' support received from immediate management.

11.5.1 Rate of change

Over a quarter (5/19) spoke directly about the excessive speed and relentlessness of the changes:

P1 F "We've had multiple, multiple changes, daily changes..." (S8 L9-10)

P1 S "...they're *ongoing* changes, so *every day*, every meeting, month to month and day to day, *bombarded with the changes.*" (S8 L25-27).

Negative feelings and low morale were largely attributed to the speed of the changes. Two participants spoke of colleagues' negativity also affecting them, reducing their sense of collegiality.

11.5.2 Communication between health visitors and the organisation

Reference to 'management' was commented on by all (19/19). This referred either to immediate managers, (team leaders/locality managers), their employing organisation's senior decision-makers, or the government and policy-makers. Two participants (2/19) made all positive comments.

As well as the speed of the implementation of the changes, almost half (9/19) of the participants commented directly about their experience of confusion and/or lack of clarity regarding them, summarised by:

P1 P "...there's loads of changes going on; no-one really knows what's happening. People keep changing things, saying "oh, this is going to happen, but we don't know when [...] everyone's sort of running around not sure what's happening" (S2 L12-17).

HVs frequently remarked that there was a lack of clear communication even between varying levels of management:

P1 C "...it's just been muddled, really, and I think they're [team leaders] trying their best to get out of the muddle themselves." (S19 L14-16)

and:

"It's very much come from 'top-down', so... I think if they [team leaders] weren't ever really clear of what was going on or what was happening [...] they haven't really been able to tell us." (S19 L18-22).

Another remarked:

P1 A "...all the unknown about the job" (S1 L27)

"...we've no clue about what we're doing" (S20 L9-10).

Two commented that they were also confused about the terminology associated with the changes, for example:

P1 J "...and everything's called 'hub', so you don't know what you're talking about, when you're talking about 'hubs' – this one? That one?" (S15 L68-9) (*chuckling*).

One very experienced participant commented about the changes of professional colleagues' titles:

P1 H "...the whole name thing is a bit confusing, the name of the nursery nurses...I don't know what is it?" (S24 L17-19)

"I'm a *health visitor still*, apparently" (*cynical, amused tone*) (S25 L2).

This links with the overall service change to corporate identity, which some participants found distressing (see 11.2.4). HVs felt that their identity as NHS staff was being subsumed by corporate 'branding'.

One very experienced HV expressed that a lack of clarity was far-reaching:

P1 K "I don't even feel that the management are aware of where we're going with the health visiting either, so that makes me feel insecure." (S3 L17-20).

Almost half (9/19) reported that they had not been consulted about the decisions regarding change and, of these, five also commented about the lack of clarity. It was considered a missed opportunity in not using HVs as a key resource with their local knowledge and understanding of client health needs. There was a consensus that HVs were in an optimal position as they interfaced with clients directly and knew what changes were likely to work 'on the ground', and what would be likely to fail. In this sense, the HVs thought their agency in effecting their future practice had been denied. This negatively affected their sense of professional worth and recognition.

P1 L remarked:

"...getting their [the staff's] opinions because they're the ones doing the job day to day [...] I just don't see how you don't have that knowledge that you can make such big decisions and big changes." (S15 L11-13, 17-19).

Another two participants summarised for many:

P1 E "...all the changes; it should have been a 'bottom-up' approach rather than a 'top-down' approach." (S6 L10-12)

"...we should have been consulted from 'Day One' [...] and for us to be valued in those decisions." (S7 L1-5)

P1 K "...we're not kept 'in the loop' [...] we are just told we are going to do this" (S4 L9-10).

Three of those who commented on the lack of consultation (3/9) went further. P1 A expressed that when HVs did offer suggestions, the response was:

“... [the organisation] ‘chop people’s heads off’ when they try to come up with ideas [...] and then people then don’t say anything who just keep it to themselves.” (S24 L11-14)

similarly:

P1 P “...we had a big meeting where boss’s boss’s boss whoever came to listen to our things but that’s happened before and nothing changes so it’s like a ‘tick-box’ for them to say they’ve listened to our colleagues [...] but then they don’t change anything so it’s a bit pointless really.” (S15 L2-10).

The other believed that the lack of real communication between HVs and management was a protective mechanism for the managers themselves:

P1 I “...I feel like senior management don’t want to deal with us face-to-face because maybe they don’t want to hear those things [lack of the ‘human element’]. If they don’t hear those things, they don’t exist.” (S29 L8-11).

Almost half (9/19) showed evidence of feeling that there was lack of clear and open communication with their organisation. Summarised thus:

P1 I “...higher management is not visible at all” (S26 L17).

However, one very experienced HV felt differently, and commented that she was aware that she was in the minority with her views regarding the changes. Speaking of the financial reality of the budget restrictions she remarked:

P1 Q “...I think it’s all done very *fairly* and I think we’re involved a lot. I really *do*; I really admire how well they [management] *involve* people.” (S20 L7-10)

And regarding meetings between HVs and management:

“...had meetings, big massive things so we could contribute and I think a lot of that has been taken into account. I think it’s managed very well.” (S20 L12-14).

Over a quarter (5/19) (and P1 V) reported that they believed that their organisation did not understand the role of the HV, resulting in changes that led to unachievable expectations. Four out of five of these HVs also felt that this left them and/or their clients vulnerable. This also led to a sense of powerlessness through HV’s inability to exercise their professional agency, reported by over a quarter (6/19) (and P1 V), for example:

P1 T “...we’re very much... ‘top-led’...I feel quite powerless because I don’t feel that my personal opinions can influence the service.” (S4 L21, 23-25.)

P1 A expressed this in even stronger terms:

“...people are being forced to do things [...] it’s just not nice” (S4 L22, 24).

11.5.3 Immediate management support

Support for HVs to fulfil their role from management had the most mixed response. Only data recording participants' experience of their support from their immediate managers has been included in this section, as comments regarding higher-level management has already been discussed. This is specifically the support that directly affected their working environment, particularly in providing "...emotional [...] and practical support" (P1 I, S13 L12-13), and thus affected their practice.

Over half (10/19) reported that they experienced support (to varying degrees) through the changes from their immediate managers that boosted their sense of professional worth and recognition. Of the remainder, 2/9 did not comment directly, but evidenced support in their contribution. Support from immediate managers was acknowledged by 3/19 as complex and compromised.

Positive support was summarised thus:

P1 N "Team leader's very...very approachable, very supportive, flexible...I think that makes a big difference having a strong team leader." (S21 L3-4, 6-7)

P1 G "...they're [immediate managers] working really hard to make it a much better working environment for us." (S9 L6-8).

Two participants who did not feel supported thought that only clinical issues were being addressed, not emotional nurturing. P1 T, a very experienced HV, said:

"...there isn't any capacity to be nurtured, I don't think. Well, there *should* be." (S13 L15-16).

11.6 Emergent Themes from the Stage 1 Interviews

Themes emerged from the data as the HVs described what they understood was required for them to work effectively and efficiently with clients. These themes also summarised factors within practice that were affected by the services changes. At the end of the Stage 1 interview analysis these themes were grouped together with other related themes to create four over-arching super-ordinate themes through analytic subsumption as described in 9.2.5 and shown in Table 9. The super-ordinate themes were communication, time, support and professional worth and recognition and formed a framework for analysing the data on the core dimensions. These will be considered further in the analysis of the Stage 2 and 3 interviews. At this point it was decided that saturation was complete as no new themes had emerged (see 8.2).

Table 9 Super-ordinate themes

Super-ordinate theme	Emergent themes
Communication	Meaningful or ineffective communication: <ul style="list-style-type: none"> • with clients • with colleagues • with management • the public
Time	Sufficient or lack of time to: <ul style="list-style-type: none"> • manage increasing caseloads • fully assess client needs • provide sufficient client care • complete administrative duties • reflect and plan care • have face-to-face contact with colleagues • keep abreast of service change directives • complete work within paid hours/achieve a work-life balance
Support	Positive or less than adequate level of support: <ul style="list-style-type: none"> • for clients • amongst colleagues • from management
Professional worth and recognition	Feeling respected as a professional and effective in practice, or otherwise: <ul style="list-style-type: none"> • respected by management • role understood by clients and the public • role appreciated by management and clients

11.7 Psychological Effects of Service Changes

11.7.1 Presentation of feelings/emotions

During the interviews, the participants showed complex, wide-ranging and inter-weaving feelings/emotions. These were evidenced through the words spoken and embodiment. The participants used emotive words to describe their feelings, views and experience of the impact of the changes on themselves as professionals, and how the effects on their HV colleagues affected them, and not least themselves as persons.

The embodiment of participants' feelings and emotions was most evident through their voice tone, facial expressions, gestures and body language. The art-making objects and pictures chosen depicted their feelings, and selected objects and materials were most often used as metaphors (see Appendix E). The choice of background colour, and the characteristics of the artefacts such as their texture and shape, enriched the meaning of their very personal contributions. For example, dry dull

colours or hard objects, such as stones for negative feelings, or soft bright objects such as feathers for positive feelings. Further examples are provided by the participants:

P1 E “I thought that was a lion! (*indicates to a picture of a dragon*) (*laughs*)...I think that would sum me up. I’m quite a strong person...however, with my job, sometimes I feel like that’s my brain; it’s just getting all muddled up...the red netting, that can sum up my brain sometimes with the workload” (S1 L12, 16-19, 21-22) (Figure 11)



Figure 11 Collage by participant E – Stage 1 interview

P1 P “I did wanna use black... (*for the background*) because I think for me personally, there’s a bit of a *shadow* in health visiting at the minute and I don’t think it’s, especially at the minute, a great profession to be in” (S29 L4, 8-11).

The prompt for the collage was very open and was interpreted by the participants in different ways. For some, the background colour represented how they currently felt about the profession, and for others it was who felt they were as persons as well as professionals. A few chose bright background colours, explaining that they considered themselves to be generally positive people, even though many of the materials chosen represented more negative views, thoughts and feelings. For example:

P1 J “...I’m quite bright...I like bright” (S30 L35), despite “...I’m in the middle and I’m trying to hold together all these bits, there’s bits on there a bit out of control” (S1 L3-5)

“The hairclips sort of *‘raining down’* are sort of the new ideas, initiative, training, changes...instructions from management [...] and that feels like *‘heavy rain’*” (S1 L27-31) (Figure 12)



Figure 12 Collage by participant J – Stage 1 interview

In contrast, for P1 Q, one of the changes proved to be motivational:

“...the top (of the collage) represents probably where I am *now* in health visiting and it's kind of quite 'chained down', weighed down from years of doing the same thing; the stones representing the *heaviness* I feel.” (S1 L3-8) (Figure 13)



Figure 13 Collage by participant Q – Stage 1 interview

P1 Q followed this by:

“...because we had the ‘new-born observation training’, which has given me a new ‘lease of life’ [...] so that’s why it’s got the pink feather and the baby and that was really exciting” (S1 L21-25)

P1 O (NQHV), although having had no exposure to the changes still identified herself as an HV through her collage (see Figure 2):

“...I’m a fairly sort of happy person, so the first thing that came into my mind was a flower” (S1 L2-4) and “...I feel like sort of the flower is growing [...] I’ve had quite a sort of steep learning curve” (S2 L3-5).

11.7.2 Analysis of feelings/emotions

The impact of the changes on HVs as persons and professionals was analysed through:

- Reading the transcriptions and identifying emotive words using a word search computer facility
- Listening again to the audio recordings
- This researcher’s interpretation, based on how the participants presented themselves. For example, through their body language, gestures and voice tone, requiring conscious reflexive engagement. (Interpretations were checked against the participants’ verbal reports and presentations of their feelings/emotions)
- Identifying representative feelings and emotions
- Assessing the occurrence of the feelings and emotions, either spoken or interpreted through participants’ presentation of themselves or their collages.

It is acknowledged that this represents a ‘snapshot’ of the participants’ perception of their experience of the changes on the interview day.

A list of 30 representative feelings/emotions were drawn up from the participants’ accounts. These were recorded only once per participant, irrespective of frequency, using the following categories:

- Spoken directly
- Interpreted by this researcher (as presented to her by the participants themselves)
- Presented ambivalently (as partial, qualified or contradicted).

Table 10 summarises these feelings/emotions for all participants (except for P1 V as she was not interviewed in person), together with totals for each according to the way they had been expressed. The negative feelings/emotions presented, such as devalued/undervalued, were how HVs’ felt about the changes themselves or those deciding on or implementing the changes.

Table 10 Participants' feelings/emotions as presented in Stage 1 interviews

STAGE 1b	Feeling / emotion keyword																														
Participant	positive / hopeful	happy / accepting	de-skilled	(sense of) loss (of id)	undervalued / devalued	disillusioned / 'let down'	disheartened	demotivated	disappointed / deflated	disempowered	disrespected	insecure / destabilised / unsettled	vulnerable	isolated / alone	"trapped"	resigned	sad / unhappy	worried / concerned	upset/tearful	anxious	work stressed	panicky/fearful/"on the edge"	distressed	depressed	tired / exhausted	pressured / overwhelmed	confused	frustrated	cross / irritated / annoyed	angry	
P1A	A	A		I	I	I	I		I	S	I	S	I				S	I	I	S	S	S	S			S	S	I	I		
P1B	A				S		I		I	I								S											S		
P1C	A	A							S											S	S				S	S	S	I			
P1D	A		S	S	S		S	I			S	S							S	S	S					S	S	S			
P1E				S	S	S	I		S	I	S		S		S		S	S		S	S	S				S	I	S	I		
P1F	A			S	S	I	I			S	S	I	S		S		S		I	S	S	S	S	S	S	S	S	S	S	S	
P1G	A	A							S			A				S	A														
P1H	S					S					I		S			I													S	S	
P1I					I	S	I			S	S		I				I	S		S	S					S	S	S	S	S	
P1J	A					S	S	I	S	S	S				A					S	S				S	S	S	S	S		
P1K				I	S	S	S	I	I	S	S	S	S		S		I	I	I	S	S	S				I	S	S	S	I	S
P1L					S	S	S	S	I	S	S	I	I				I	S		S	S	S				S	S	I	S	S	
P1M	S																			I	S					S					
P1N				S		S	S		S											S	S						S				
P1O	No exposure to service changes																														
P1P				S	S	S	S		I	S	S						S	S			I					S	S	S	S	S	
P1Q	S	S																													
P1R	A		S	S	S	S	S	S	I	S	S		I			S				I	I					S	I	I			
P1S	A					S	S		I	S	I	I		I		S				I	S	I				S	S	S	I		
P1T					I	S	I		I	S	S			S		S		S		S		S						S			
S – Spoken directly	3	1	2	6	8	11	8	2	5	10	10	3	4	1	3	1	7	5	1	7	13	8	3	1	5	14	9	13	6	2	
I - Researcher's interpretation	0	0	0	2	3	2	6	3	8	2	3	3	4	1	0	1	3	1	3	4	2	1	0	0	1	0	3	3	4	0	
A - Ambivalent	9	3	0	0	0	0	0	0	0	0	0	1	0	0	1	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	
Total	12	4	2	8	11	13	14	5	13	12	13	7	8	2	4	2	11	6	4	11	15	9	3	1	6	14	12	16	10	2	

Based on the above table, Figure 14 below details the occurrence of the feelings/emotions expressed by the participants in their initial interviews.

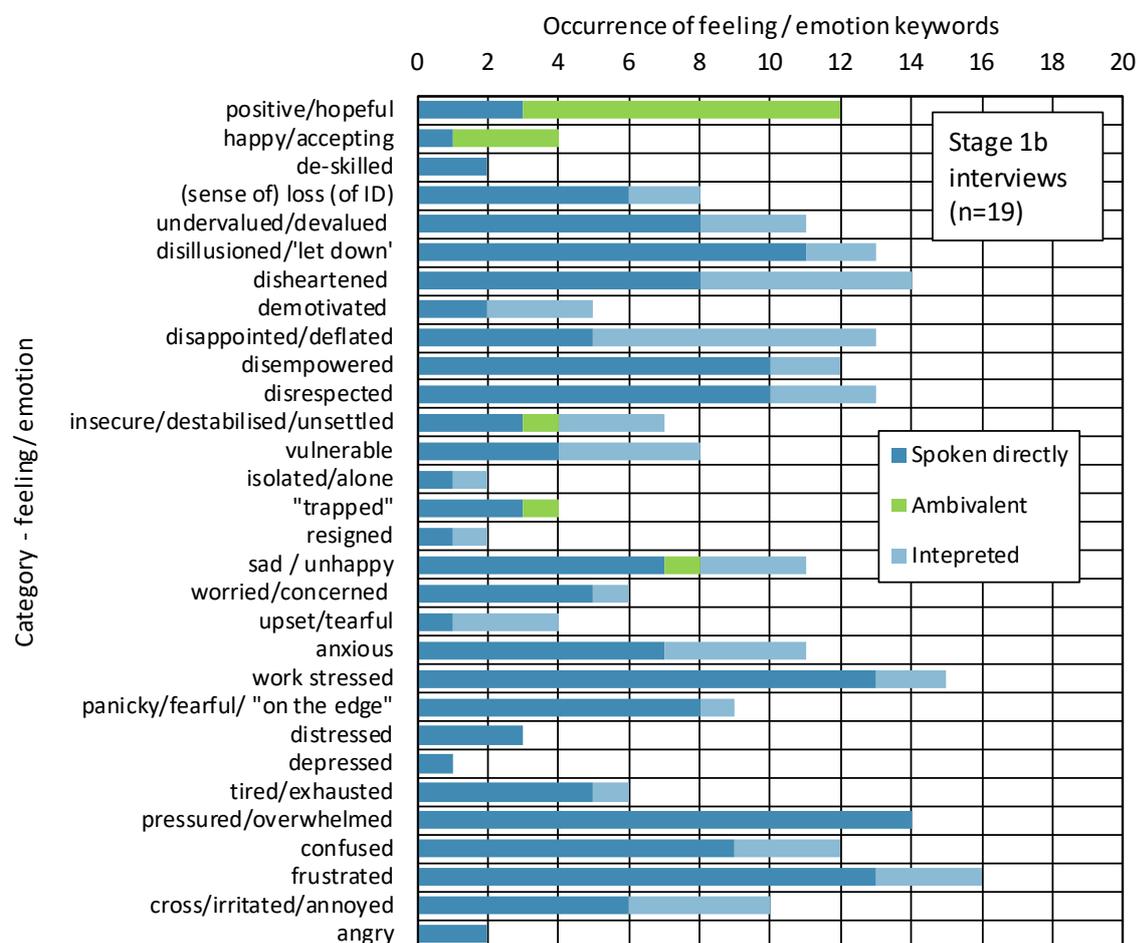


Figure 14 Stage 1 Interviews - Feelings/emotions expressed by the participants, directly, through researcher interpretation or ambivalently

The occurrence of feelings/emotions summarised in Table 10 have been broken down for each of the three categories (spoken, interpreted or ambivalent), and shown in Table 11 to Table 13. The tables show the number of times the feelings/emotions occurred, some of which were equally expressed.

Table 11 Occurrence of feelings/emotions spoken directly or embedded within what was said

Proportion of participants	Feelings/emotions spoken directly or embedded within what was said by participants	Occurrence (n/19)	Number of feelings/emotions
More than one half	pressured/overwhelmed	14	6
	frustrated work stressed	13	
	disillusioned/'let down'	11	
	disempowered disrespected	10	
One quarter to one half	confused	9	11
	undervalued/devalued disheartened panicky/fearful/"on the edge"	8	
	anxious sad/unhappy	7	
	(sense of) loss (of HV professional identity) cross/irritated/annoyed	6	
	tired/exhausted disappointed/deflated worried/concerned	5	
Less than one quarter	vulnerable	4	13
	distressed insecure/destabilised/unsettled "trapped" positive/hopeful	3	
	de-skilled demotivated angry	2	
	isolated/alone resigned upset/tearful depressed happy/accepting	1	

Table 12 Occurrence of interpreted feelings/emotions

Feelings/emotions spoken based on interpretation of body language/voice tone/gestures	Occurrence (n/19)
disappointment/deflated	8
disheartened	6
vulnerable anxious cross/irritated/annoyed	4
frustrated confused disrespected undervalued/devalued demotivated insecure/destabilised/unsettled sad/unhappy upset/tearful	3
work stressed disempowered disillusioned/'let down' loss (of HV professional identity)	2
isolated/alone resigned tired/exhausted worried/concerned panicky/fearful/"on the edge"	1

Table 13 Occurrence of feelings/emotions based on ambivalence of feelings/emotions in the accounts

Ambivalence of feelings/emotions in the accounts	Occurrence (n/19)
positive/hopeful	9
happy/accepting	3
insecure/destabilised/unsettled sad/unhappy "trapped"	1

The ambivalent feelings/emotions were by definition, partial, qualified or contradicted, and were not considered sufficiently reliable for further consideration in the analysis.

Figure 15 below shows the occurrence of feelings and emotions with the ambivalent category removed.

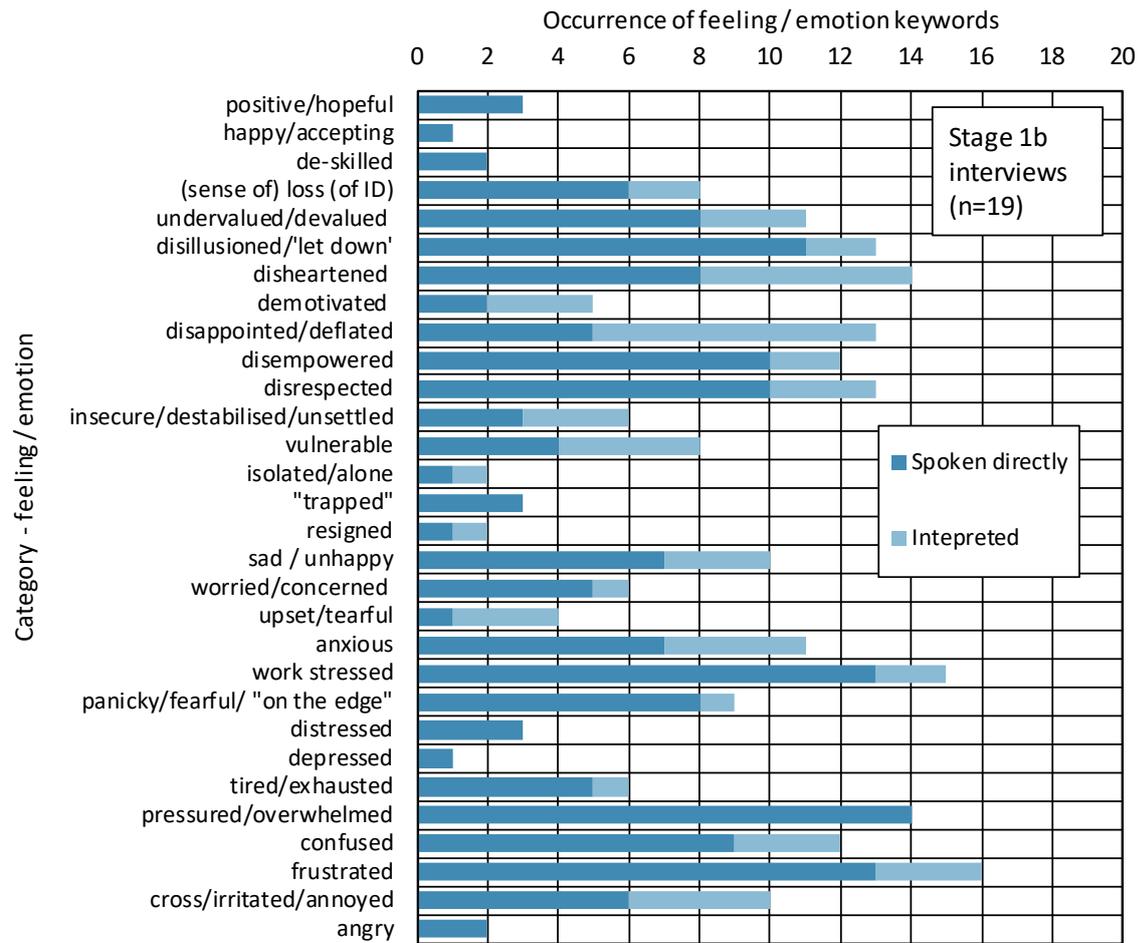


Figure 15 Feelings/emotions expressed by the participants directly or through researcher interpretation

11.7.3 Commonly occurring feelings/emotions

The most commonly occurring feelings/emotions have been identified, comprising those spoken directly, or as interpreted by this researcher, for over half of the participants (10+/19) in Table 14. These feelings/emotions were often inter-related and spoken of together.

Table 14 Thirteen feelings/emotions expressed in half or more of the interviews

Proportion of participants	Feelings/emotions either spoken of directly, and/or as interpreted by researcher	Occurrence (n/19)	Number of feelings/emotions
Half or more	frustrated	16	13
	work stressed	15	
	pressured/overwhelmed disheartened	14	
	disrespected disillusioned/‘let down’ disappointed/deflated	13	
	confused disempowered	12	
	undervalued/devalued anxious	11	
	sad/unhappy cross/irritated/annoyed	10	

The feeling/emotion most often revealed is *frustration* regarding the service changes. Although the actual word ‘frustration’ was seldom used directly, 13/19 described this emotion/feeling within their account. This researcher interpreted that a further three showed evidence of it in their body language/voice tone/gestures. Examples were:

P1 P “...there’s loads of changes going on, no-one knows what’s *happening*, people keep changing things and saying ‘oh, this is going to *happen* but we don’t know when [...] everyone’s sort of running around not sure what’s happening” (S2 L12-17) (Figure 16)

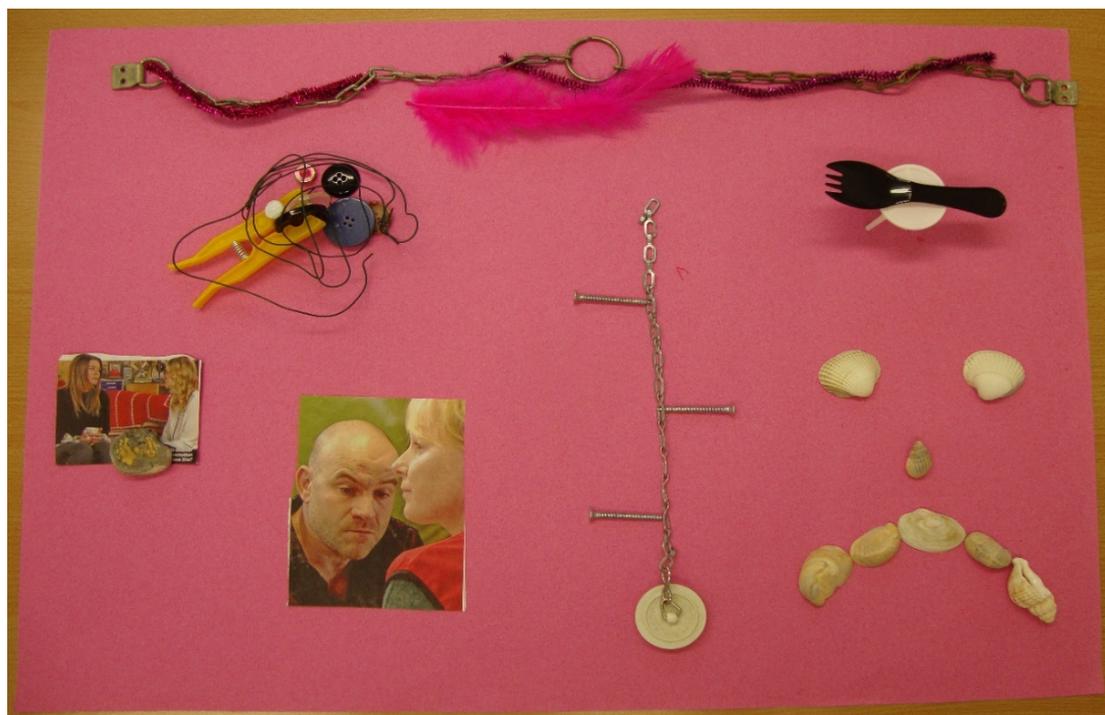


Figure 16 Collage by participant P – Stage1 interview

P1 P's collage depicted a sense of frustration and confusion:

"...so, I've got the peg that's holding different aspects of health visiting, so all the things we have to do...it can't hold all of them, so some of them sort of spilled on the floor" (S2 L2-6)

Significant *work stress* was revealed in 15/19 accounts. The practical implications of delivering a service with staff shortages through sickness and resignations was widely commented upon. Over half (11/19) (and P1 V in writing) attributed the stress and pressure of increased work to staff sickness, resignations and service redesign.

Alongside *work stress*, there was evidence of feeling *pressured/overwhelmed* and *disheartened* in 14/19 participants' contributions. This was summarised in one very startling, unsettling and powerful contribution offered by P1 S through metaphor and words. Indicating to the tangle of wire on her collage she gestured the placing of the wire on her head commenting:

"...that's what I see in people. Very stressed, very 'enjangled', really hard to get order...to be organised day to day. Just absolutely 'up to their eyes'." (S7 L3-7) (Figure 17).

Whether this participant intentionally or subconsciously was aligning herself and her colleagues with this religious connotation of defeat was not spoken of directly, but for this researcher the metaphor of a 'crown of thorns' was very clear.

P1 A also commented:

"I think the negativity came from all the changes rather than one big change [...] the changes are coming too fast and too many at once [...] can be overwhelming [...] depressing" (S2 L13-18)

P1 T, in her concluding comments in her interview summarised the *disheartened* feelings of 14 (14/19) participants:

"...it's just very sad that the way things are, have become." (S14 L33-34).

Feeling *disillusioned*/*'let down'*, and *disappointed/deflated* with regards to the impact of the changes was also experienced by 13/19 participants. This was summarised by P1 R:

"...everybody moans and everybody's disheartened and everybody's disillusioned." (S15 L9-10)

and of herself, comparing her role from on qualifying as an HVIP HV and now:

"...it was just a *fabulous, fabulous* time [...] then [...] all the changes started" (S1 L8-15)

"I just feel so demotivated...I just feel that *this* isn't the job that I signed up to do." (S2 L12-14)

"I'm constantly looking for other jobs." (S3 L19).

Alongside feelings of *confusion*, 12/19 claimed they felt *disempowered* and/or *disrespected* (13/19).

The reasons cited ranged between a lack of genuine consultation regarding future plans,

professional ideology and commitment, opinions and comments disregarded, new work allocation practices, and HVs' stress of unmanageable workloads. Summarised by:

P1 K "...we're not kept 'in the loop'...we are just told we are going to do this" (S4 L9-10).

Regarding one of the changes, P1 F reported:

"...nobody had *warned* us [...] nobody had *explained* it [...] there was no discussion, there was no *questioning* about things." (S9 L12-13, 16-17)

P1 B "You're a *highly-trained professional*. You should be able to practise safely in a more autonomous way." (S21 L25-27)

but added:

"...previously when we were more autonomous practitioners, that we really are not anymore." (S2 L13-16).

Over half (11/19) reported, showed evidence or were interpreted as feeling *anxious*. Seven of these also showed extremes of anxiety as *panicky/fearful*/"*on the edge*". A further two only showing extreme feelings:

P1 K "...it's fragile, so that's how I'm feeling at the moment [...] and that's to do with all the changes, the pressure" (S3 L13-16)

"...my mind is feeling [...] 'spiralling out of control'" (S3 L22-23).

The same number (11/19), presented as feeling *undervalued/devalued*. P1 P said:

"...we're just almost 'brushed off' and we're the ones who'er actually doing the work." (S16 L3-4).

There was evidence of *sadness/unhappiness* by over half (10/19) of the participants. A smaller but significant number presented as *upset/tearful* (4/19).

Commenting on the diminished HV role, P1 S describes it in terms of a very small group of feathers in one corner of her collage:

"It's a corner because it's small. And it's not how it should be [...] this shouldn't be like this; it should be bright, coloured, ordered and there should be more...it should be full of feathers and full of colour and soft [...] so, it's quite sad really, this is very sad." (S9 L12-20) (Figure 17)

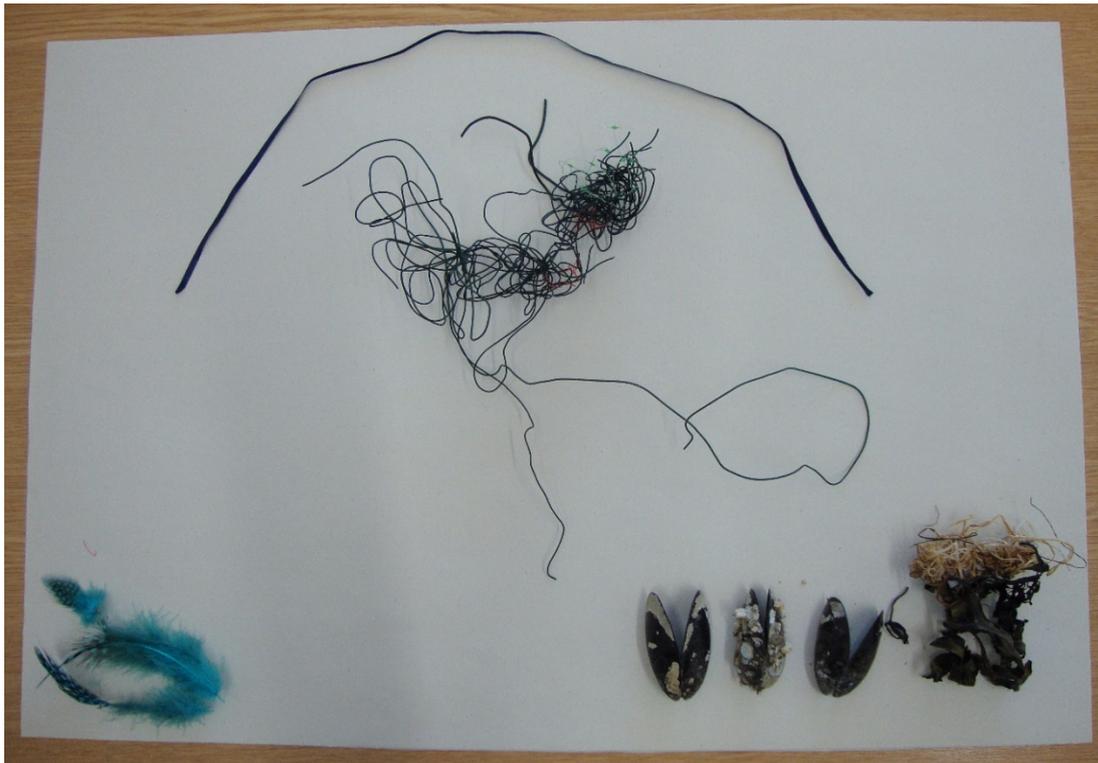


Figure 17 Collage by participant S – Stage 1 interview

All (19/19) showed a commitment to health visiting and belief in its worth to varying degrees. However, the overall consensus was that, due to the service changes, it was not a job that they currently enjoyed, and they were unable to fulfil their HV role as they understood it and believed it should be. This was summarised well by P1 P:

P1 P "I do love health visiting and I love the visits that we do and I love working with the clients" (S6 L1-2)

"And there are positives to health visiting *definitely*, and it's a *great* job...the *principle* of it I really enjoy." (S31 L1-3)

however, she qualified this:

"At the minute it's *not* a job that I enjoy...and I would leave if there was something that I would want to do, but I think there's a lot of people that are feeling the same way, so it's not just me." (S31 L5-9)

"...it's a *shame*, because it is, if you look at it on a piece of paper, it's a *lovely* job, but the practicalities of it I don't think at the moment are...(pause)...quite there." (S31 L11-14).

P1 A showed the mismatch between how she felt her practice should be and the reality of what it was. Her collage was in two halves:

P1 A "I've chosen these two colours because there's two ways I feel" (S1 L2-4)

"... the green one [...] is me offering my service to families [...] I sort of give them hope [...] I like to make a difference and I see that as a 'green line'." (S1 L4-7, 15-16),

and of the left-hand side:

"...brown [...] this is all the unknown about the job and with all the changes" (*pause, sigh*) (S1 L29-31) (Figure 18)



Figure 18 Collage by participant A – Stage 1 interview

The changes had also led to over half (10/19) of the participants feeling *cross, irritated or annoyed*, and two even *angry*.

11.7.4 Hope

Hope expressed by participants was complicated to analyse. It was difficult to distinguish between genuine hope for participants' future as HVs and, or, the future of the profession and, or, eventual outcome of the changes, or how they wished to present themselves. Some added that they felt hopeful as a 'rounding-up' comment near the end of the interview, interpreted as not wishing to present themselves as a negative personality or reactionary in their views.

Of the 12/19 participants who either spoke directly about hope, alluded to it, or spoke of it in qualified terms, this researcher interpreted that only 2/12 spoke about it wholeheartedly. The others spoke in terms of trying to remain hopeful, or only hopeful of some of the changes. For example, after evidencing very negative feelings/emotions regarding the impact of the changes, P1 R commented sadly:

"...maybe further 'down the line' things'll settle and it'll become the job I love again, so that's what I'm hoping but...yeah" (S14 L15-18).

Chapter 12 Analysis – Stage 2 Interviews: The Lived Experience of Service Changes Pre-Covid-19 Pandemic

12.1 Introduction

Data from the second interviews (n=8/20) was analysed in a similar way as the Stage 1 interviews. Additionally, an analysis of participants' reflective diaries if kept, with their permission, formed part of the data set. The four inter-related super-ordinate themes of communication, time, support and professional worth and recognition continued to be revealed through the participants' accounts. The psychological effects of change are discussed separately as before.

Commonalities and differences were loosely compared with the data from the Stage 1 interviews, but as this was a relatively small sub-sample compared to the original sample, comparisons are only provided to present a broad overview. Also, the interview schedules were flexible, and the topics commented upon by each participant in the interviews varied, therefore direct comparisons cannot be made.

Table 15 Summary of Stage 2 analysis

Timing	Stage 2 interviews held approximately 1 year after Stage 1 (prior to Covid-19)
Number of participants interviewed	n=8/20 - Two participants from the original sample of 20 were no longer available for interview
Information sought	<ul style="list-style-type: none"> • What it is like to be an HV living through change • HVs' lived experience of service changes mapped against core dimensions of their professional identity
Methods of analysis	<ul style="list-style-type: none"> • Audio recordings listened to and initial post-interview notes read • Line-by-line analysis of the transcriptions • Initial exploratory comments made • Commonalities and differences identified • Super-ordinate themes considered

12.2 Social Identity: The Effects of Service Changes

12.2.1 Core dimension: Self-identification with health visiting as a professional group

As previously, the changes had not affected HVs' commitment to the professional values, principles, 'orientation to practice' (Cowley et al., 2013: 11) (see 3.7) and ideology. Once again, no-one commented that the service changes had negatively affected their own sense of self-identification with HV profession. Comments by one participant summed this up for the group:

P2 C “I still feel the core substance of a health visitor remains the same [...] maybe how I construct my workload is slightly different” (S13 L1-4).

However, almost all (7/8) participants, similar in proportion to all (19/19) in the first interviews, commented on how the changes had negatively affected one or more aspects of their social identity. Only one participant showed evidence of sufficient time to reflect on her professional identity, and that was during a period off work through illness. This gave her the time to reflect on her role and update her knowledge, which resulted in increased motivation.

12.2.2 Core dimension: The sense of collegiality

The super-ordinate themes of communication, time and support again underpinned the participants’ comments regarding their sense of collegiality.

Three-quarters (6/8), a similar proportion as previously, commented about their experience of collegiality, five of these valued the support and positivity of working as a team, summarised as:

P2 I “...so we *do* get through it [pressure of changes/volume of workload] because we’re a team” (S2 L10-11).

However, one participant felt guilty that her stress was negatively affecting her team:

P2 G “...you can’t find your way out of it because you’re struggling the whole time; that makes you, as a team member, quite difficult or quite absent.” (S13 L7-8).

Regarding shared attitudes and behaviours, one participant felt very strongly that a change in the overall culture of the organisation had created divisions between herself and her HV colleagues:

P2 F “...the culture has *changed*, [...] less support, it’s more accusatory, if a visit’s not done in *time*, people get *blamed*.” (S2 L1-3)

adding that this created divisiveness between colleagues:

“...there’s a lot of criticism, and so people themselves within the teams are looking out for themselves, not supporting one another: Looking to ‘shift blame’. There was quite a bit of bullying going on and so it just got *worse*; a lot *worse*.” (S2 L4-7).

Two of the three changes affecting participants’ sense of collegiality discussed in the Stage 1 interviews surfaced again:

- Team restructuring and relocation of smaller teams into larger teams with a central base (‘hub’)
- Increased focus on mobile working.

The restructuring of teams

For those who commented about team restructuring, and for some team relocation, there was a mixed response. It appeared to depend upon individual circumstances, such as the functioning of

the former team, workload, distance from new hub and practicalities such as parking. There was a marked difference between the minority who benefitted and those who did not:

P2 C (diary entry, 27-08-19) “I feel I have really gelled well with my new team; everyone seems really supportive.”

and:

(diary entry, 03-03-19) “Feeling much more positive about the changes.” “I do feel having new team mates, new team leads [who listen more] a new base have improved my working environment [...] I feel things are settling; I feel a better sense of control and support again.”.

P2 K, a very experienced HV, following her transfer to a small office and, facing practical difficulties precluding her from joining colleagues in a central hub, commented on some of her working days:

“I’m on my own with a computer [...] I feel really, really isolated...not actually see a colleague apart from a ‘WhatsApp’ message.” (S15 L17, 15) (*distressed tone*) (which in itself created stress, as allocation, not support messages would be sent including beyond working hours, and the phone difficult to temporarily disable)

and further:

“I’ve tried to explain to the [management], ‘do you not realise people working in isolation are probably the ones going off sick with stress? If you brought back *teams* as they were [...] we supported each other; people go off *less*’.” (S16 L43-44, 47-51).

Mobile working

The type of communication was also commented upon. As mobile working was now more prevalent, a quarter (2/8) commented that the new change to install ‘WhatsApp’ on their mobile phones to keep in touch with their colleagues was appreciated:

P2 G “...it’s just kind of quite uniting.” (S5 L24).

Although for the majority, nothing replaced having time to have face-to-face communication with their colleagues, summarised thus:

P2 I “...we see each other face-to-face more, and I think that’s really important [...] technology is great [...] but actually you need that face-to-face to understand.” (S5 L19-22).

12.2.3 Core dimensions: Identity affiliation with the NHS/Identity as a healthcare professional

These two linked core dimensions are discussed together here.

A quarter (2/8) of the HVs commented directly that the service changes had negatively affected their identity with the NHS and undermined their sense of professional worth and recognition. This was a similar proportion as in the initial interviews (5/19). This linked directly with their sense of being a healthcare professional. One participant expressed how her background as a nurse and wearing an NHS logo was important:

P2 B “*Massively important...absolutely, absolutely.*” (S12 L31)

and for visits:

“I’m going as a nurse. I’m wearing my NHS lanyard.” (S12 L28-29) (*as opposed to the corporate lanyard*)

and:

“...people recognise it on the doorstep; you get access fairly easily. It says a lot...you’re honest, you respect confidentiality, you’re employed by an organisation with good governance...I haven’t got time to be explaining this! [corporate lanyard]” (S13 L2-3, 7-12).

One participant commented that her affiliation with the NHS had been ‘dumbed down’ by wearing the corporate logo that represented the Family Base rather than health visiting, which had been mentioned by 4/19 previously:

P2 K “We look like [Family Base] staff that have [been] trained up in twelve weeks or six weeks or on the job. We are *qualified* with degrees and masters [...] we’re *nurses* as well” (S6 L38-41).

Another commented that although she was confused about who she was representing on her new lanyard, for her, knowing her qualifications was what mattered:

P2 G “I’m still a nurse, I’m still a health visitor, I’ve got a midwifery qualification, I still work for the NHS” (S18 L21-22).

However, little comment had been made about her relationship with her clients throughout the interview.

12.2.4 Registered professional with a professional code and accountability

Half (4/8) commented about their professional accountability in the light of the changes, compared to almost a quarter (4/19) in the initial interviews who had been especially concerned about greatly reduced staff numbers.

Reduced record-keeping (presumed to be implemented as a time-saving measure) was commented on ironically by two, in the sense that the records were now in danger of becoming too sparse and generic, potentially threatening their accountability. One stated:

P2 D “...if I looked at that in six weeks’ time, I wouldn’t remember, I wouldn’t have a *clue*... [client’s identity]” (S5 L16-17).

Although one participant was pleased with this change:

P2 C (diary entry) “Does feel like some positive steps have been taken to reduce some stress of the work.”

Another two (2/4) commented about their accountability, linked with their professional autonomy, being affected by the pressure of additional work through staff shortages:

P2 B “...the Code of Conduct is *always* paramount over organisational policy [...] if I miss a target organisationally, sure, I can be disciplined for it, but *clinically* I want to make sure my clients’ needs are met...” (S3 L4-7) (linking again with the primacy of client-care)

P2 I “...you’re making those decisions within the visit, *but*...you’re conscious of the time, you’re conscious of where else you’ve got to be, all the meetings you’ve got to go to” (S23 L14-17).

12.2.5 Core dimension: Professional status and expertise through training and qualifications

The theme of professional worth and recognition was clear in the accounts of this aspect of professional identity. Half (4/8), a very similar proportion as in Stage 1, commented that the changes had denigrated their sense of expertise and status as professionals, and/or underutilised or discouraged their professional skills, through the way they were now directed to work by management. This linked with actioning the principles of health visiting (see 10.4.1), which will be further discussed under role identity. Again, there is a cross-over here between the HVs’ social and role identities:

P2 F “...they want us to work like robots, and they try and take away how we do visits [...] Yes, I can fill in a questionnaire [...] but for *me*, the questionnaire is a secondary part of my visit.” (S3 L9-10, 13-16)

P2 D “...*increasingly* I feel that the service is completely formulaic [...] I feel it’s more uniform, ‘tick-boxing’ [...] ‘you’re not *actively* doing anything; close it, end care’.” (S2 L8-9, 17-19)

followed by:

“And I do always struggle with that because I like to keep families on, just to ‘pop’ over every six weeks or three months [...] that’s the *best* way of working because I feel it’s a lot more preventative.” (S2 L20) (Figure 19)



Figure 19 Collage by participant D – Stage 2 interview

The underutilisation of expertise linked with prevention was mentioned by another participant:

P2 B “There is *nothing there about prevention*. We’re just reactive.” (S20 L9-10).

Continuous professional development (CPD) was commented on by a quarter (2/8) of participants. One reported that there was a wealth of in-house training, but due to time-restrictions and poor staffing levels, these were not necessarily enabling her in her role. The other, however, recognised the value of keeping up with the changing focus of health visiting. For example, in-house and private study on breastfeeding support, and the early recognition of maternal mental illness, domestic abuse, autism and tongue-tie, had refreshed her practice:

P2 G “It’s like rain...like food, water” (S2 L2) (*although this was mainly achieved through time off work*).

For a quarter (2/8) of the participants, their sense of expertise and status appeared not to be affected by the changes and these made very confident statements regarding their practice.

Almost half (3/8) also commented again that changes go around in cycles; one calmly philosophical, the other two feeling that her status and expertise as a professional was unrecognised:

P2 K "...this is a *cycle* and we've done this before, and I know from experience it's probably not going to work [...] why would we waste our time letting it fail and then changing it" (S1 L25-28).

12.3 Role Identity: The Effects of Service Changes

The ability to adhere to the four principles of health visiting were challenged by the changes. Almost all (7/8) of the participants reported that these greatly threatened, or compromised, aspects of their HV role and what they perceived constituted good practice.

12.3.1 Core dimension: Professional autonomy, agency and caseload ownership

(Linked with '*Uniqueness and complexity of the HV role*')

As previously, all (8/8) made reference to a sense of limitation as to what services they could, or were directed to, provide for clients. This was either because of the way the work was now directed, the performance and audit culture, and, or, staff shortages/increased workloads (frequently ascribed to sickness caused by work stress). The HVs thought that, increasingly, their service was commissioned to be more strictly directed, prescribed and target-driven. This greatly reduced their professional autonomy, agency and caseload ownership, and further reduced their sense of professional worth and recognition from others. Participant C's collage (Figure 20) was interpreted by her to show the new power of the commissioners over her work:



Figure 20 Collage by participant C – Stage 2 interview

P2 K “I just feel that our professional judgement is taken away a lot of the time; that we can’t *make* that judgement on what that family needs.” (S6 L9-11)

P2 G felt the pressure to conform and adopt the changes:

“...you’re ‘in a sea’, and this is the change that the ‘sea’ is bringing you [...] this is what you’ve *got* to do, so part of you has to go along with that change.” (S16 L14-15, 19-20).

Over half (5/8) spoke of how they still practised autonomously despite the constraints, thus demonstrating their strong sense of professionalism. They evidenced that they always put clients’ needs above other directives, even though they commented that their autonomy had been reduced. Three of these participants also admitted to finding ‘ways around the system’ so that they could practise in a way that aligned with their professional values and the Code (NHS, 2018), but that did not raise concerns with management:

P2 H “...I find a way to get it [record template] ticked, or at least the ones I can’t get away with *not* ticking [...] I will make a judgement about how much ticking to counter-balance against delivering the service [...] to have a meaningful dialogue with the client” (S11 L11-16)

adding:

“...I find a way to include the minimum [...] what the organisation demands, while at the same time trying to meet the clients’ agenda. Sometimes those are the same, and sometimes they’re not.” (S11 L18-21).

12.3.2 Core dimension: Uniqueness and complexity of the health visitor role

The notion of the ‘human element’ as fundamental in health visiting was again surfaced by almost all participants (7/8). Three-quarters (6/8) reported this ‘human element’ to have been restricted by time, or difficult to maintain due to the changes. The license and time to assess holistically, being client-focussed and respecting their individuality were all cited as negatively affected by the changes. Face-to-face client contact and the value of communication, especially non-verbal, were also negatively affected and commented upon. Participants again questioned the rationale for the increased use of client questionnaires and record-keeping templates.

Half (4/8) commented very strongly that, although the changes encouraged less home visiting than previously, they still held firm from experience that there was no replacement for face-to-face contact with clients, and three of these stated that they continued to do so. They cited reasons such as the value of assessing clients’ needs through non-verbal communication using their professional insight, expertise and experience, and summarised thus:

P2 B “Face-to-face *completely* important; it’s *so* important” (S7 L1)

“...you’re never [...] can reduce us to an ‘App’ [...] because the majority of communication’s non-verbal; so, it’s only when we’re face-to-face with people that we really get a good feel for what’s going on for them. Talking to them on the phone or ‘Skype’ or whatever...you’re not going to get the whole picture.” (S6 L23-24, 26-30)

P2 F “...although the tools ‘say zero’, my clear [face-to-face] assessment is that this person needs more support, and I’ve had to *justify* that” (S5 L41-43).

Almost all of the contributions evidenced that insufficient time was available in order for HVs to work with clients effectively and efficiently. For those that did not comment on this directly, it was in the sub-text of the pressure to cover work with clients if other staff were off-sick. Summarised by P2 F thus:

“...they want to time how the visits are. You can’t *time*, like a maternal wellbeing visit [...] how can you assess someone’s whole *mood*? Yes, you can fill in a questionnaire [...] but for *me*, the questionnaire is a secondary part of my visit.” (S3 L10-16)

adding:

“If someone knows that they’re ‘on a clock’ they don’t necessarily talk as freely” (S3 L22-23).

For all participants (8/8), in trying to deliver a health visiting service that they felt was acceptable to them, time restrictions were reported to be creating pressure and stress. It is noteworthy that over half (5/8) reported that they were continuing to work according to their professional values and the

Code (NHS, 2018), irrespective of the personal cost to themselves, or were finding ways to ‘get around the system’:

P2 H “...I find a way to include the minimum [...] what the organisation demands, while at the same time still trying to meet the client’s agenda.” (S11 L18-20).

P2 F shows evidence of her struggle between her autonomy to deliver a what she feels is a good health visiting service and how her work is being directed:

“I’m doing my best to maintain my standards, but it’s very hard when we’re asked why we’re doing extra visits, and it’s really challenging to justify so much.” (S5 L33-35).

A quarter (2/8), however, acknowledged that there had been some improvements made in the time required to complete the record-keeping templates. However, as already mentioned, a further quarter (2/8) thought that the information required on the templates had been so pared down that client records now appeared homogeneous, and it would be difficult to remember these clients if required to do so.

12.3.3 Core dimension: Enact professional values/personal values

As in Stage 1, there was no evidence that the changes had any significant effect on the core professional values held (8/8), only how they were realised in practice. Out of seven participants who reported that practice was significantly negatively affected by changes, six held fast to ensure they delivered the high level of service that they aspired to, despite the pressures. Two out of these six felt empowered to do so through their professional confidence and lengthy HV experience:

P2 H “...when I’m in contact with clients then no-one can really change what I’m doing at the moment!” (S10 L18-19).

Another described her emotional struggle in choosing to place her clients’ needs above her own professional reputation as an effective and competent practitioner:

P2 F “...it was forever justifying, and then making me look bad to my managers, but [...] the families [...] were getting a good service and were appreciating and enjoying it” (S10 L30-33).

A quarter (2/8) spoke of their inability to fully embrace their professional principles in their practice due to the changes.

Regarding the principle ‘search for health needs’, P2 F remarked:

“...it *feels* like we’re not *wanted* to find where there’s a problem. It feels like our job is to ‘tick-box’ to say we’ve asked there’s a problem, but it’s *better* not to find a problem, and that doesn’t sit right with me at all” (S4 L11-15).

Another remarked that innovation to ‘facilitate health enhancing activities’ was now curtailed:

P2 B “...people will work towards a target, and something else may be happening locally that could *need* more attention [setting up support groups] but it won’t get it because it doesn’t meet the target” (S18 L14-16)

“...newly qualified health visitors are meant to do ‘building community capacity’ projects in the community. We would have done those as qualified staff in the past.” (S19 L12-15).

Over half (5/8) also spoke of the importance of holistic assessment, but thought that the way the work was now directed threatened to limit this through the use of questionnaires, and/or reducing face-to-face contact or home visits with clients.

12.3.4 Core dimension: Emotional and personal commitment, investment and attachment

All (8/8) evidenced attachment to the role in the sense that it was very worthwhile, summarised thus:

P2 D “...what we offer and the *job* [...] I still think it’s a *wonderful* job; we’re incredibly privileged to do it” (S2 L27-28)

and 3/8 spoke directly of their positive emotional feelings for the work:

P2 I “I do love the job” (S19 L21).

However, a proportionate rise to previously, almost half (3/8), would resign if they could, but felt ‘trapped’ and unable to leave. These three had also been those who reported feeling the most emotionally distressed by the changes and the effects of these over the intervening year. However, one had felt more able to cope more recently, compared to another who reported that her depression at the time of interview was attributed directly to the changes.

12.3.5 Core dimension: Inter-professional working

As in the Stage 1 interviews, participants mostly commented on their working arrangements and relationships with the newly formed Family Base staff. Inter-professional working (IPW) with other staff, such as GPs and social workers, was mentioned, but comments were in the minority. The super-ordinate themes of communication, time and mutual IPW and client support underpinned the contributions.

All (8/8) commented that the changes had detrimentally affected their working relationships with the Family Base staff. It was acknowledged that this was not ‘personal’, as it was beyond the Family Base staff’s control. Confusion still existed over ‘who was who’, and who offered ‘what’ to clients, even after a year since the initial change to corporate working. However, a few did concede that the Corporate Service was still in its transition phase. Commonly voiced issues included working physically further apart from Family Base staff, changes of staff, insufficient opportunities to meet face-to-face, and the constraints of the Family Base ‘packages of care’ on offer.

Although it had been over a year since the restructuring to form the Corporate Service, no participant considered their work as yet being actually corporate. A similar proportion of participants as before commented on the organisational and relationship aspects of the changes that affected them as professionals. Almost all (7/8) thought that the Corporate Service was still not working well, summarised as:

P2 I “...we get on with our job, but what was promised to us with the collaborative working hasn’t necessarily transpired” (S13 L1-3).

Almost all (6/8) commented that the new working arrangements within the Corporate Service had a detrimental effect on their workload, or their ability to ensure their clients’ needs were met. This was reported to be due to a combination of the Family Bases’ lack of capacity, the movement away from locally based working (the way the disbanded Children’s Centres had worked previously) and rigid set packages of care. P2 H considered some of the consequences:

“...so, you don’t feel [...] able to make sure that people are as safe as you might have been able to before.” (S16 L19-21)

“...our workload means that if people want to evade our service [...] those are the families that are hard to keep safe [...] will take longer before [...] support is put into families.” (S17 L4-5, 10, 14-15).

Almost half (3/8) acknowledged that the Family Bases’ lack of capacity was a due to their reduced budget, and one highlighted that it was not the staff themselves that had created any negativity or poor working relationships:

P2 K “Now they’ve streamlined them because of government money” (S8 L5-6)

P2 G “I did feel annoyed, annoyed with them [...] and she *represented* that.” (S15 L18,20) “No, it wasn’t *her*, it’s the fact that she represented this new [...] thing that we’d all been included in” (S15 L23-24).

Negative effects of the changes on working relationships were commented upon by three-quarters (6/8), summarised thus:

P2 D “...I just don’t feel that there is that contact anymore” (S9 L27-28).

Confusion of roles and identities was also directly spoken about by over a quarter (3/8) of participants:

P2 G “...sort of really confusing that their structure’s all *changed* and the service they offer’s quite *confusing*.” (S14 L18-20)

P2 B “...you’re not sure who’s doing what, where, and they’ve been moved.” (S11 L14-15)

P2 I “...we know them less than ever [...] because it’s big [...] you don’t know who does what, and you don’t know who’s who.” (S28 L12-16).

Over half (5/8), a significant proportionate increase from the initial interviews, also commented on their sense of frustration and regret at the loss of the strong and effective working relationships they had previously with local Children's Centres:

P2 D "...so much was undone in the [...] tendering process and the restructuring process, that we're probably years away from getting things back [...] it was a service that worked fantastically" (S9 L22-26)

P2 K "The Family Bases [Children's Centres] used to be brilliant, *absolutely* brilliant, and we *used* to work really well with them" (S8 L1-3).

12.3.6 Core dimension: Public worth and value

Professional worth and recognition were central in the discussions on HVs' relationship with, and service to, the public. All again (8/8) evidenced in varying ways that, despite the changes, health visiting was a very valuable service and clients appreciated and benefitted from the service:

P2 B "...it's *such an important role* [...] it's a *universal* service [...] we can cover a whole range of different things" (S6 L5-8)

"...*we are so well-placed* to support families" (S6 L9).

However, two commented on the public's view and understanding of the value of the service based on their current experience of the changes. Speaking of the generic nature of the role decreasing:

P2 D "We won't be seeing much of them [the public] ...what people will perceive of our role being will kind of just disappear. People kind of think; 'health visitor...*what do they do?*'" (S7 L19-22)

contrasting with:

P2 I "If they've [the public] had a universal service *some* praise it a lot, but I think it's probably the people who've had the additional work who really understand the value of it." (S15 L17-20).

Despite concerns over the level of service provided, a quarter (2/8) spoke directly regarding the clients' praise for their service:

P2 F "...all my clients say to me, 'what a great service', and, how *helpful* it's been, ... 'what a *support* it's been'" (S11 L4-6).

Significantly, (7/8) evidenced that they believed clients were not receiving a level of service that they aspired to provide, a greater proportion than in Stage 1.

However, one spoke of the changes positively in refocussing her role on other health concerns, such as safeguarding and tongue-tie. She added that, in order for the profession to survive, different ways of working need to be embraced to meet the 'new' needs of clients and communities:

P2 G "...things change; communities change over time" (S11 L1)

and:

P2 G “...it’s important to save this job and to work hard at working differently so that we can maintain this job, because I think it’s important.” (S22 L7-9).

12.4 The Public Face of Health Visitors’ Professional Identity: The Effects of Service Changes

Comments regarding the participants’ perception of the public’s understanding of health visiting, and HVs’ own understanding of their collective public identity in light of the changes, again focussed on two areas. Firstly, similar to the Stage 1 interviews, strongly held views were held by a quarter (2/8) of the participants regarding the importance of retaining the NHS logo:

P2 B “...people recognise it on the doorstep; NHS logo and brand, I think, is probably known internationally as one of those strong brands like the BBC” (S13 L2-5).

Secondly, all (8/8) evidenced in varying ways that their role was different from that of the Family Base staff, despite the change to a corporate model of working, and that health visiting as a profession was still separate.

12.5 Health Visitors’ Professional Identity in the Context of Change Implementation

The themes of communication, time, support, and professional worth and recognition again ran through the HVs’ experience of the changes with specific reference to ‘management’. As before, this was commented on by all (8/8), referring either to their immediate managers or higher-level management, policy and decision-makers. The areas specifically commented upon were:

- Rate of change
- Communication between HVs and management
- HVs’ support received from immediate management.

12.5.1 Rate of change

Half (4/8), a similar proportion as previously, had experienced relentless change, excessive speed and/or confusion over the changes. This was summarised by two very experienced HVs:

P2 K “There are *constant* changes still...they [decision-makers] rush, rush, rush things; implement things so fast and then it doesn’t work.” (S6 L27-29)

“...the changes don’t stop [...] it’s like we haven’t even accepted and got used to the changes; it’s over the year now” (S43 L8-9)

P2 B “...*constant* move, *constant* organisation change is disruptive.” (S12 L4-5).

The words “muddle”, “mess” and “confusion” were repeated several times by another very experienced HV, pointing to the muddle of objects on her collage representing the changes, said:

P2 H “But somehow in order to actually *deliver* the service we’ve got to get through *all* of this!” (S3 L8-9) (Figure 21)



Figure 21 Collage by participant H – Stage 2 interview

P2 C concurred:

(diary entry, 26-06-19) “The merger [Corporate Service] is chaotic and no-one knows what’s going on.”

Half (4/8) commented that they thought that the changes had directly and indirectly led to staff shortages:

P2 G “...it felt like a *husky pack*...and they just took the *huskies* away [through team-restructuring] so you’re always ‘pulling the load’, but they’re just taking out the huskies! I found that really hard.” (S3 L29-32)

echoed by:

P2 C (diary entry, 22-08-19) “Someone’s off work in our team due to stress – now covering more work, and still not sorted my own caseload”.

The increased pressure of extra work created by constant change ran throughout all of the eight contributions:

P2 K “It is scary; it’s overload, and that’s why everyone is at ‘breaking point’. People just go off sick and then their work is distributed out until they come back” (S13 L38-40),

qualifying ‘everyone’ as:

“Everyone I’m working with has reached ‘breaking point’ or they’re *expressing* they have.” (S2 L11-13).

12.5.2 Communication between health visitors and the organisation

Almost all (6/8) commented directly, or implied that they had a good relationship with their immediate managers. However, all except one, and reflecting a similar proportion as in the Stage 1 interviews, experienced poor communication with the organisation’s senior decision-makers during this time of change. This included receiving directives remotely, with virtually no face-to-face contact, which left many feeling disrespected and/or their role as HVs misunderstood. Lack of consultation, feeling that they were not ‘being listened to’, and their expertise and ‘local knowledge’ being underutilised, were again raised as significant issues. This left HVs feeling that their agency in their ability to affect change was denied, and their professional worth and recognition disregarded.

Examples included:

P2 I “Actually get us together. They [organisation’s decision-makers] seem to miss out on very basic things, like communication [...] just to come and say ‘I hear what you’re saying and that I do empathise’” (S29 L6-8, 12-13)

and referring to being able to cover new initiatives/workload:

“Are they listening to us? I don’t think they *listen* to us when we say there aren’t enough of us” (S17 L18-19)

“You [the senior decision-makers] need to come out and spend [enough] time with us and feel what it’s really like” (S25 L5-6)

P2 K “...They’re [senior decision-makers] not really *listening* anymore” (S1 L12-13).

Another thought that although she understood that the in-house meetings and mandatory training were designed to support effective working, the time taken up with these was disproportionate to the time working with clients:

P2 I “Are they *really* enabling us [organisation’s decision-makers] to do our job?” (S17 L17-18).

Being consulted on the changes was commented on from two different and contrasting perspectives, beyond just a general lack of consultation per se. In the minority P2 G said:

“They [management] were *always* asking us [...] ‘what’s your opinion?’...and we were so short-staffed [...] well, it was their *world* making the bid, but our world was just getting on with the job.” (S17 L7-8, 12-13).

Concerning more recent changes, such as working out of hours to run groups:

P2 I “...there was no collaboration with *staff*; there’s nothing about how *staff* feel about anything: it’s all about service-users, and have they *actually* asked service-users if that’s what they want...?” (S7 L12-14).

A mismatch of what they were being led to believe, and the reality that they experienced, were commented upon:

P2 K “...*management* are reassuring us, ‘everything’s improving’: ‘it will get better’. But we’re a year down the line again now and I don’t see *anything* that’s better.” (S2 L14-16).

Commenting on one of the organisation’s slogans, P2 H questioned some of management’s communication:

“‘...*agile* set of values’, which kind of made me laugh because it’s not your *values* that are supposed to be ‘agile’” (*sarcastic tone*) (S6 L25-26).

Although all (8/8) made some negative comments with regard to the organisation in the context of change, hope and positivity was also expressed by over half (5/8). They were either hopeful of more clarity of future changes, or that the psychological rewards of practice and collegiality were enough to over-ride the negative issues, supporting a positive sense of professional worth and recognition; summarised thus:

P2 I “I’m still here, so it’s not that bad (*laughs*), but it is *tough*. I’ve got the team.” (S27 L3-5).

12.5.3 Immediate management support

Only data has been included recording participants’ experience of their support from their immediate managers, which directly affected their working environment, and thus their practice.

Almost all (6/8) commented or showed evidence that they received adequate/good support from their immediate line managers during the changes that aided effective practice and their sense of professional worth and recognition.

12.6 Psychological Effects of Service Changes

12.6.1 Analysis of feelings/emotions

The HVs’ self, and their emotional and personal commitment and attachment to their profession and practice are embedded in their professional identity. All (8/8) commented directly, or showed evidence that they continued to feel a deep personal attachment to their practice as summarised here:

P2 I “I do love the job” (S19 L21).

As before, the participants showed complex, wide-ranging and inter-weaving feelings/emotions through the words spoken, embedded within the narrative, and as embodied.

The same process for analysing the psychological effects was used as previously (see 11.7.2). The 30 feelings/emotions surfaced by the participants, whether spoken directly, as interpreted by this researcher or presented ambivalently were recorded and are presented in Table 16 below:

Table 16 Participants' feelings/emotions as presented in Stage 2 interviews

STAGE 2	Feeling / emotion keyword																															
Participant	positive / hopeful	happy / accepting	de-skilled	(sense of) loss (of id)	undervalued / devalued	disillusioned / 'let down'	disheartened	demotivated	disappointed / deflated	disempowered	disrespected	insecure / destabilised / unsettled	vulnerable	isolated / alone	"trapped"	resigned	sad / unhappy	worried / concerned	upset/tearful	anxious	work stressed	panicky/fearful/"on the edge"	distressed	depressed	tired / exhausted	pressured / overwhelmed	confused	frustrated	cross / irritated / annoyed	angry		
P2B	A				S																									I	A	A
P2C	S	S																		S					S							
P2D			S		S				S								A	S							A	S	S					
P2F					S	S				S	S	S	S	S	S		S	S	S	S	S	S	I	S	S	S						
P2G	A									S						S					S		S		S	S	S		S			
P2H	A										S																A					
P2I					S	S					S															A			S			
P2K					S	S				S	S	S		S	S		S		I	I	S	I	I		I	S		I	S	S		
S – Spoken directly	1	1	1	0	5	3	0	0	1	3	4	2	1	2	2	1	2	2	1	1	4	1	1	1	2	4	2	1	3	1		
I - Researcher's interpretation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1	0	1	2	0	1	0	0	2	0	0		
A - Ambivalent	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2	1	0	1	1		
Total	4	1	1	0	5	3	0	0	1	3	4	2	1	2	2	1	3	2	2	2	4	2	3	1	3	6	3	3	4	2		

Based on Table 16, Figure 22 below details the occurrence of the feelings/emotions expressed by the participants in the Stage 2 interviews. Following the analysis of the Stage 1 interviews, the ambivalent interpretations have been discounted.

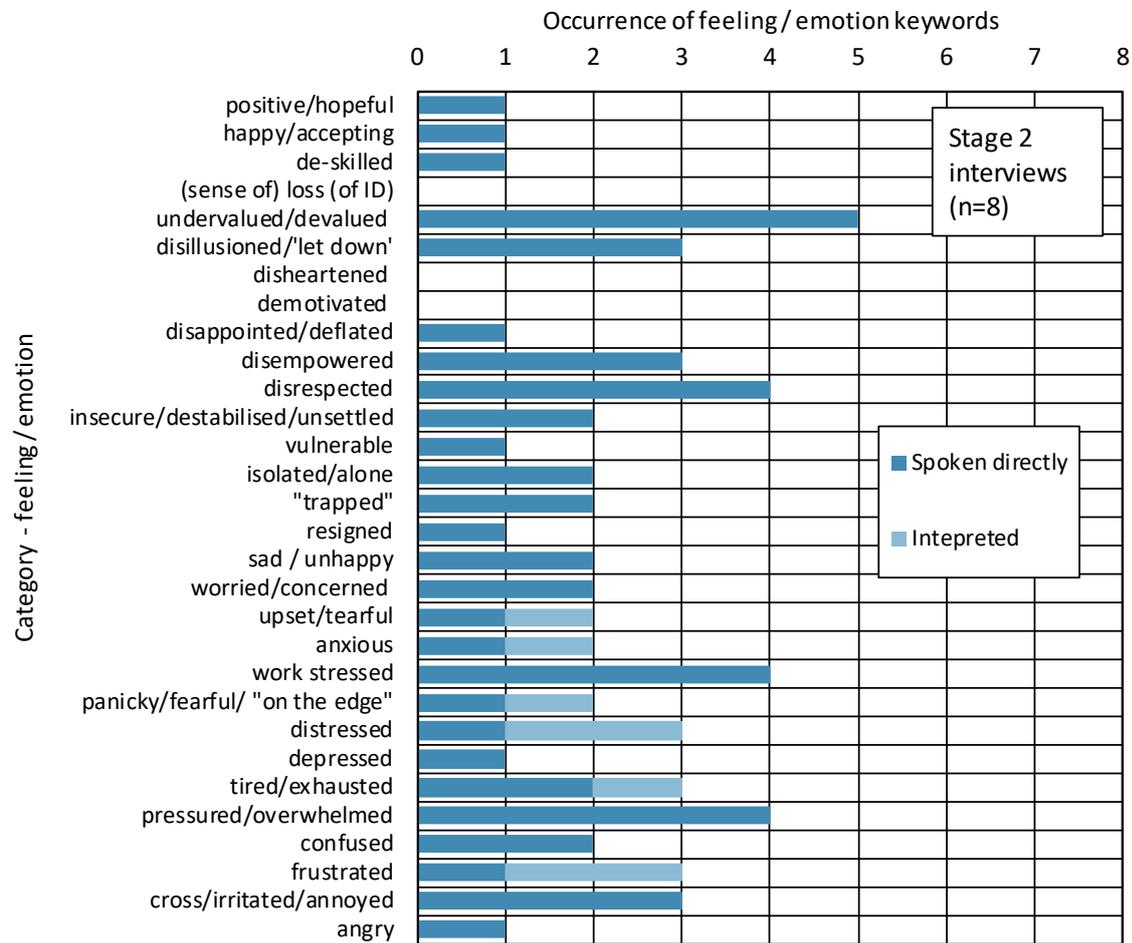


Figure 22 Stage 2 Interviews - Feelings/emotions expressed by the participants, directly or through researcher interpretation

The occurrence of feelings/emotions summarised in Table 16 have been broken down by those spoken or interpreted, as shown in Table 17 and Table 18. The tables show the number of times the feelings/emotion occurred, some of which were equally expressed.

Table 17 Occurrence of feelings/emotions spoken directly or embedded within what was said

Proportion of participants	Feelings/emotions spoken directly or embedded within what was said by participants	Occurrence (n/8)	Number of feelings/emotions
More than one half	undervalued/devalued	5	4
	work stressed pressured/overwhelmed disrespected	4	
One quarter to one half	disempowered disillusioned/‘let down’ cross/irritated/annoyed	3	10
	isolated/alone confused tired/exhausted insecure/destabilised/unsettled worried/concerned sad/unhappy “trapped”	2	
Less than one quarter	distressed de-skilled resigned frustrated disappointed/deflated vulnerable anxious upset/tearful angry panicky/fearful/“on the edge” depressed positive/hopeful happy/accepting	1	13

Table 18 Occurrence of interpreted feelings/emotions

Feelings/emotions spoken based on interpretation of body language/voice tone/gestures	Occurrence (n/8)
distressed frustrated	2
tired/exhausted anxious upset/tearful panicky/fearful/“on the edge”	1

12.6.2 Commonly occurring feelings/emotions

Leaving aside the feelings/emotions presented ambivalently, of the 30 different feelings/emotions that surfaced from the data, one was experienced by over half of the participants, and a further three by half.

Table 19 Four feelings/emotions expressed in a half or more of the interviews

Proportion of participants	Feelings/emotions either spoken of directly, and/or as interpreted by researcher	Occurrence (n/19)	Number of feelings/emotions
Half or more	undervalued/devalued	5	4
	work stressed pressured/overwhelmed disrespected	4	

Although again the strength of feelings was not analysed, several participants evidenced that they were struggling psychologically. Two HVs in particular commented on their poor mental health as a result of the changes, representing a quarter of the participants. One tearful participant expressed that she felt depressed and the level of her poor mental health spoken of directly, was also reflected in her collage:

P2 F "...I've put 'breaking *point*' but really probably it should've said 'broken' "...the last year in health visiting has *destroyed* me." (S1 L11-12) (Figure 23)

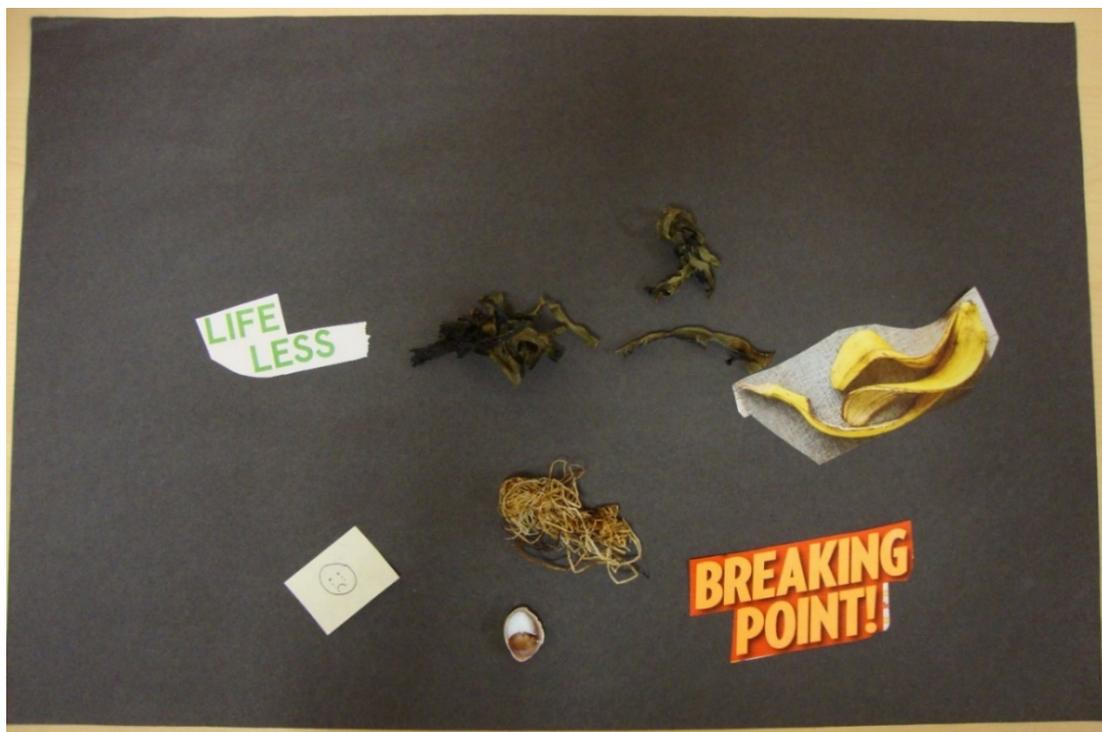


Figure 23 Collage by participant F – Stage 2 interview

Additionally, P2 G showed evidence of a noticeable level of confusion and contradiction in her account, interpreted by this researcher as a continuing psychological struggle to cope with the changes and maintain equilibrium. However, looking at the bright, yellow 'future' space on the right-hand side of her collage, she stated that if changes now settle:

“...that'll be great, I can cope with that.” (S19 L12-13),

qualifying this with,

“...I'm not sure I can stand much more than this” (S19 L5) (Figure 24)

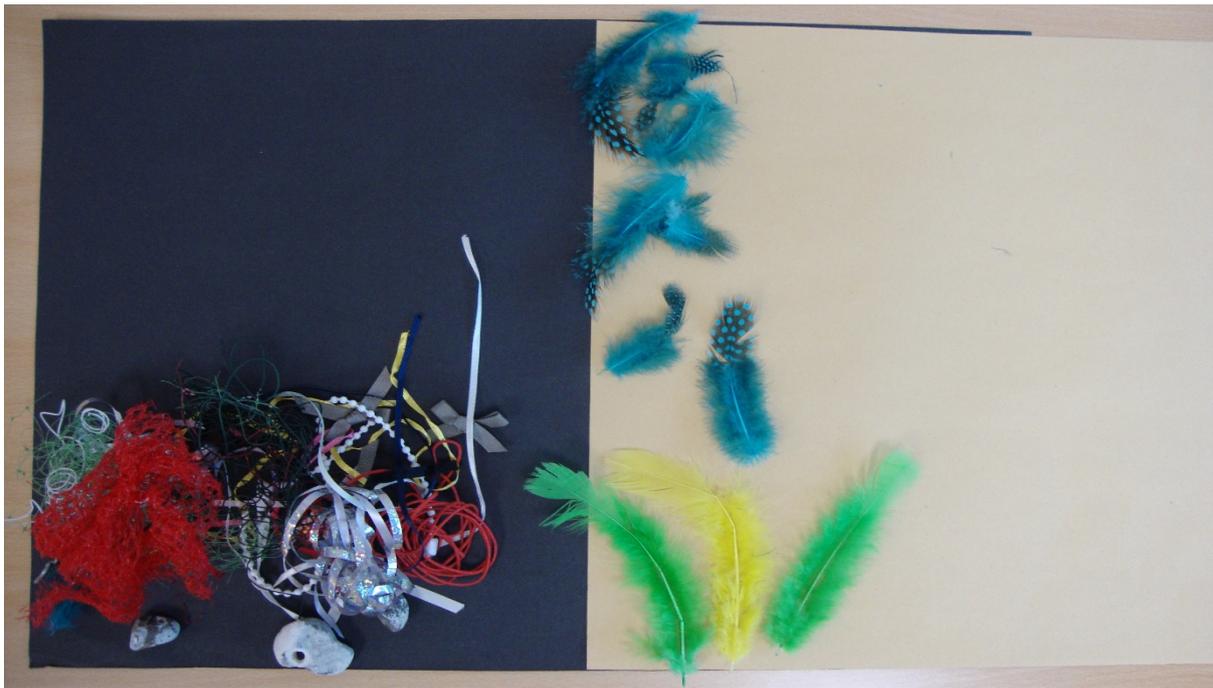


Figure 24 Collage by participant G – Stage 2 interview

12.6.3 Hope

There was some evidence of hope, as before. Although half of the participants (4/8) spoke of hope, only one did so wholeheartedly. The others appeared to want to feel hopeful of the future, but this was ambivalently presented within their contributions. Others, including P2 B and P2 H, both long-standing HVs, remained stoic through the changes, possibly due to their professional confidence and experience, continuing to work as before as far as able.

Chapter 13 Analysis – Stage 3 Interviews: The Lived Experience of Service Changes Post-Initial Peak Covid-19 Pandemic

13.1 Introduction

The analysis of the Stage 3 interview data followed the approach taken previously, although circumstances were radically different for these participants due to the impact of Covid-19. Some broad comparisons with the previous interviews could be made, and further insights due to the pandemic were revealed.

The four inter-related super-ordinate themes of communication, time, support and professional worth and recognition were again threaded through the participants' accounts. The psychological effects of change are discussed separately as before.

Table 20 Summary of Stage 3 analysis

Timing	Stage 3 interviews held approximately 15 months after Stage 1 (post-initial peak Covid-19)
Number of participants interviewed	n=7/20 (+2 written responses, P3 J and P3 T) ⁹
Information sought	<ul style="list-style-type: none"> • What it is like to be an HV living through change • HVs' lived experience of service changes mapped against core dimensions of their professional identity
Methods of analysis	<ul style="list-style-type: none"> • Audio recordings listened to and initial post-interview notes read • Line-by-line analysis of the transcriptions • Initial exploratory comments made • Commonalities and differences identified • Super-ordinate themes considered

13.2 Social Identity: The Effects of Service Changes

All (7/7) participants interviewed face-to-face (and P3 T) recognised that the Covid-19 outbreak, by necessity, was bound to cause further and more dramatic changes to practice.

13.2.1 Core dimension: Self-identification with health visiting as a professional group

As in Stages 1 and 2, all (7/7) participants continued to show their self-identification with the profession, and their commitment to the professional values, principles, 'orientation to practice'

⁹ In Stage 3, participants P3 J and P3 T responded in writing and their contributions were also included where appropriate.

(Cowley et al., 2013: 11) (see 3.7) and ideology, despite the radical changes. However, all of these aspects of practice had been affected by the changes in some way.

All (7/7), as previously, self-identified with the professional group and commented or showed evidence that clients' needs were still their primary priority, in line with their professional Code (NMC, 2018). P3 M said:

“...we're still trying to kind of put the needs of the families first, even if we're having to change the way we're doing things and make adjustments.” (S4 L5-7).

Almost half (3/7), when discussing their mission, spoke the words '*making a difference*' (Whittaker et al., 2013, original emphasis). This shared mission remained their fundamental goal during the health crisis, and two (2/7) commented they had to try to set aside anxiety over personal risk:

P3 N “...when I went into people's homes and realised how much extra support they needed [...] I tried to put sort of the worry about covid to the side” (S4 L7-8, 11-12).

However, one HV thought that this mission was now unattainable, not just because of the restrictions imposed by Covid-19, but because of the on-going emphasis on performativity and their organisation's unrealistic expectations:

P3 R “I feel it's very much 'tick-boxing'; pleasing commissioners, meeting KPIs, which I don't feel necessarily benefits the families we're working with.” (S1 L17-20).

13.2.2 Core dimension: The sense of collegiality

Communication, time, and support were particularly relevant as regards participants' positive sense of collegiality.

All (7/7) (and P3 T) expressed that a positive sense of collegiality was essential, even more so working through the health crisis. At this time there was no evidence of differences in attitudes and behaviour of colleagues. They all evidenced a very strong desire to be with their colleagues in person, although if 'shielding' accepted the situation stoically. Almost half (4/7) showed evidence that they put their colleagues first, even when they were personally struggling with the work, or even feeling unwell.

Ironically, at a time when colleague face-to-face contact and support was so desired, in reality this was seldom possible due to the Covid-19 restrictions. Team cohesion was essential for most as a way to 'get through' the crisis. Over half (4/7) commented that the team members had become closer, more empathetic towards one another, and worked more cohesively:

P3 L “I couldn't have got through it without them [colleagues]. They have been such a bolster for me mentally in the job.” (S11 L1-2)

explaining:

“...I ‘*cracked*’ during Covid, it was awful, and it took me *phoning* a colleague in *tears* for them to say: ‘I’m in the office, come in’ and ever since that day, I went in everyday” (S11 L10-12)

P3 M “...as a *team* we’ve become a lot closer through this [...] we’ve really supported each other...probably had a lot more telephone contact than usual” (S17 L1-2, 4-6)

followed by:

“...we’re noticing if people are struggling [...] maybe we’re being a bit more empathetic to our *colleagues* and *ourselves*” (S18 L5, 11-12)

and:

“...we’re very, yeah, supportive *now* as a team. Maybe not that we weren’t *before*, but I think even more so” (S19 L17-19).

The effects of the Covid-19 restrictions on face-to-face colleague contact did, however, impact negatively. One newly qualified HV (NQHV) remarked:

P3 O “...the morale has been low in the team [...] people have missed that ‘team feeling’ ...working with colleagues [...] that’s so important - with some of the families we have that are quite complicated or quite draining [...] doing that virtually, it’s *not* the same” (S5 L5-10)

but qualified this with:

“...my little hub is good [...] we’ll just text [...] sit in the park [...] just trying to keep a little bit of contact.” (S5 L14,16,19)

followed by:

“...*that* contact’s *really important*. Because you don’t see *anyone* otherwise. So yeah, it can be a bit lonely if you don’t see anyone in the office, and as much as you can talk to people on the phone, it’s not the *same*” (S6 L4-7).

Another commented:

P3 S “...when we’ve had Covid and we *haven’t had* the adhesive team, we *haven’t had* much face-to-face and I think we’re all craving for that” (S11 L15-17)

“...we’re *human* and everybody needs to have that face to face...it’s a normal human thing.” (S13 L2-4)

and reflecting on her collage:

“...we haven’t had much face to face [...] so you *are* quite isolated, that’s the dryness” (S7 L3-4) (Figure 25)

other community health professionals (midwives and GPs) now offering a very limited face-to-face service. HVs were therefore seeing themselves as the main providers of community health care.

13.2.4 Core dimension: Registered professional with a professional code and accountability

Over half (4/7) spoke of their acute awareness that their professional responsibilities had increased due to the pandemic. Prior to the health crisis, professional concerns had often centred around inadequate staffing levels. Although staffing levels were still a problem, exacerbated by the redeployment of HVs to other clinical areas, the HVs had further concerns. 'Covering' the work of other professionals' work who were not providing a face-to-face service left participants feeling more responsible and vulnerable, summarised by three HVs:

P3 N "...other services stopped but we kept going." (S4 L1)

adding:

"...those vulnerable children are not always being seen...by other professionals and it's *such a huge* responsibility [...] during that time...It's a *huge* responsibility anyway, I but I feel it really did *increase*." (S6 L4-8)

P3 L "...we were the *only ones* really who were *going there* to the homes, even GPs weren't seeing them face-to-face, it was all telephone triage" (S18 L1-3)

P3 O "...I think we've been holding a *lot* compared to other professionals...some of the social workers aren't going to the home anymore...they're only doing video calls and they're not actually seeing the children. That does put a lot of responsibility on us" (S9 L6-11).

The HVs were torn between the anxiety of personal risk and transmission of the infection, and their dedication to their clients, especially as there was a surge in client need.

13.2.5 Core dimension: Professional status and expertise through training and qualifications

Again, there is a cross-over here between social and role identities. The ability to use their skills and expertise working through the outbreak produced mixed comments. Several participants, although acknowledging the necessary restrictions, thought that they were unable to practise effectively, especially regarding the guidance to see clients face-to-face for a very limited time:

P3 N "...just going in no more than fifteen minutes [...] didn't work that well" (S10 L3-5)

"...in theory, yeah, but in practice [it] 'went out of the window'" (S11 L3-4)

P3 O felt "...disempowered, because [...] I can't make as much of a difference [...] we can't provide the level of care that we are used to in fifteen minutes" (S3 L4-5, 7-8).

Two (2/7) thought that the virus outbreak had served to illuminate a situation that already existed due to staff-shortages, restricted time and how their work was now externally directed:

The participants' views of their status were also mixed. The majority (5/7) commented that the clients were very appreciative of the health visiting service they received during the outbreak, again increasing their sense of professional worth and recognition:

P3 L "...with this pandemic [...] people appreciate what we actually do and know what we do!" (S8 L6-8).

In contrast, four (4/7) stated that they did not feel valued as professionals by their organisation, national policy and decision-makers. They thought that a lack of understanding of their role led to unrealistic expectations, causing many of the HVs stress. Two (2/7) also commented that their expertise as professionals was not recognised financially. P3 M thought that by wearing a uniform now (to try to minimise infection transmission) access to clients' homes was more accepted and her clinical skills had been more recognised by clients:

"...I certainly think that [...] people have more kind of respect for your knowledge level [...] I've been asked more kind of clinical questions" (S10 L4-6).

However, two (2/7) participants commented that they were still able, in small ways, to exercise some agency in how they could shape their service to meet client need, whilst adhering to 'covid-safe' guidelines.

13.3 Role Identity: The Effects of Service Changes

The HVs had been directed to continue to visit a number of priority groups, while ensuring 'covid-safe' precautions were taken.

13.3.1 Core dimension: Professional autonomy, agency and caseload ownership

(Linked with '*Uniqueness and complexity of the HV role*')

Unlike in the previous interviews, work restrictions were accepted more readily. It was recognised that these changes were largely non-negotiable as they were a response from government to an unprecedented health crisis. Both agency in the way the HVs could direct their work, and autonomy, were understandably more restricted. Caseload ownership had become difficult due to increased staff-shortages, exacerbated by redeployment.

13.3.2 Core dimension: Uniqueness and complexity of the HV role

All (7/7) showed evidence or spoke of how the uniqueness and complexity of practice had been amplified and intensified during the pandemic. The extended scope of the role was mainly due to restricted working practises of other professional groups. Health needs also broadened, with mental ill health increasing due to isolation, fear of infection, a rise in relationship difficulties and domestic abuse, and job and financial security.

As communication and time were necessarily restricted, autonomy was emphasised as an even greater requirement for effective practice:

P3 O, reflecting on the time-restrictions said “...it’s never simple, where you’re going in [home visits]” (S3 L9-10)

P3 R “Being able to decide for *yourself* whether you need to go back into a home...and delve a little deeper...not being controlled by set time visits...autonomy is very important.” (S5 L1-5).

A change where clients ‘self-weighed’ their babies, overseen by another health-worker other than HVs, was remarked upon, suggesting a decrease in her sense of professional worth and recognition by decision-makers:

P3 S “...it’s not just about ‘plonking’ the baby on [the scales]. There’s more to weighing than just weighing.” (S21 L8-10).

Over half (4/7) (also P3 J) commented, where they were able to visit clients, the imposed time restrictions did not allow for client-focussed holistic assessments to take place. Building professional-client relationships and meeting the client’s needs, which had increased exponentially due to the health crisis, were also compromised. Even the basic information required to be gathered at core visits appeared difficult to achieve for most. Over half (4/7) (also P3 J) reported that administrative duties, even during the health crisis, were still excessive and time-consuming to complete.

A mismatch between the organisation’s expectations and what could be realistically achieved, given the complexity of the HVs’ role was highlighted. However, much of this was due to chronic underfunding, inadequate staffing levels and redeployment during the pandemic outside of their organisation’s control.

Face-to-face contact continued to be a priority wherever possible, although for some the increase in telephone communication and the introduction of video contact with clients showed potential. P3 M reported that she thought that the pandemic had opened up future options for greater blended communication between professionals and clients:

“I think in the future, a lot of parents actually said they prefer a telephone call [...] maybe parents that [...] don’t need the support as much” (S15 L1-2, 4-5).

P3 M also thought that less travelling to visits had created more time for other work.

The anxiety surrounding what may be missed during this period due to practice restrictions and limitations was a great concern, especially as regards the safety of vulnerable children. This added to the negative psychological impact all the participants evidenced that they had experienced at varying times during the health crisis.

13.3.3 Core dimension: Enact professional values/personal values

All (7/7) showed evidence that their core professional values remained strong. However, all commented on how the Covid-19 restrictions created extreme difficulties in their ability to practise effectively, as discussed.

All commented, or showed evidence, that clients' needs remained their primary priority. Several had gone the 'extra mile', offering follow-up visits if clients required further care than could be addressed within the time suggested in the Covid guidelines. Two commented that they continued to visit and accept the personal risk of infection, one even before she was able to access personal protective equipment (PPE). In an attempt to meet clients' needs and practise effectively and safely, several participants commented that they stayed longer in the homes than directed, compromising their own infection risk:

P3 M "...you're kind of *bombarded with questions* when you go in" (S12 L11-12).

There was a real fear of infection, even with PPE, commented upon by a few of participants. P3 T wrote:

'I am so scared of catching the virus'.

Looking back prior to the Covid-19 outbreak, as well as currently, P3 R stated that effective HV practice was no longer possible due to the visit time restrictions, which created a sense of negative professional worth and recognition:

"...the way I practise, is that [...] I'll watch and I'll look and I'll listen and maybe pick up subtle clues about what's going on in that household" (S4 L26-28)

"There's *no scope* for having that holistic approach anymore [...] there's no allowance [...] for *reflection* [...] then you're given a set time [...] to write it up [...] there's an expectation that you will do so many visits in a day" (which she felt was divisive, and effectiveness was being sacrificed for efficiency) (S4 L13, 16-17, 20-23).

13.3.4 Core dimension: Emotional and personal commitment, investment and attachment

All (7/7) showed strong attachment and commitment to health visiting. Almost all (5/7), as previously, felt high personal 'reward' from client appreciation, thus maintaining their sense of professional worth and recognition from clients. Conversely, one felt differently, commenting both on clients' and management's appreciation of her:

P3 S "...very rarely they would say 'well done'" (S4 L8) (*instead relying on self-affirmation for job satisfaction*).

Two (2/7), compared to almost half previously, were either actively seeking to resign or contemplating to do so, due to the changes prior to and during the pandemic. This was because

they could not practise according to their values and principles and were experiencing high levels of work stress and a lack of job satisfaction.

13.3.5 Core dimension: Inter-professional working

Most remarked about the lack of IPW during the pandemic. The majority commented that the Corporate Service was not working at all at this time, as the Family Base staff were either not available or only communicating with clients by telephone. As aforementioned, this was also the same with social workers and GPs. This situation added to the HVs' workloads, which were already stretched.

P3 P viewed her role as an HV as a 'Rawl Plug', lacking proper professional boundaries:

"...we work with all other services [...] we hold a lot of other services in place and [...] if us as a service *stopped* [...] a lot of other services would crumble and 'fall out of the wall!'" (*laughing*) (S16 L8, 11-14)

However, P3 S commented that teamwork was important, especially during the pandemic:

"...we've all got to work together" (S17 L13).

13.3.6 Core dimension: Public worth and value

All (7/7) discussed the increase in client need and contact due to the impact of the Covid-19 outbreak. Almost all (5/7), similar to previously, spoke directly about how the pandemic had highlighted their awareness of the value of who they were and what they did. As aforementioned, most remarked that their clients valued the service and contacted the HVs in far greater numbers than previously for health advice, and almost all (5/7) used the word 'reassurance' in relation to what many clients required at this time. Summarised thus:

P3 L "...my phone has been non-stop because of families *wanting* to get in touch with us, *wanting* that support, wanting that reassurance" (S8 L2-4)

P3 N "...I felt that families *really appreciated* us [...] it made me feel more *valued* as a health visitor" (S5 L4, 8-9)

this was in the context of her earlier comment:

"...I did actually struggle with [...] why health visitors were taken away [...] at a really vital time, when families, especially vulnerable families needed that support' (S1 L28-30).

Almost half (3/7) remarked that the effectiveness of HV interventions were only apparent in the long-term. One commented that HV practice was not valued in the same way as more immediate care because of this. The other two remarked that there needed to be an appropriate way of measuring effectiveness of practice as well as performance-based measures.

13.3.7 The public face of health visitors' professional identity: The effects of service changes

Two participants commented on the general public's recognition of health visiting from their perspective. One thought that by wearing a uniform, health visitors' backgrounds as clinicians were more readily recognised. The other commented that she thought the general public did not really understand the role of the health visitor, and that often she is forgotten more easily by clients than their midwife.

13.4 Health Visitors' Professional Identity in the Context of Change Implementation

Unlike previously, most participants acknowledged that the changes implemented during the health crisis were largely outside of the organisation's control, however similar concerns as before were raised:

- Rate of change
- Communication between health visitors and management
- HVs' support received from immediate management.

13.4.1 Rate of change

One participant raised the concern that she understood HVs in other regions were practising differently. She felt aggrieved that she was expected to work more intensively. Several others thought that management not only expected higher efficiency (more work covered), but that the lack of staff and early infection risk was not taken into account. These compounded to reduce their sense of professional worth and recognition:

P3 P "...we do a lot *more* with a lot less staff. The expectation is a lot higher [...] the things we do massively outweighs other areas. They're shocked the kind of things we do." (S19 L1-4).

13.4.2 Communication between health visitors and the organisation

Effective communication and contact with the organisation's decision-makers continued to be a long-standing issue. The lack of collaboration between HVs and management in local decision-making, prior to and during the Covid-19 outbreak, created a sense of powerlessness and was commented upon by almost half (3/7) participants. P3 R, speaking of HVs' responses to the seemingly relentless changes:

"...a lot of health visitors were quite vocal and they would speak up [...] now, people's voices have just gone. I think people are so deflated that they just go 'oh, OK'" "...upsetting to see that everyone's *just lost all fight* for what's right" (S3 L15-21).

All (7/7) said that there was still a lot of confusion and multiple changes in a short space of time.

This reflected the uncertainty in the government's response to the Covid-19 outbreak, and in how the HVs themselves were managed:

P3 S "... 'what's going on here?' 'Where are we?' 'What is going to happen with our team?'" (S5 L1-2).

The apparent gap between the organisation's decision-makers' understanding of the HV role and the reality of interfacing directly with clients was summarised when, in commenting on her collage, P3 P said:

"...you've got this nice little 'fairy tale thing' which I think is what they [decision-makers] envisage everything's going to be: it's all going very well, very easy...the two dogs fighting is [...] what it actually becomes further down!" (S1 L10-14) (see Appendix E).

As previously, the format of team meetings (*both online and held in the open air*) was raised again as unsatisfactory by two participants. One commented that the meetings were just for information-giving only, and the other that there was insufficient time for colleagues to interact informally together.

13.4.3 Immediate management support

Most commented that they had felt well-supported by their immediate Team Leads:

P3 O "...my team leads are brilliant [...] I think I could easily go and talk to them if I had any worries" (S12 L1-2).

13.5 Psychological Effects of Service Changes

The same process for analysing these data were used as previously. The participants' feelings/emotions, whether spoken of directly, as interpreted by the researcher, or presented ambivalently were recorded¹⁰, as shown in Table 21 below.

¹⁰P1 J and P1 T are not included in Table 21 as they were not interviewed in person.

Table 21 Participants' feelings/emotions as presented in Stage 3 interviews

STAGE 3	Feeling / emotion keyword																													
Participant	positive / hopeful	happy / accepting	de-skilled	(sense of) loss (of id)	undervalued / devalued	disillusioned / 'let down'	disheartened	demotivated	disappointed / deflated	disempowered	disrespected	insecure/ destabilised / unsettled	vulnerable	isolated / alone	"trapped"	resigned	sad / unhappy	worried / concerned	upset/tearful	anxious	work stressed	panicky/fearful/"on the edge"	distressed	depressed	tired / exhausted	pressured / over-whelmed	confused	frustrated	cross / irritated / annoyed	angry
P3L	S				S								S	S			S	S	S	S	S	S				S	S	S		
P3M	S	S																S							A	A	S			
P3N					S		I	A			S		S			S			S	A	A					A	S			
P3O		A								S				S												A	S			
P3P					S		I		S		S		A	A					S						S	A	S	S	S	
P3R			S	S	I	I	S	S	S	S	S	S	I		S	A	S		I	S	S	I	I	S	S	S	S	I	I	I
P3S	A	A	S	S						S				S		A					S				S	S	S			
S – Spoken directly	2	1	2	2	3	0	1	1	2	3	3	1	2	3	1	1	2	3	1	4	3	1	0	1	3	3	7	2	1	0
I - Researcher's interpretation	0	0	0	0	1	1	2	0	0	0	0	0	1	0	0	0	0	0	1	0	0	1	1	0	0	0	0	1	1	1
A - Ambivalent	1	2	0	0	0	0	0	1	0	0	0	0	1	1	0	2	0	0	0	0	1	1	0	0	1	4	0	0	0	0
Total	3	3	2	2	4	1	3	2	2	3	3	1	4	4	1	3	2	3	2	4	4	3	1	1	4	7	7	3	2	1

Based on Table 21 above, Figure 27 below details the occurrence of the feelings/emotions expressed by the participants. As for the previous interviews, the ambivalent interpretations have been discounted.

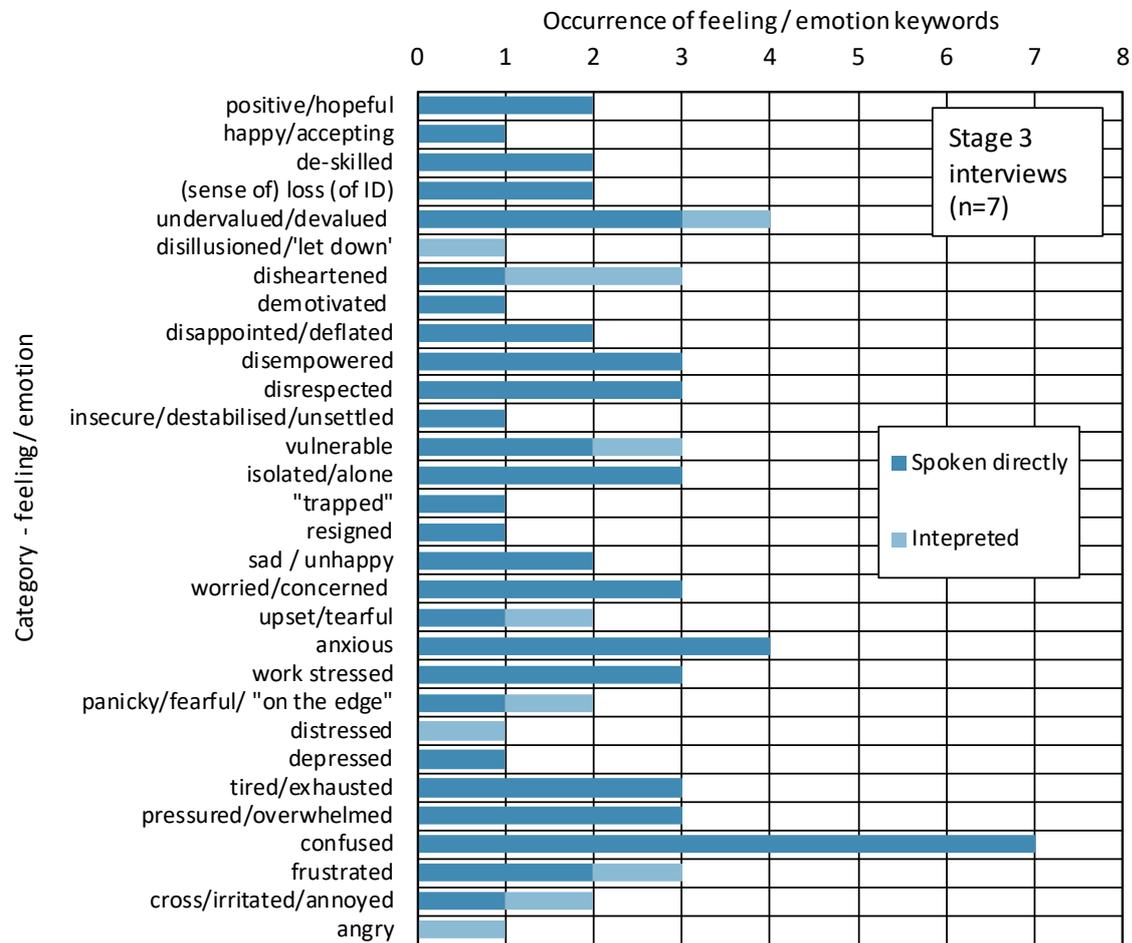


Figure 27 Stage 2 Interviews - Feelings/emotions expressed by the participants, directly or through researcher interpretation

The occurrence of feelings/emotions summarised in Table 21 have been broken down for each of the three categories (spoken, interpreted or ambivalent), and shown in Table 22 and Table 23. The tables show the number of times the feelings/emotion occurred, some of which were equally expressed.

Table 22 Occurrence of feelings/emotions spoken directly or embedded within what was said

Proportion of participants	Feelings/emotions spoken directly or embedded within what was said by participants	Occurrence (n/7)	Number of feelings/emotions
Over half	confused	7	2
	anxious	4	
One quarter to one half	isolated/alone work stressed pressured/overwhelmed disempowered disrespected tired/exhausted undervalued/devalued worried/concerned	3	8

Table 23 Occurrence of interpreted feelings/emotions

Feelings/emotions spoken based on interpretation of body language/voice tone/gestures	Occurrence (n/7)
disheartened	2
distressed frustrated undervalued/devalued disillusioned/'let down' vulnerable upset/tearful angry cross/irritated/annoyed panicky/fearful/"on the edge"	1

13.5.1 Summary of the psychological responses to service change

The changes that these participants had experienced were vastly different to those which had been lived through previously. There were some interesting findings directly linked to this period of unprecedented change. In discussing the findings, the relatively small sub-sample is acknowledged.

The range of feelings/emotions presented in these interviews was mixed, mainly as a direct result of working in the unprecedented conditions resulting from the pandemic.

Of the 30 different feelings/emotions that surfaced from the data, three were experienced by over half (4/7) of the participants. In order of frequency, these were:

- confused (all 7/7)
- undervalued/devalued, and anxious (equally revealed) (4/7).

Due to Covid-19, feelings/emotions had surfaced which were situation-specific, such as anxiety regarding infection risk and trying to manage high caseloads with fewer staff, exacerbated by redeployment of HV colleagues. Concerns over vulnerable children who may be ‘slipping through the net’ were also raised. The feeling of confusion experienced by all participants reflects that of the general public, very frequently discussed in the media. These will be discussed further, along with other findings, in the following Chapter 14 .

Two (2/7) participants were considering resigning from post; one more actively than the other. Their reasons were linked more to the on-going service changes that continued to restrict their practice, rather than those more recently imposed by the pandemic. Both felt that they could no longer practise according to their professional principles and values, and both presented with a significant level of low mood. P3 R presented her depressed feelings verbally, and visually in her collage (Figure 28) with its dramatically dark background and strongly negative imagery:



Figure 28 Collage by participant R – Stage 3 interview

Chapter 14 Discussion of the Findings Part One: Health Visitors' Professional Identity in the Context of Local Service Change

14.1 Introduction

The main findings from all the interviews will be discussed in this chapter. This is in the context of the service changes that were implemented in the locality where the study participants worked, and over the period from late 2018 to mid-2020.

14.1.1 Sources of change

To place the local service changes in a wider context, the main sources of change are identified in conceptual framework in Figure 30 below:

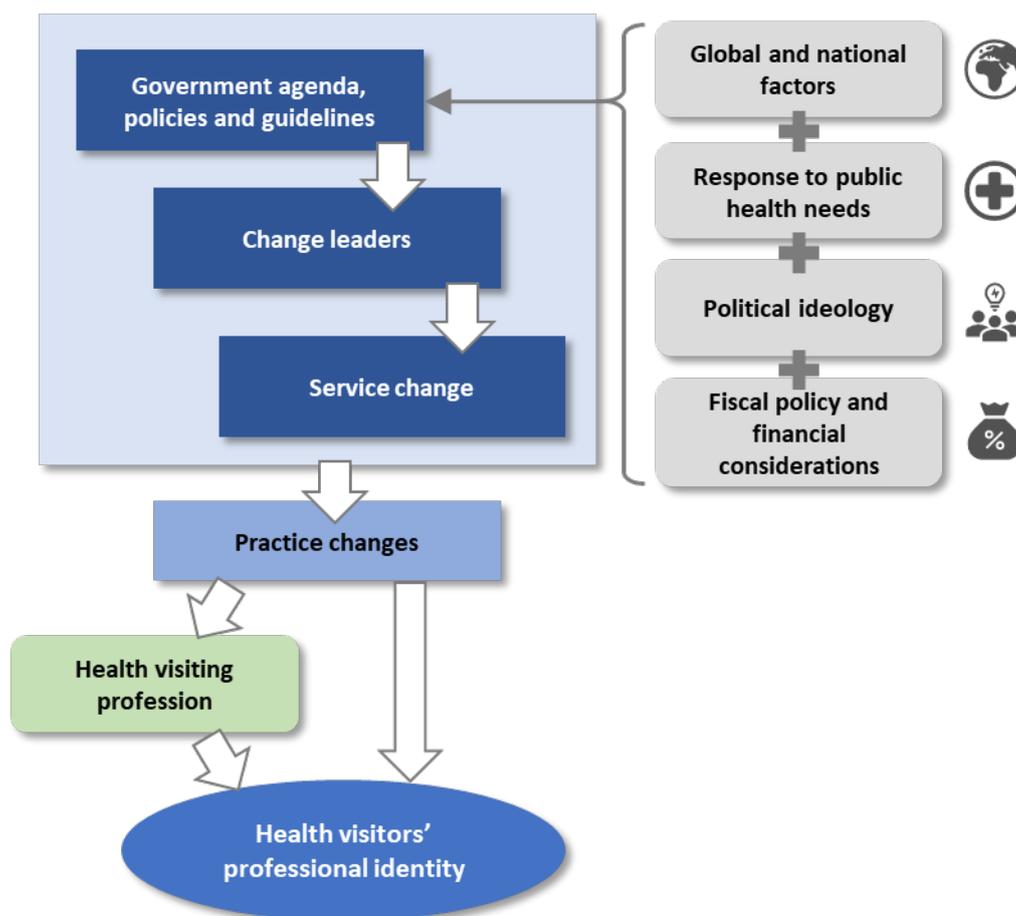


Figure 30 Conceptual framework of the sources of service change on health visitors' professional identity

The following terms are used in Figure 30:

- Government agenda, policies and guidelines depending on external drivers such as financial considerations. (By the end of this study this included the response to the Covid-19 pandemic and associated public health needs)
- Change leaders – Local Authorities (LAs), commissioners, employing organisations
- HV profession – embodying principles, values, 'orientation to practice' (Cowley et al., 2013: 11), the 'three core practices' (Cowley et al., 2013: 12), attitudes and behaviours, mission and response to change.

The effects of the changes on each of the core dimensions will be discussed in this chapter to answer the research question of how service changes affected HVs' professional identity. The experience of living through changes for the HVs, and the psychological effects of the changes on them, are discussed in 14.6.

14.1.2 Super-ordinate themes, common findings and a presentation of the conclusions

The four inter-related super-ordinate themes that emerged from the data were communication, time, support and professional worth and recognition (see Table 9). These themes surfaced as the HVs discussed what they perceived to be important in maintaining their professional identity and in their ability to practise effectively. In most cases these themes were linked to relationships that had been affected by the service changes in some way. This researcher decided that the recurrence of a super-ordinate theme would be classified as such if shown in 50% or above in all accounts in the Stage 1 interviews. These themes emerged in 75% or above of the interviews in all of the stages (see Appendix F). These four super-ordinate themes formed a framework when analysing each of the core dimensions of the HVs' perceived professional identity.

Considering findings at group-level is useful in understanding the experiences that are commonly shared. Common findings were considered at group-level if presented by approximately 25% or above of the participants. This is a lower than the 50% frequently used and was chosen for a number of reasons. For example, the two sub-samples (Stages 2 and 3) were relatively small and, as HVs' perceived professional identity is composed of 14 dimensions, naturally they did not include all of these in each individual account, or always repeat previously discussed topics. Also, several aspects of professional identity, such as agency, although less spoken of directly, showed greater significance when considered as an underlying concept in the wider context of change (see Chapter 15). The underlying philosophy of phenomenology (including and IPA) considers that experience is individual, particular and idiosyncratic, and as such each story of experience was respected and

valued. Therefore, the discussion includes some atypical 'lone voices', where appropriate, to provide a broader insight.

The discussion on the effects of service change on the core dimensions of professional identity draws together the findings from the Stage 1 and 2 (pre-Covid-19 pandemic) interviews held over a year apart. The information presented was found to be common across both interviews.

As the final (Stage 3) interviews were conducted post-initial peak of the pandemic (2020), the findings from these are mostly discussed separately, as the HVs experienced far more radical changes necessary to practise safely during the Covid-19 outbreak. However, any findings that were appropriate to draw into the main discussion are included.

Any significant changes when comparing the data over time are highlighted. Caution, however, was exercised when drawing comparative conclusions as the working environment continued to alter as service changes were on-going. The interview questions were also adapted to the changing circumstances. Additionally, as mentioned, topics raised in the Stage 1 interviews may not have been explored again by the same participants in their Stage 2 or 3 follow-up interviews.

Many aspects of change and situational factors, such as alterations to the delivery of the service and staff shortages, spanned across the core dimensions as they are interlinked, and therefore may be discussed in more than one context. A presentation of the conclusions regarding each of the core dimensions now follows.

14.2 Health Visitors' Professional Identity

Professional identity is important for optimal professional efficacy (Björkström et al., 2008). Further, and pertinent to this study, a strong sense of identity is important, especially in times of change (Wilson et al., 2013) and when significant changes in the health visiting profession are being implemented (Rooke, 2015).

No consensus could be found in the literature as to what professional identity was in general and, specifically, this researcher also failed to find a comprehensive and current definition of HVs' professional identity. As all definitions and descriptions found were partial or incomplete, this researcher initially explored the participants' perceived understanding of their professional identity in Stage 1a (see Table 7).

All HVs showed a strong sense of their professional identity in their accounts across all of the interview stages (1, 2 and 3). Their professional identity was formed through their identification with the profession, themselves as individuals and interaction with their HV colleagues. They all presented clear evidence that their professional identity embodied who they were (social identity)

and what they did (role identity), aligning with Stets and Burke's (2000) theory. Their professional identity also embraced the personal values and the commitment they brought to their work, agreeing with the views of Rabow et al. (2010) and Wilson et al. (2013).

14.3 Health Visitors' Social Identity

Positive social identity and a sense of belonging is an essential foundation for HVs to fulfil their role optimally and effectively (Beauchamp and Thomas, 2009; Sabanciogullari and Dogan, 2015). According to Wenger (2017/1998), identity is formed through various human interactions and understandings and through participation and reification in the group. Professional identity is continuously forged and renegotiated. One understands 'who one is' through membership of a community (Stets and Burke, 2000: 234), and what is familiar and what is alien. The sense of group cohesion is also important for positive mental health and self-esteem (Stets and Burke, 2000). This is discussed further in 14.3.2.

14.3.1 Core dimension: Self-identification with the health visiting profession

Every participant across all interviews (Stages 1, 2 and 3) showed evidence they personally self-identified as members of the distinct professional group of HVs, i.e., they belonged. This reflects Johnson et al.'s (2012) literature review finding that professional identity in nursing and individual self-concept were closely related. The HVs' self-identification with their profession also fulfils the core social human need to belong (Maslow, 1987/1954). This self-identification was despite the fracturing of a small number of aspects of HVs' social identity, such as the apparent differences in behaviour or priorities of a minority of HVs, which participants attributed to the changes.

14.3.2 Core dimension: Collegiality

Humans are 'hard-wired' to connect, interact, relate and communicate with others and this evolutionary-based drive towards sociality fosters good mental health (Gilbert, 2015: online). Adams et al.'s (2013) study of community nurses found meeting informally and interacting were of great value if they were to work effectively, as well-functioning 'co-creative' teams (Anderson and Anderson, (2010/2001: 191), and as 'communities of practice' (Wenger, 2017/1998: 6). Meeting together consolidates the sense of social identity in belonging to the group (Adams et al., 2013). Cowley (2008/2002), discussing inter-professional teamwork, argues that time is required to continuously work on and sustain the complex relationships involved. This researcher suggests that this is relevant for all teams.

Collegiality was negatively affected to some degree by the service changes. The reasons offered by the HVs were various, but all were underpinned by one or more of the four super-ordinate themes.

When the reasons offered were drawn together collectively, the negative effect of the changes on collegiality was apparent across all interview stages.

Team restructuring and relocation

Team restructuring raised a variety of concerns, especially in the Stage 1 interviews. The HVs desired sufficient and quality opportunities to meet together in person for mutual support, camaraderie, to share experiences, to 'off-load', and to pool ideas for good practice and learning. Most, however, did not experience this. One of the contributing factors cited as disrupting collegiality was the re-forming of teams and also relocating smaller teams into larger ones with a central base (hub). It was not always necessarily the size of the team that was crucial for positive colleague interaction, but the lack of time to be together on an informal basis, compounded by the increased work demands brought about by factors such as staff shortages. Practical issues were also highlighted, such as parking difficulties and limited physical working space within the new buildings. Dougall et al. (2018a: online) advises change leaders to provide 'physical spaces and personal contact' and acknowledge the need for staff peer support (Allcock et al., 2015; Dougall, 2018b).

There was a mixed response from HVs to the restructuring and relocation in the Stage 2 interviews. One determining factor was how well, or otherwise, the former teams had functioned, mirroring Pound's (2013) view that teams may be dysfunctional for various reasons, and that harmony is not a given. Further challenges were raised, including the accessibility to the new bases, such as distance from the caseload locality, and again on-going practical issues. The excessive times teams had been relocated in the recent past and the associated waste of resources was commented upon, the irony being that the perceived reason behind the moves was believed to be an organisational cost-saving exercise.

Missed opportunities were also raised, such as the potential benefits of co-locating with the Family Base staff. The physical move away from GP surgeries and, more recently the HV administration staff, compromised communication and working relationships, as these were both considered to be important for effective practice. A small minority welcomed the new location/team arrangements as they brought about relief from managing large caseloads with fewer staff or other previously existing team problems. However, the majority found the new situation challenging. Again, this mainly appeared to centre around the frequency or otherwise of HVs meeting face-to-face. Physical isolation experienced by several HVs, compounded by the increased volume of work, time-pressures and increased mobile working, resulted in poor mental health, and in a few extreme cases, distress and depression.

Team meeting format

The change in the format of the formal team meetings led by the HVs' immediate managers was also commented upon. The HVs desired that team meetings be more than just information-giving exercises if they were to be of real worth and value to them. Those who commented wanted to revert to meetings that included a more open exchange of ideas, especially regarding the changes. Restricted time was again a significant factor in stifling informal communication between colleagues at team meetings. HVs reported that they needed more time built in as an opportunity for comradeship and collegiate support. It is noteworthy, however, that more than half evidenced they felt supported by their immediate managers, and some recognised that these were often in a difficult and compromised position.

Mobile working

Collegiality was also disrupted by an increased focus on mobile working. The use of mobile devices had been promoted by the government to increase productivity, efficiency and reduce community care costs (DH, 2013). The National Health Worker Project: Final Report (DH, 2013: 22), highlighted benefits to staff that included increased flexibility, better work/life balance, ability to work 'outside "normal" hours', improved 'general communication' and reduced safety issues for lone workers visiting 'un-manned offices'. There was a general feeling amongst the HVs that, having been supplied with mobile devices, there was an implicit understanding from management that working from home would then be the 'new norm', and thus savings from reducing office bases could take place.

The drive for increased mobile working reduced opportunities for HVs to come together informally, again increasing the problems associated with isolation. Additionally, although not officially encouraged by the organisation, many also commented that working 'outside "normal" hours' (DH, 2013: 22) meant continuing their work at home beyond their paid hours to meet the demands of administrative duties. This led to frustration, excessive tiredness and stress for many, and juggling competing loyalties, such as family commitments.

Team inter-relationships

Although mobile phone contact, such as the recent introduction of 'WhatsApp' messaging, was appreciated by some, many again highlighted that this could not replace direct contact with colleagues. Although Wenger (2017/1998) claims that communication between community members is essential in whatever manner it is carried out, this study shows that while remote communication had some value, face-to-face contact was considered irreplaceable by the majority.

Proportionally, an increased number of participants in the Stage 2 interviews directly addressed the need for themselves and fellow HV colleagues to meet regularly face-to-face.

Meeting face-to-face with colleagues was a particular concern for the final group interviewed (Stage 3). Ironically, at a time when the HVs were expressing the need for more direct contact with one-another, for many, the necessary restrictions imposed by the Covid-19 outbreak precluded this. Gilbert (2015: online) emphasises how 'stress and vulnerability' may be alleviated through secure attachments and continuous support from others. West (2020a) adds that this was especially true during the pandemic. The difference, especially in mental health and the ability to cope during such a stressful time, was evident when comparing the accounts of those HVs who could be in regular direct face-to-face contact with colleagues, and those who could not. Many HVs highlighted that it was the peer support they received from colleagues that helped them to cope with the changes, mirroring the views of Gilbert (2015) and West (2020a). The HVs gained strength from the fact that challenges posed by the changes were a shared experience. This strength of collegiality was amplified by the group interviewed, who had worked through the initial peak of the pandemic, and whose accounts showed evidence of even closer ties to, and greater empathy for, one-another.

Pound (2013) argued that excessive office time spent by HVs interacting with other potentially created work distraction, reduced efficiency and increased stress. Since the recent changes, HVs were now appreciative of when they did have time together, as much of their work was carried out remotely, alone, and away from colleagues. As the HVs recognised the need for greater collegiality and more time set aside for face-to-face interaction, some informal measures were taken to increase collegiality and inter-colleague communication. These included 'away days' and craft groups, but these were in isolated pockets, and again the success ironically depended on having enough time and resources to arrange and attend them.

There was some evidence that when morale amongst some team colleagues was low, this negatively affecting other team members. Neumann and Strack (2000: 211) describes this as 'mood contagion', or the 'emotional contagion' of mood transfer in groups as explored by (Barsade, 2002: 644).

In summary, HVs required adequate time and a working environment conducive for informal, face-to-face communication to facilitate good quality peer support in order to practise efficiently and effectively. In practical terms, they required ease of access to, and adequate space within their bases, to work and communicate together.

14.3.3 Core dimensions: Identity as an NHS and/or healthcare professional

Health visitors' identity as an NHS and/or healthcare professional was important to many. Several commented using very robust and emotionally-charged language. They rejected the change which outwardly identified them as corporate health workers and largely indistinguishable from the Family Base staff. This was extended to their public identity as HVs, in that clients should be able to easily recognise their status as trusted health practitioners, with their background as qualified nurses/midwives and NHS affiliation.

A few HVs, however, did not perceive that their identity as nurses/HVs had been diminished through the changes. These commented that they still knew themselves to be HVs with a clinical background, which to them was what mattered, and were more concerned about other changes. This suggests that the strength of their own sense of their professional identity and worth was enough, and their outward visual identity was of lesser importance. They also assumed that this self-belief, translated into their professional role and actions alone, would be sufficient for them to receive professional recognition from their clients.

For the final sub-sample, the Covid-19 pandemic had brought with it a change in that they were now provided with nurses' uniforms as part of their personal protective equipment (PPE). This had inadvertently solved the issue of recognition as HVs and their status as clinical practitioners affiliated to the NHS. It was now clearly communicated to clients and the public, however temporarily.

In summary, all HVs were proud of their professional identity. They claimed they needed to be able to *communicate* clearly who they were if their professional worth and recognition was to be fully recognised, either visibly as nurses with an affiliation to the NHS, and/or through their actions.

14.3.4 Core dimension: Identifying as a registered professional with a professional code and accountability

As professionals with a professional Code (NMC, 2018), HVs are ultimately accountable for their decision-making and actions in practice (NMC, 2020). Accountability was linked in this study with the liberty or otherwise of HVs to enact their autonomy, agency, values and principles embedded in their professional role, which will be further addressed in 14.4.2.

Accountability was a significant aspect of professional identity in the context of the changes. A significant number of HVs had feelings of vulnerability regarding their accountability for their practice. This mainly centred around work pressures resulting from staff shortages, and how HVs understood that they were now directed by their employing organisation to practise within a specified time-frame regarding routine client contacts. Accountability for client safety was directly

addressed in several accounts. Proportionally, the number who raised concerns regarding their accountability increased between the Stage 1 and Stage 2 interviews.

Those working during the pandemic (Stage 3) appeared to be the most acutely ill-at-ease with their professional accountability. The imposed 'partial-stop service', prioritising only certain client groups for HV visits (iHV, 2020c: online), and time-restrictions to limit infection risk and staff shortages, prevented them from providing an inclusive and comprehensive service. 'Invisible' children (Morton, 2020b: online), i.e., children not seen by any professionals during the pandemic, were of a great concern, partly from the perspective of HVs' professional accountability, but more importantly for the safety and welfare of the vulnerable children themselves. This concern was also extended to include vulnerable adults. HVs were aware of the rise of strained family relationships, increasing unemployment, mental ill-health and domestic abuse attributed to the effects of the Covid-19 lockdown restrictions, which included staying at, and working from, home and the closure of schools. Many HVs expressed that their concerns were compounded by them being the only community professionals visiting families. It was believed that other community professionals, such as social workers, were instructed by their managers not to risk Covid-19 infection by entering clients' homes.

In summary, HVs were concerned that their professional accountability was not fully recognised by their managers, prior to, and during the pandemic. The changes that resulted in increased time-pressures, and the way in which their work was often directed by managers, left many HVs feeling professionally vulnerable, 'ontologically insecure' (Ball, 2003: 220) and that their status as professionals was not being recognised by those directing the service.

14.3.5 Core dimension: Professional status and expertise through training and qualifications

As aforementioned, there is a cross-over here between social and role identities.

HVs are nurses and/or midwives who have undergone further specialist training. The research sample of 20 included seven who had between ten and 25 plus years' health visiting experience at the time of the Stage 1 interviews. As staff who interfaced directly with the public, HVs understood themselves to be expert and knowledgeable in identifying and understanding individual, family and community health needs. They thought that their local knowledge and relationships with local professionals and client groups were important factors in client care and achieving positive health outcomes.

Approximately half of the participants (at interview Stages 1 and 2) commented or showed evidence that their expertise and status as a professional was reduced by the changes, and/or their

professional skills were underutilised. A number of HVs also commented that the service changes had imposed restrictions on their practice, which narrowed their public health role. For example, they commented that they were no longer at liberty to facilitate client/parenting support groups, such as breast-feeding or baby massage. This group-work was now the responsibility of the Family Base staff. 'Building community capacity' (DH, 2011a: 16) through facilitating client-led public health work, and once a familiar part of an HVs' role, had been largely set aside.

Throughout the Stage 1 and 2 interviews there was a mixture of responses regarding how HVs' status as professionals was viewed by clients. This appeared to be largely dependent on if, and in what way, clients had contact with the service, and if the HVs' clinical background and role was known and understood. Generally, if there was a positive interaction and strong professional-client relationship, clients tended to view the profession very favourably. Arguably, it follows then that changes that reduced relationship-building and continuity of care were likely to diminish HVs' status and that of the profession.

The Stage 3 participants considered that, although there were understandably tighter restrictions on what they could provide during the pandemic, the majority thought that the service was even more highly regarded and appreciated by their clients. This was evidenced by the surge in client-initiated contacts. In addition, a broadening of HVs' knowledge, skills and expertise grew at this time due to the increase in demands in meeting Covid-19-related threats to health, and the lack of direct client contact provided by other agencies, as mentioned.

In summary, HVs thought that their expertise, skills and knowledge were underutilised at best, and at worst, unrecognised or ignored by their organisation. The health visiting service was generally highly regarded by clients, notably during the health crisis, but not always prior to that, especially if the HV role was unclear. A few remarked on the relevancy of communication, and expressed that, as a profession, health visiting could do more to raise public awareness of who they were and what they did.

14.4 Health Visitors' Role Identity

14.4.1 Core dimension: Professional autonomy, agency and caseload ownership

This dimension and '*Uniqueness and complexity of the HV role*' are inter-related.

Autonomy and agency are well-recognised aspects of professional social identity, and also an integral part of a professional role (Raelin, 1991). Further, Wilensky (1964) spoke of autonomy as synonymous with the concept of professionalism. Professionals highly value their autonomy as practitioners (Heldal, 2015). Posavac's (2009) study findings indicate that potency (agency) was one

of three values required for a positive professional experience. This is a well-documented phenomenon throughout professional identity literature, especially regarding teachers' autonomy. There is also a wealth of literature documenting conflict between professionals and their employers when autonomy was felt to be unrecognised or over-ridden; a phenomenon described by Raelin (1991/1985), Deem and Brehony (2005) and Evetts (2018) amongst others.

Autonomy in health visiting practice is recognised as essential to realise the profession's aims to improve children's outcomes (Pound, 2013: 524-525). A call to 'regain professional autonomy' was embedded in the Health Visitor Implementation Plan 2011-2015: A Call to Action (DH, 2011a: 12), and robustly welcomed and endorsed by influential figures in the health visiting profession including Cheryll Adams¹¹ and Sarah Cowley¹².

Autonomy and caseload ownership were aspects of professional identity that were spoken of frequently and at length by the majority of HVs when discussing their role, and both are also considered in section 14.4.2. Agency, as in the ability to effect change, although not spoken of directly by the HVs, was present as an underlying concept and is considered in 15.1.2.

14.4.2 Core dimensions: Uniqueness and complexity of the HV role and enacting professional values/personal values

These two dimensions have been considered together to make the discussion more meaningful. It also takes into account of the linked dimension of '*Professional autonomy, agency and caseload ownership*'.

HVs have a unique and complex role in visiting all families in England (Cowley and Frost, 2010; iHV, 2019a). Their role involves prevention, identifying health needs and early intervention, which all require a complex set of skills and an 'ability to see beyond the task' and assess the 'complex contextual issues' that affect health (iHV, 2019a: 3).

Restrictions to professional autonomy were evidenced by all the participants in some way, directly or indirectly across all the interview stages (1-3). For example, HVs frequently commented that their work was becoming increasingly more centrally directed by management and formulaic, reducing their autonomy in practice. Another example of change deemed to be a threat to professional autonomy was the increased use of client needs assessment questionnaires and other similar tools. HVs reported that these threatened to interfere with the holistic process and skills involved in HVs' assessments of clients' needs, as described by Appleton and Cowley (2008). Possible outcomes of this included restricting the building of sound professional-client relationships. Examples were given

¹¹ Dr Cheryll Adams, Founding Director of the Institute of Health Visiting (iHV).

¹² Dame Professor Sarah Cowley, Emeritus Professor from King's College, London, specialising in health visiting.

where the results of questionnaires were deemed more valid by managers than HVs' professional judgement, potentially resulting in less-than-optimal client care.

All participants evidenced the three core components of practice, i.e., holistically assessing client needs, visiting them in their homes and building strong professional-client relationships (Cowley et al. (2013), were essential to provide clients with adequate support, advice and guidance. The lack of time to carry out assessments, which are inherently complex and multi-factorial, highlighted in this study mirrors Appleton and Cowley's findings (2008). The on-going problems of staff shortages, the increase in performative and auditing measures (Evetts, 2018), and time-consuming administration duties, were all cited as contributing factors in decreasing the amount of time available for clients. The HVs showed evidence that a lack of time (Evetts, 2018) and the pressure to reach the key performance indicator (KPI) targets (see Appendix A) again threatened to obstruct the building and development of sound professional-client relationships (Greenway et al., 2013; Pound, 2013). This view was supported by a recent 'Channel Mum' survey (iHV, 2020a: online) where parents reported 'feeling rushed' during HV contacts.

Despite the restrictions of HVs' autonomy, over half showed evidence of continuing to practise as before, aligning with Power's (1997: 6) claim that this is a likely outcome for professionals working in an 'audit society'. Almost all evidenced that they were resolute in their determination to uphold their 'cherished professional values' (Schilling et al., 2012: 1230) despite the changes. HVs showed evidence they continued to exercise professional autonomy wherever possible. They held fast to their primary aim: to ensure clients' needs and safety continued to be met. This is in line with their professional Code: to 'put the interests of people [...] first', and the directive, 'you make their care and safety your main concern' (NMC, 2018: 6). For example, using their professional judgement, they strove, when possible, to give clients more time than was (officially) allocated for home visits, development checks, or in arranging follow-up visits. This was despite the knowledge they were breaching their organisation's guidelines and could be open to challenge. A few went further, confidently admitting to 'playing tick-box games' (McGivern and Ferlie, 2007: 1361), i.e., recording just enough on the questionnaire-style record templates to satisfy their organisation's auditing requirements, demonstrating disguised compliance and obedience (Townley, 2002).

Aligning with Loman's claim (2019), the participants referred to upholding health visiting values that they believed in as persons as well as professionals. Their personal values of justice, fairness, compassion and kindness amongst others, fused with the profession's values such as ensuring that clients' interests remained their primary concern (NMC, 2018), and addressing health inequalities (Cowley and Frost, 2010; iHV, 2019b).

Linked with the HVs' values are the four inter-related principles of health visiting practice (Cowley, 2007: 757):

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

A few HVs in the Stage 1 interviews commented directly that the changes threatened not only their professional values, but also the first two principles. The other principles were not overtly named, although there was evidence of the fourth principle being enacted in practice, for example, in prioritising support for breastfeeding and immunisation. The third principle was not commented upon or evidenced in practice. This was unsurprising given the climate of rapid change, the stresses and time-pressures of managing heavy workloads, and the variable relationships with their organisation.

Caseload ownership and continuity of care were also highlighted by the HVs as vital for effective practice, mirroring Whittaker et al.'s (2013) study, and were thwarted by moving towards a more 'task-based' work allocation process. It is also widely recognised that continuity of client care and caseload ownership working is more meaningful, satisfying and less stressful for practitioners (Pound, 2013). As long ago as 1960, Menzies' research into hospital nurses' high levels of chronic stress and anxiety, and excessive resignations, led to a recommendation that a 'task-list system', believed to be a contributing factor, was replaced by 'patient assignment' (Menzies, 2016/1960: 119).

Building trusting professional-client relationships and continuity of care not only supports and improves client welfare (Olds, 2006; Donetto, et al., 2013), but is a preferred and desired type of contact by parents (Bidmead, 2013; iHV, 2020a). It was also preferred by the practitioners themselves (Bidmead, 2013) and provides job satisfaction (Whittaker et al., 2013b). Direct evidence of this was apparent in virtually all accounts, and the importance of the 'human element', especially face-to-face contact with clients, as with colleagues, cannot be overstated. The 'human element' as central to practice reflects the first of the three core principles introduced by Aneurin Bevan when he launched the NHS in 1948, namely 'that it meet the needs of everyone' (Politics.co.uk, 2021: online).

The Stage 3 participants accepted that restrictions to practice were necessary to limit the risk of infection. These included time restrictions on home visits which did not permit the quality of client contact that the HVs' would normally aspire to foster in other circumstances. Redeployment of HVs

to other clinical areas, and the shielding of some colleagues, exacerbated the pre-existing challenges of high caseload numbers and staff shortages, further restricting time for client care. Caseload ownership and continuity of care, in the form of follow-up visits, were also compromised due to the limited time available. Professional autonomy and agency were also restricted, resulting in a sense of powerlessness for some. The HVs' belief in autonomy as a fundamental tenet of practice is mirrored in the iHV commissioned report on the effects of the pandemic on health visiting in England. It states, 'professional competence and control requires staff to have sufficient autonomy to lead a personalised health visiting service' (Conti and Dow, 2020: 3).

For those HVs who were able to work closely with families during the pandemic, the clients' appreciation of the service appeared to off-set the challenges. A number also exercised their autonomy by putting their clients' needs and care above their own, even risking infection by staying in homes for longer than directed, particularly before they had access to personal protective equipment (PPE). This group also all showed evidence that the uniqueness and complexity of practice was amplified and intensified during the Covid-19 outbreak. Several spoke of their role being extended and broadened, not only because many community services had temporarily halted, but also because of the increase and widening of health needs and challenges, such as financial problems from sudden unemployment.

In summary, many of the changes had a detrimental impact on HVs' professional autonomy, agency and caseload ownership. The main changes that had a negative impact were the way the service was now directed to be delivered and the increased caseloads. Despite these challenges, almost all HVs showed evidence that they were resolute in their determination to uphold their practice principles, professional and personal values, and exercise their autonomy whenever possible. Many reported they brought themselves into their work, not only through their personal values, but also their experiences and personalities, aligning with the views of Cruess et al. (2016a). HVs understood the complexity of their practice, and many continued to practise in line with their professional Code (NMC, 2018), even if this was not in-line with management directives. As one participant, P2 C, summarised for many:

"I still feel the core substance of a health visitor remains the same" (S13 L1-2).

Of the very few who did not speak out so strongly or showed evidence of this in their contributions, other matters appeared to dominate at the time of the interviews, such as striving to maintain their own mental health and wellbeing.

The Stage 3 participants tried to maintain their professional and personal values despite the restrictions. However, not being able to exercise these fully in their practise created some of the negative psychological effects of the changes, which will be discussed in 14.6.

14.4.3 Core dimension: Emotional and personal commitment, investment and attachment
HVs as professionals are 'cosmopolitans' as opposed to 'locals' (Gouldner, 1957: 281), meaning that they are affiliated to a group outside their employing organisation, and as such their sense of self-continuity is bound with this external group (Schilling et al., 2012). There is a professional need to feel authentic at work, and for 'professional happiness', the freedom (autonomy) to practise freely, and have the time and ability to work according to one's priorities (Posavac, 2009: 574).

Significantly, an increased number of HVs at Stage 2 interview evidenced that they felt saddened that their clients were not receiving a level of service that they, as professionals, aspired to provide, as previously discussed. That said, all expressed positive emotional feelings of self-worth and achievement, which were the psychological rewards they experienced from working with appreciative clients. All the participants in the second interviews shared a deep personal and emotional attachment to their practice. Amongst the most impactful comments were the following:

P2 G "...it's an amazing job." (S10 L18)

P2 I "I do love the job" (S19 L21).

Although all participants demonstrated a clear personal attachment to health visiting, a significant number had contemplated, or actively sought, to resign from post. The number of HVs who had contemplated resignation proportionally increased over time; over one-third at the Stage 1 interviews, to almost half at Stage 2. All but one evidenced that, for them, this was as a direct result of the challenging effects of the various changes on the service that they were now directed to deliver, and/or on themselves as professionals. This appears to link with the correlation between job satisfaction and staff retention (Withey and Cooper, 1989; Saari and Judge, 2004).

All HVs interviewed during the pandemic felt a very strong attachment to the health visiting profession, although their experience of the practice changes felt even more challenging. In contrast to the Stage 1 and 2 interviews, these HVs generally accepted that the changes were largely outside the jurisdiction of their organisation, as they originated from the government. The rewards from practice were amplified, as most commented on how greatly the service, and themselves as professionals, were appreciated by clients. This was demonstrated through the verbal gratitude received from clients and the increased requests for advice and support. Some HVs commented they became more acutely aware of the value of health visiting, strengthening their personal

commitment to the profession. Significantly, a smaller proportion than in the previous interviews said they were actively seeking or contemplating resignation.

In summary, all of the HVs showed a strong commitment to their health visiting practise. They felt a sense of fulfilment and professional worth when they were able to practise in a way that optimally benefitted their clients' health and wellbeing.

14.4.4 Core dimension: Inter-professional working and the Corporate Service

Over the course of this research there have been an increasing number of reports from government-affiliated bodies and other parties regarding the integration of health and social care as part of the greater NHS transformation plan (Alderwick and Ham, 2017). Many have been amended to include additional thinking following the Covid-19 pandemic, frequently citing this as an even greater reason to realise this integration. This has culminated in the government's White Paper, 'Working together to improve health and social care for all' (DH, 2021) published at the time of writing.

As stated, inter-professional working (IPW) is a key aspect of HVs' professional identity, in that it is recognised as essential for clients' safety, welfare, and their best interests (Laming, 2003; Wackerhausen, 2009). Several HVs commented that the HV profession, being a universal service, was at the centre of health (and social care) for clients. One summarised, for others, that she likened the HV profession to a 'Rawl Plug', not only working collaboratively with others but as a pivotal anchor, i.e., at the very centre of care.

Those interviewed prior to the pandemic raised a number of professional concerns regarding the effects of change on their ability to work and easily liaise with other health professionals. HVs thought that their contact and professional relationship with GPs had reduced, mainly due to HVs' relocation away from surgeries, which had been a slow transition over several years. The majority had concerns with the working arrangements outlined in the new Corporate Service, including the need for a clearer definition of roles, the need for more recognition of HVs' extensive training, expertise and experience, and the possible de-skilling and depletion of the HV role, all of which threaten professional identity (Baldwin, 2012; Heldal, 2015).

Although a year or more had passed since the roll-out of the Corporate Service, in Stage 2, the HVs reported that the Family Base branch was still lacking the capacity to deliver a full service, or was performing in a way that did not fulfil clients' needs or expectations. Almost all stated that they believed the Corporate Service was still not functioning as they were led to expect by their organisation at the outset, and spoke of their own HV practice as separate and unintegrated. Significantly, almost all thought that the arrangements had resulted in a direct, detrimental effect on their practice. They stated that their workload had greatly increased, not just through HV

resignations (commonly cited as a result of the changes), but also taking on work the disbanded Children's Centres had previously covered. Additionally, their clients' needs were not being met through cuts to the service, for example, in the reduction of client support groups.

It was noteworthy that in the Stage 2 interviews there was a proportional increase in the number of HVs who spoke of their regret at the loss of the close and functioning relationships they had experienced with the disbanded Children's Centres' staff prior to the Corporate Service. A paucity of good communication, especially face-to-face with the new Family Base staff, was often cited as a concern. Many of the Family Base staff were still unknown to them, adding to the confusion and uncertainty over what this sister branch of the Corporate Service could offer. However, a few conceded that the Corporate Service was still in its transition phase and that the changes had future potential. It was also widely acknowledged that this was not any fault on the part of the Family Base staff themselves, recognising that they too were undergoing substantial reorganisation, and that financial constraints were an underlying cause.

For a minority, the changes had led to a re-thinking of the future role of the HV. They had reflected deeply about their professional identity, becoming 'strangers to themselves', which Wackerhausen (2009) advocates is required as the world rapidly changes, and for effective inter-professional working. For example, a very experienced HV accepted their future role would likely look very different, possibly taking more of a leadership in public health, rather than as practitioners individually holding universal caseloads. It appeared that the majority understood their professional identity as appropriate, not just for the present but also for the future, especially regarding the universality of the service and direct contact with clients.

There is also much evidence in this study that the HVs actively desired and engaged in IPW. Many were frustrated that the merger of the health visiting and former Children's Centre services into one umbrella service had ironically created barriers, albeit if only temporary.

The challenges of IPW considered to have been created by the changes were greatly amplified during the pandemic. Although the ideal was to work together, the fact that most other professionals were working almost completely online with clients led the HVs to feel they were working in isolation. They felt solely responsible and accountable for greater numbers of clients, especially for the more vulnerable families and children.

In summary, all the HVs showed a commitment to work collaboratively with other professionals, understanding this to be essential in their public health and safeguarding role. All of the HVs considered their ability to put IPW into practise was very limited due to various service changes. This was either through team relocation, early challenges with the Corporate Service roll-out, or the

radical changes made in response to the pandemic, and in many cases undermining effective communication and support for one-another.

14.4.5 Core dimension: Public worth and value

Health visiting is 'a cornerstone of primary care' and has provided a public health service in the UK for over a century and a half (Cowley and Frost, 2010: 73). Another important finding was that all the HVs' accounts showed their continued perceived public worth and the recognition of the value of the health visiting service, despite the on-going changes. As discussed, many cited positive responses from most of their clients. In all cases the rewards of practice were uplifting and affirming for the HVs and, for many, helped to offset the negative psychological effects of the changes. As mentioned, the proportion of HVs who felt that they were still 'letting their clients down' through not being able to deliver the quality of service to which they aspired, had increased by the Stage 2 interviews. The majority in the final interviews expressed they had become even more aware of the value of their work as HVs. The exponential rise in clients contacting the service, supporting the notion that health visiting was valuable and worthwhile. This mirrors Morton's (2020a: online) comment, especially regarding providing a 'vital "safety net"' for the vulnerable:

"It's taken a global public health pandemic to shine a light on the importance of health visiting".

Barnett (2008: 192) recognised that there has been a 'de-mystification of knowledge', and that professionals are now only one of many sources of health information available to the public, all of which can be accepted or contested by them. However, this study shows evidence that parents continue to respect and trust HVs' knowledge and expertise, despite the growth in readily available online information.

How HVs practise was being evaluated was strongly questioned by a few. As mentioned, HVs understood their practice to be complex and holistic, and they believed its worth cannot be adequately assessed through auditing tools, such as standardised templates, aligning with the views of Cowley (2002). This issue will be further addressed in 15.1.1. A few HVs also thought that other ways to evaluate the service were needed, although this would likely require a process that looked at long-term, rather than short-term, outcomes in public health.

In summary, this study shows that, based on the views of the participants, the health visiting service was valued and appreciated by the majority of clients who received it. The HVs' thought that in providing a universal public health service and collaborating with other professionals to support families and help safeguard the vulnerable, their worth and value needs to be more broadly recognised.

14.5 The Public Face of Health Visitors' Professional Identity

As the public were not interviewed it is acknowledged that only the HVs' perceptions of the public's understanding and recognition of their role and status can be discussed.

A notable number of HVs were concerned the changes had resulted in a detrimental effect on their public identity by denigrating their professional identity as NHS affiliated healthcare professionals. The HVs' NHS lanyards and identity badges had been replaced by others with the new Corporate Service logo on them. HVs who raised this as a concern were resolute that their NHS affiliation should be communicated clearly to their clients and the public at large, and these identity items should continue to bear the internationally recognised NHS logo. For those who commented, the NHS logo was understood as being respected and easily recognised by the public, irrespective of their background or nationality. It was understood to be a symbol of trust with good governance, welcomed by the public, and provided HVs with a relatively easy access to homes and families.

For those working through the pandemic, very few commented about their public image beyond their clients' appreciation of them. One expressed her delight in wearing a nurse's uniform as part of her personal protective equipment (PPE), which she thought helped the public recognise her professional background, clinical expertise and knowledge.

In summary, those HVs who commented on their NHS affiliation and clinical background did so in strongly emotive language. They thought that the public greatly benefitted from being made aware of this and it was important for the status of the health visiting profession.

14.6 The Psychological Effects of Service Changes on Health Visitors as Professionals and Persons

14.6.1 Psychological effects in the context of change

Change per se can be disturbing and stressful (Anderson and Anderson, 2010/2001), but Schilling et al. (2012) propose that individuals' change responses can vary. Reactions can be influenced by personality type, loss of control, concerns over an insecure future, or a perceived lack of personal status or security. As the transformational change in the NHS is the most radical of all types of change, Anderson and Anderson (2010/2001) claim it is normal for such a change to result in the greatest emotional and psychological disruption to staff.

This researcher explored what it was like to be an HV during a time of service change. It is acknowledged that the views and feelings expressed by the HVs were in the context of time, i.e., the transient points between when this researcher entered and exited the scene (du Plock, 2008). The following discussion on the psychological effects of the changes experienced by HVs brings together

much of what has been previously presented. This highlights the understanding of individuals' professional identity as nested within their other identities and demonstrates how professional identity and the self are closely related (Johnson et al., 2012). It also aligns with Vignoles et al.'s (2011) claim regarding the comprehensive nature of identity, that all aspects are both personal and social.

HVs are professionals in one of the 'caring and healing professions' (Wackerhausen, 2009: 457). As such, they come to work with a personal desire to care and heal, as evidenced in all the HVs' accounts, and also bring their own values to their work (Loman, 2019). Their 'values, morals and attributes' are integrated with their professional identity, creating their 'professional selves' (Wilson et al., 2013: 372). Considering such a high personal investment, the psychological rewards of practice, as mentioned, can be a source of great self-affirmation and work satisfaction. However, when met with challenges that adversely affect their ability to practise according to their professional and personal principles and values, undesirable psychological effects may result. This reflects Bourdieu's concept of 'hysteresis' (Hardy, 2014/2008: 127), which occurs when there is a disruption between one's 'habitus' (for the HVs this was their cultural 'capital' of their understanding of themselves and their work as HVs), and 'field' (their workplace). This disruption can lead one to feel like a 'fish out of water' at that time (Maton, 2014/2008: 56). If unable to fulfil one's role as one understands it to be, potential feedback is a diminished concept of the self (Hogg et al., 1995). Further, focussing on HVs, Whittaker et al. (2015) propose that if HVs' aspirations, work motivation and satisfaction are to be fulfilled, HVs need to feel psychologically in-tune with their role. Their 'orientation to practice' (Cowley et al., 2013: 11) (see 3.7) and their 'workforce values' (Whittaker et al., 2015: 13) (see 10.4.1) need to be realised. The ultimate outcome of these not being fulfilled can lead to a breach in the 'psychological contract' with their employer and in turn may lead to problems with staff retention (Maben, 2008, cited in Whittaker et al., 2015: 16).

14.6.2 Review of psychological effects across the study

Table 24 below records the occurrence of the feelings/emotions expressed across all of the interview stages, either spoken directly or interpreted by this researcher. The six feelings/emotions most often presented by the participants have been highlighted.

Table 24 The occurrence of the feelings/emotions presented by the participants across all interviews

S = spoken directly
I = researcher interpretation

Feeling/emotion keyword	Stage 1b (n=19)			Stage 2 (n=8)			Stage 3 (n=7)			Total all Stages
	S	I	Total	S	I	Total	S	I	Total	
positive/hopeful	3	0	3	1	0	1	2	0	2	6
happy/accepting	1	0	1	1	0	1	1	0	1	3
de-skilled	2	0	2	1	0	1	2	0	2	5
(sense of) loss (of ID)	6	2	8	0	0	0	2	0	2	10
undervalued/devalued	8	3	11	5	0	5	3	1	4	20
disillusioned/'let down'	11	2	13	3	0	3	0	1	1	17
disheartened	8	6	14	0	0	0	1	2	3	17
demotivated	2	3	5	0	0	0	1	0	1	6
disappointed/deflated	5	8	13	1	0	1	2	0	2	16
disempowered	10	2	12	3	0	3	3	0	3	18
disrespected	10	3	13	4	0	4	3	0	3	20
insecure/destabilised/unsettled	3	3	6	2	0	2	1	0	1	9
vulnerable	4	4	8	1	0	1	2	1	3	12
isolated/alone	1	1	2	2	0	2	3	0	3	7
"trapped"	3	0	3	2	0	2	1	0	1	6
resigned	1	1	2	1	0	1	1	0	1	4
sad/unhappy	7	3	10	2	0	2	2	0	2	14
worried/concerned	5	1	6	2	0	2	3	0	3	11
upset/tearful	1	3	4	1	1	2	1	1	2	8
anxious	7	4	11	1	1	2	4	0	4	17
work stressed	13	2	15	4	0	4	3	0	3	22
panicky/fearful/"on the edge"	8	1	9	1	1	2	1	1	2	13
distressed	3	0	3	1	2	3	0	1	1	7
depressed	1	0	1	1	0	1	1	0	1	3
tired/exhausted	5	1	6	2	1	3	3	0	3	12
pressured/overwhelmed	14	0	14	4	0	4	3	0	3	21
confused	9	3	12	2	0	2	7	0	7	21
frustrated	13	3	16	1	2	3	2	1	3	22
cross/irritated/annoyed	6	4	10	3	0	3	1	1	2	15
angry	2	0	2	1	0	1	0	1	1	4

Table 25 below lists the six most prevalent feelings/emotions expressed by the participants and where the feelings/emotions were recorded across all the interviews in percentage terms:

Table 25 The six most prevalent feelings/emotions expressed by the participants across all interviews

Feeling/emotion keyword	Stage 1b	Stage 2	Stage 3	% of participants presenting feelings/emotions ¹³ at each stage		
	Total	Total	Total	1b (n=19)	2 (n=8)	3 (n=7)
work stressed	15	4	3	79%	50%	43%
frustrated	16	3	3	84%	38%	43%
pressured/overwhelmed	14	4	3	74%	50%	43%
confused	12	2	7	63%	25%	100%
undervalued/devalued	11	5	4	58%	63%	57%
disrespected	13	4	3	68%	50%	43%

Interesting insights can be gained by reviewing the data, although only broad trends can be presented as participants experienced different changes between interviews, thus their working conditions were not directly comparable. This was especially the case for the final sub-sample working during the pandemic. That said, reviewing the six most common feelings/emotions presented by participants and in percentage terms does offer a cautious overview and backs up this researcher's observations.

Comparing the data from Stage 1b and Stage 2 interviews shows some striking similarities. There were four (4/30) most commonly experienced feelings/emotions presented by half or above of the participants in both groups. Work stress was one of these. This aligns with the link made between organisational change and increased work stress (Anderson and Anderson, 2010/2001; Contreras and Gonzalez, 2020). The others were feeling pressured/overwhelmed, undervalued/devalued and feeling disrespected as a professional (by their organisation and national policy and decision-makers).

There was a proportionate decline by Stage 2 interviews of all but one of the six most common feelings/emotions expressed. There may be several possible interpretations for this decline. The

¹³ Percentage calculation. The number of participants presenting feelings/emotions out of the total number in each sample, multiplied by 100. For example, 15 participants in the initial interviews showed evidence of work stress. This number was divided by the total sample number (19) multiplied by 100 = 79%.

participants may have grown more accustomed, accepting or resigned to the on-going changes, or having discussed their feelings on related topics in the initial interview, these were not repeated. The exception of feeling undervalued/devalued as a professional which persisted and slighted increased.

Returning to Table 24, seven other feelings/emotions were expressed by over half of the participants during the Stage 1 interviews. In descending order of prevalence these were:

- disheartened
- disillusioned/'let down', disappointed/deflated
- disempowered
- anxious
- sad/unhappy, cross/irritated/annoyed.

In Stage 2, half or more of the feelings/emotions were also expressed in half or more of the Stage 1 interviews. Being distressed and tired/exhausted emerged as additional, commonly expressed (3/8) feelings/emotions in Stage 2.

With reference to Table 25, when cautiously comparing the sub-sample (Stage 2) working before the pandemic, and the similar number of those working during it (Stage 3), there was a small decline in all of the negative feelings/emotions except for two. A possible interpretation could be that the sense of achievement and camaraderie working through the health crisis may have offset the more negative effects of the service changes. However, frustration had continued and slightly increased, and there was a noticeably large increase in feeling confused, rising to 100 percent of all participants; this possibly echoed the general sense of confusion felt country-wide. For this final sub-sample, anxiety was also presented by over half of the participants, comparable with the findings in Stage 1 interviews. Again, this is unsurprising as when initially interviewed, all the participants were experiencing a rapid onset of change, and the final sub-sample were working during an unprecedented health crisis. A particularly noteworthy finding was that over half of the final sub-sample also showed evidence of feeling undervalued/devalued by their organisation, policy and decision-makers, which was virtually the same proportion as in the Stage 1 and 2 interviews.

As mentioned, caution is required when comparing feelings/emotions, not only as changes were ongoing, but because the frequency of feelings/emotions presented does not necessarily indicate their strength or gravity. For example, feeling disrespected was presented/reported 20 times across all interviews, whereas, feeling depressed only three times, yet arguably a more serious indicator of poor mental health.

Reasons given for the HVs' negative psychological responses were multifactorial. Almost all were based around relationships, whether these were with colleagues, management/decision-makers and implementers or clients. As stated, any reduction of the service to clients was judged by the HVs as of paramount concern. Many HVs commented that the way the service was now directed to be delivered would negatively affect client care, with changes to work allocation, and a breaking down of caseload ownership resulting in the reduction of autonomy and agency.

Lack of time was cited by many to have contributed to their work stress. Many HVs reported that they were struggling to manage large caseloads and complete administrative tasks, leading to anxiety for the wellbeing of their clients, and their own professional accountability and mental health. The HVs also reported that the lack of a fully functioning Corporate Service also contributed to the stress of increased work-loads and time-pressures.

Another inter-related issue was the shortage of staff as a result of resignations and sickness absence. Maguire (2019) highlights that the recent increase of levels of absence from work attributed to stress and mental ill health amongst nurses/HVs is greatly concerning. During 'The Courage of Compassion' online event, contributors discussed the present situation for nurses and midwives at the time of writing (The King's Fund, 2020e). It was stated that nursing is facing its biggest crisis to date, with unsurpassed levels of debilitating and chronic work stress causing illness and absenteeism. They identified the two inter-related key problems of an unprecedented workforce shortage and chronic excessive workloads, which are contributing to a high staff turnover and vacancies in the NHS.

Some HVs commented that the fundamental issues of staff shortages and excessive workloads need to be addressed at a national level, not just through the provision of resilience training, for example. Many HVs also commented that the confusion, contradiction, excessive speed and relentlessness of the changes created additional stress, pressure and frustration, aligning with Vähäsantanen's (2015) claim that these are the possible effects of change.

Communication was another central issue for the HVs. For example, team relocation or increased use of mobile devices led to poorer opportunities for staff to meet informally face-to-face. This was especially cited as a problem during the pandemic, exacerbating low morale. A significant number of HVs commented there were barriers to communication with their organisation, and thought as professionals their opinions were not sought in a meaningful way. With reference to the service changes, the majority thought that they were not genuinely consulted, despite their experience and knowledge of what implementations were likely to succeed and what were not. HVs thought that, being 'closest to the ground' and interfacing directly with the public, they were the staff most

knowledgeable about the local context and circumstances that affected their clients' health and wellbeing. Unlike in Oshikanlu's (2015) underlying assumption that HVs need prompting to be proactive in decision-making, most participants were frustrated that they were not invited to do so. There were a very small minority of exceptions to this view. One HV thought that she had been sufficiently consulted, and the other that her opinion had been sought many times, but she had not responded due to the pressure of her increased caseload, and believing that this was not part of her role.

Most HVs perceived the style of leadership to be hierarchical, with directives filtered down to them as passive recipients, as if dependent on instructions in order to practise (Woods and Roberts, 2018). The implications of this were that the majority thought their professional autonomy and agency was disregarded, leaving a shared sense of powerlessness, low morale and a feeling that they were not recognised or respected professionals. This aligns with Oreg et al.'s (2011) claim that a sense of control is a predictor of wellbeing and work satisfaction.

It must be acknowledged that there was a noteworthy minority of HVs with different attitudes towards, and perspectives on, the various changes. By the Stage 2 interviews some thought that the changes had brought about improvements. Commonly this was centred around the positive impact of being relocated into a more well-functioning team, with an increased sense of team support and collegiality that helped off-set work stress.

A few very experienced practitioners often presented with seemingly blasé attitudes. These HVs commented that changes 'go around in cycles' and that the current situation was bound to change again, thus enabling them to keep a calm and a less emotionally-charged perspective. One HV described her experience of change as a struggle between pragmatism and her cognitive understanding of the need for change, through her confused emotions. There was a sense of powerlessness and inevitability, which conflicted with her hope for the future. She understood her reactions to the changes mirrored the stages of grief as outlined by Kübler-Ross and Kessler (2005).

Many of the HVs working during the pandemic continued to feel undervalued/devalued by their management, and policy and decision-makers, for similar reasons as given in the previous interviews, but other factors also came into play. Comments included the expectation by management to continue to visit clients even before supplies of PPE were readily available, and the rapid return to provide a wider service beyond the 'partial-stop' (iHV, 2020d: online), despite the many challenges associated with staff shortages. One participant also commented that she was aware that there was a disparity between what she was expected to deliver by her employer and other HVs across the country, as recognised by the iHV (2020b). However, a few HVs also

commented that they had collaboratively made some successful minor changes to practice at a local level, which appeared to increase their sense of professional worth and recognition.

The final sub-sample reported high levels of work-stress and anxiety over the infection risk, workload and 'invisible' children (iHV, 2020d: online), and HVs were concerned that they were unable to deliver the service they aspired to under former circumstances. However, it appears that this was partly offset by a team-spirit of 'all in this together' and fortitude in facing adversity. Comments were made that very few colleagues took sickness absence at this time, and the sense of camaraderie, empathy and support for one another was stronger than pre-pandemic. There was also some sense of hope and future opportunities for a few. Most felt appreciated by their clients, building their sense of pride and achievement. Illuminated by the crisis, they realised just how valuable the health visiting service was.

14.6.3 'Health Visitor Implementation Plan practitioners'

The 'Health Visitor Implementation Plan (HVIP) practitioners', seven of which were interviewed at Stage 1, notably showed evidence of being significantly affected by the changes. These HVs had been strongly encouraged to join the service, train, and be fast-tracked to meet the government's plan to substantially increase the HV workforce between 2011-2015 (DH, 2011a). Over half commented directly that their experience of the service and their role had changed dramatically for them since qualifying. Of the original seven, one resigned from post before the Stage 2 interviews, and of the remaining six, three were interviewed again pre-Covid-19 pandemic. Their experiences and the psychological impact of the changes were varied. At one extreme, one felt more settled and happier at work, as opposed to another, whose experience was such that she felt she could not continue in her role as an HV due to work-related stress.

14.6.4 Hope

Although hope was expressed by some participants across all of the interview stages, it was complex and multifactorial, thus challenging to analyse. Only two of the 12 HVs during the Stage 1 interviews who spoke in some way about hope did so wholeheartedly and unambiguously. One very experienced HV remained upbeat and philosophical, accepting that radical change was inevitable, given the reality of the challenging financial situation in the NHS. Others spoke in terms of trying to remain hopeful, even if only in respect to some of the changes. Hope was referred to either in local terms of the settling, slowing, and/or the positive potential of some of the changes, or in the wider terms of hope for the profession's future. Similarly, during the Stage 2 interviews, only one of the four who spoke about hope did so wholeheartedly. Interestingly, a greater proportion of participants at Stage 3 interviews spoke of hope unreservedly. Although comments were often

ambiguous, those who spoke of hope across all the interviews were optimistic that, in time, the changes would become clearer and more embedded in practice, and that overall health visiting as a profession would survive because of its public value.

14.6.5 Summary of the psychological responses to service change

Many of the HV research participants in this study presented and/or reported significant challenges to their health and wellbeing as a result of the service changes. The possible effects that significant change may have on its recipients are a subject which is gaining ground at the time of writing, especially since the pandemic. Leslie (2021) argues that the potential enormity of the impact of radical change on the mental health of staff needs to be recognised and properly addressed. Anderson and Anderson (2010/2001) propose measures are required to allow negative views and feelings to surface and be explored if adaption to change is to be successful. The general view of the HVs was that there was not enough provision or time allocated for them to explore their feelings and emotional responses to the changes. The HVs cited a number of other ways that would support their sense of wellbeing and morale. For example, increased time for face-to-face contact between themselves and their colleagues and the need for clearer communication and collaboration between all tiers of staff in their organisation.

Compassion, not only towards clients, but between all staff members in an organisation has been especially highlighted during the pandemic as fundamentally important for the mental health of all staff (West, 2020a). The HVs emphasised the need for greater professional recognition of their worth by their organisation, and by national policy and decision-makers. The sentiments underlying many of the accounts align with The King's Fund (2020c) 'The Courage of Compassion' report and West's (2020a) call to move forward and create a more compassionate working environment for all.

Hope and positivity were evident in some of the HVs' accounts. The majority of the HVs in this study reported experiencing high levels of work stress and frustration as a result of the changes. However, when directly engaged with clients and able to practise at a level to which they aspired, work remained rewarding and meaningful. Reviewing the overall impact of the changes reveals what supports the health and wellbeing of the HVs and what does not. In turn, this is valuable for the effective functioning of the organisation, and in providing an optimal service for clients.

Chapter 15 Discussion of the Findings Part Two: Health Visitors' Professional Identity in the Wider Context of Change

The previous chapter focussed on the core dimensions of HVs' professional identity using the framework of the four super-ordinate themes of communication, time, support and professional worth and recognition. This chapter considers the effects of change on the HVs' professional identity from other perspectives.

15.1 Professionals Working Within Organisations

15.1.1 Implementing national change locally

The challenges and difficulties for both professionals and the organisations who employ them has long been recognised and extensively addressed in the literature. Far-reaching changes made to the service that professionals offer the public can challenge their professional identity and adds a further dimension to the potential conflict of a pre-existing 'clash of cultures' (Raelin, 1991/1985: xiv).

From the participants' responses it appeared that the leaders of change within their organisation and the HVs were often fundamentally at odds with one another. Whilst the aims to optimise health and reduce health inequalities, and the values of fairness and justice appeared to align, each were obliged to 'serve different masters'. According to Anderson and Anderson (2010/2001: 141), 'justice and fairness' are a 'core human need'. A significant number of HVs showed evidence that they thought that many of the changes and/or the way they were implemented were unfair to them as professionals and persons, which can induce resistant behaviours (Armenakis et al., 2007).

Effectiveness and efficiency often seemed to misalign. In the current financial climate, there is a need for greater efficiency in the NHS (NHS England, 2017, 2019). This is to be balanced with providing an effective public health service, which if underfunded and understaffed is seriously compromised (Brook et al., 2019; iHV, 2019; The King's Fund, 2020e). The result of this conundrum for one HV, contemplating the effects of the changes on HVs' professional identity, is stark:

P1 E "...slowly, we're losing our identity and I think it's just down to cost" (S19 L1-3).

Only a few HVs acknowledged the reality of the national situation regarding the NHS funding constraints or recognised that NHS leaders were operating 'in a climate of extreme pressure' (The King's Fund, 2020a: online). This pressure was of course exacerbated by the unforeseen Covid-19 pandemic. The constraints on the NHS were largely more recognised and accepted by the final sub-sample working through the health crisis, although opinion was divided as to whether their managers always acted in their best interests when directing the service.

The changes implemented, locally rather than nationally, were the main focus of the HVs' concerns. As discussed, almost all the HVs showed very clear evidence that they placed their clients' interests above all else in line with their professional code (NMC, 2018). The client-focussed processes involved in assessing, identifying and addressing health needs are complex (Appleton and Cowley, 2008), as summarised here:

P1 B "One size does not fit all, not by any stretch of *anybody's* imagination" (S7 L9-11).

The organisation, on the other hand, was required by government to establish standardised procedures and meet targets through key performance indicators (KPIs) relating to HVs' practice. In reality, HVs agreed with Cowley (2002) that practice is too complex to be fully evaluated through a simple and standardised auditing tool. This reflects Evetts' (2018) view of the challenges for professionals increasingly being managed by large organisations (although Evetts balances this with possible opportunities). Pound (2013) acknowledges that this may result in frustration for managers trying to implement national guidelines and meet KPI targets, when HVs exercise their autonomy to meet clients' needs in ways that they, as professionals, judge as most appropriate.

15.1.2 Managing change locally

As discussed, the majority of the HVs thought much more could be done to improve communication and increase collaboration between the organisation and themselves as front-line staff. Many HVs called for increased open, respectful and fruitful dialogue, and for senior staff to be more accessible and visible, as suggested by Anderson and Anderson (2010/2001). This would support an atmosphere of trust (Schilling et al., 2012). One HV spoke for many when she offered a possible way forward. She felt strongly that the organisation's decision-makers should meet HVs more regularly face-to-face, even if only to acknowledge HVs' concerns and empathise with them. It is interesting to note that Griffin (2002: 61), reviewing chaos and complexity theories, suggests that no members of an organisation stand apart as all are integrated into a 'living system'.

Many of the HVs reported feeling frustrated, irritated and a sense of powerlessness resulting from not feeling genuinely consulted, which would have been a characteristic of a more collaborative style of leadership. Anderson and Anderson (2010/2001), amongst many, claim that change is more accepted, successful and optimally effective if there is collaboration between professionals and employers. Johnson et al. (2006) claim that staff work stress decreased if they collaborated in decision-making. Oliver (2010), Oshikanlu (2015), and more recently, Dougall (2018b) and The King's Fund (2018, 2020c), all argue that professionals need to play an active role in decision-making relating to change and in the re-shaping of their profession.

Although the concepts of distributed, collaborative and more hierarchical styles of leadership are too complex to be explored in depth, some aspects of these are relevant in this discussion. For example, Harris (2013) claims that effective distributed leadership structures are still headed-up by formal leaders. These leaders tap into the staff's potential and create opportunities for them to informally lead and influence the organisation, based on the notion that there are many influential sources within it (Harris, 2013; Woods and Roberts, 2018). However, Hargreaves and Fink (2008) warn that this should not be used as a hidden way of increasing the staff's workload, or as another way of motivating demoralised staff into achieving government-set targets.

Involving staff very early in the NHS change process, and adopting a distributed leadership style is highly recommended by the McKinsey Hospital Institute (2015), de Silva, (2015), Dougal et al., (2018a), NHS England, (2016, 2018) and The King's Fund (2020a). This can reduce potentially divisive 'top-down power dynamics' (Dougal, 2018: online). The King's Fund (2020a: online) recommend that NHS leaders engage with and listen to staff to develop a 'shared understanding of the challenges'. Further, NHS England (2018: 21) speaks of harnessing the energising and motivating 'sense of us', creating unity through the sharing of a vision, values and mission (Anderson and Anderson, 2010/2001; NHS England, 2018). Day et al. (2009) and Hargreaves and Harris (2015) add that distributed leadership also has the potential to increase staff morale.

In Dougal's report summary (2018b: online), she proposes that change leaders would be wise to 'build from the rich experience' that is already in place, rather than 'starting afresh', and that change should be led 'from within' (Dougal et al., 2018a: online). Several HVs commented that collaborating in change decisions, based on their professional expertise and knowledge of 'what works', could also have saved resources. They reported that when some of the changes were implemented at great speed without any consultation they subsequently failed.

15.1.3 Pace of change

Time is also a factor commonly highlighted in the literature on change. Whilst there is a recognised need for urgency in transforming the NHS, enough time is also required for change to embed and be accepted (de Silva, 2015; Alderwick and Ham, 2017; Dougal et al., 2018a). Individuals need time to work through the change process (Anderson and Anderson, 2010/2001). Thomson (2014/2008: 78) adds that, not only does change takes time to embed, but there are always 'antagonistic [...] sites of struggle'. In addition, Woods and Roberts (2018) claim collaborative leadership is not an individual, but a collective phenomenon, and as such would require the HVs to have more time and the ability to be in greater direct and regular contact with one another.

The HVs in this study thought service changes could have been delivered at a more measured pace. The reality that the NHS transformational change plan requires speed did not appear to be fully recognised or appreciated by the HVs, or their organisation's position regarding this. It was not only the fast pace of the changes that was a concern, but that overall, the changes implemented lacked clarity and consistency, and were often contradictory and confusing. The Stage 3 participants generally accepted that change as a response to all the unknowns of the pandemic was, by its very nature, likely to be chaotic and fluctuating.

15.1.4 Core needs

In addition to how the changes were implemented, it was often the 'direction or content' (Anderson and Anderson (2010/2001: 143) of them that was unacceptable to many HVs. Alongside the rise in the intention or contemplation to resign between the Stage 1 and 2 interviews, there was a notable level of resistance towards many of the changes, as seen for example when HVs continued to practise as previously.

This researcher matched the HVs' perceived workplace needs, and what is required for these to be met against Anderson and Anderson's (2010/2001: 141) six 'core human needs' (see Table 26). The authors claim that these require stability if change is to be accepted by its recipients.

Table 26 Core human needs in the workplace

Core human need	Desired workplace needs
Security	<ul style="list-style-type: none"> • A working environment that ensures HVs' sense of security regarding their professional accountability
Inclusion and Connection	<ul style="list-style-type: none"> • A working environment that provides adequate time and the ability to meet with colleagues, clients and managers face-to-face • A leadership style and culture that fosters open communication and collaboration, especially in early decision-making
Power	<ul style="list-style-type: none"> • A working environment and culture that supports autonomy and agency in practice • A working environment and culture that fosters empowerment through collaboration
Order and Control	<ul style="list-style-type: none"> • Communication from management that is clear, well-paced and consistent
Competence	<ul style="list-style-type: none"> • A working environment where HVs can succeed in practising according to their professional priorities, principles and values

Core human need	Desired workplace needs
Justice and Fairness	<ul style="list-style-type: none"> • A working environment and culture where HVs believe that their professional expertise, knowledge and experience is recognised, respected and valued by their employing organisation • A working environment and culture where HVs feel respected and valued as persons by their employing organisation • A working environment and culture that supports a healthy work-life balance

Alongside these six core human needs, sits the 'ABC framework of nurses' and midwives' core needs' (West, 2020b: online). West (2020b) suggests that these need to be met if nurses are to flourish and thrive at work. See Table 27 below:

Table 27 The ABC framework of nurses' and midwives' core needs

Autonomy	<ul style="list-style-type: none"> • Having control and the freedom to 'act consistently with one's values'
Belonging	<ul style="list-style-type: none"> • The sense of having a 'stable home team to return to' for care and support
Contribution	<ul style="list-style-type: none"> • The sense of having the competence to be effective

The HVs showed evidence they understood these three 'core needs' (West, 2020b: online) as essential for themselves as professionals to thrive at work within their organisation.

In summary, there are clear links between high staff turnover and poor work satisfaction (Saari and Judge, 2004). In nursing this can lead to a weak psychological commitment towards their employer (Caricati et al., 2014). Conversely, work satisfaction is likely if employees are granted autonomy, and feel supported, respected and appreciated by managers (Gelsema et al., 2006; Oreg et al., 2011). Job satisfaction for the HVs came from working with their clients and their personal desire to 'help and heal'. For most, this was enough for them to remain positively engaged and continue in their work. However, almost all desired a more collaborative style of leadership, with the benefits of being able to exercise 'relational freedom' (Woods and Roberts, 2018: 1), i.e., freedom to exercise their autonomy and agency in their work for the public good.

15.2 Identity Saliency

Identity saliency sometimes emerged through HVs' experiences of the changes, which impacted upon them as professionals and persons. They questioned how their professional identity fitted in

with their other identities, such as being mothers and/or partners as depicted in Figure 1. According to Wenger (2017/1998), our identities are enmeshed and require negotiation. If the HVs' experience was particularly challenging, they often looked to previous or alternative identities, such as nursing in other settings. In a few cases these identities strengthened and began to take precedence, or at least vied for a more dominant position in their lives, reflecting the views of Stryker (1968) and Thoits (2013). There were occasions when this created dilemmas for the HVs, who became torn between their personal and professional loyalties, sometimes resulting in them resigning from post to pursue alternative careers.

15.3 Health Visitors' Professional Identity: Stable or Evolving?

The HVs surfaced through their accounts whether they understood their professional identity, in the context of constant change, to be stable or dynamic. Trying to link this with extant literature however was problematic, as the term 'professional identity' is variously used. Some authors equate it to the professional role only (what they do), and not a more encompassing concept which includes professional social identity (who they are) and a professional public identity.

Many theorists propose that professional identity is dynamic and evolving, as many professionals face the changes and challenges of marketisation and commodification (Evetts, 2018). According to Wenger (2017/1998: 154), professional identity is a process in 'continuous motion', which is re-shaped and remoulded through individual togetherness as a professional group. Focussing on teaching, Sachs (2001) summarises that when change is fast, identity is 'negotiated, open, shifting, ambiguous', and requires professionals to develop different forms of professional identity (Sachs, 2001: 154). For professionals, there are ever-increasing demands being made from a variety of sources in this time of 'supercomplexity' (Barnett, 2008: 190).

Specific to this study, Baldwin (2012), states that the HV role has continuously changed in emphasis since its inception, largely due to various government policies and organisational responses to them. Others, including Machin et al. (2012), when discussing HV professional identity state that the stability of professional identity is important. Sabanciogullari and Dogan (2015) claim that if professional identity is strong, effective practice, patient care and satisfaction, competence and expertise is optimised. Rooke (2015) echoes this, in that a robust health visiting identity (both social identity and role) is vital in changing times.

Throughout their accounts, the HVs' self-identification with health visiting as a distinct professional group remained stable. Their desire for self-continuity and authenticity to be able to be themselves at work (Dutton et al., 1994) also remained steadfast. Many accounts showed evidence that they understood their primary role as community health practitioners committed to delivering the

Healthy Child Programme (DH, 2009), and the '4-5-6' model¹⁴ (iHV, 2016) through a universal service. The findings suggest that the HVs' collective experience of living through radical service changes affirmed the core dimensions of their professional identity, rather than diluting them. This was particularly evident in the dimensions of autonomy and agency, which most HVs believed to be of fundamental importance if their practise was to be effective. This aligns with professional autonomy being one of the 'eight key elements' for effective practice that is family and relationship-centred (iHV, 2019b: 5).

Many HVs, throughout all stages of the study, continued to practise according to their professional principles (Cowley and Frost, 2010) and traditional values, such as prioritising their clients' needs, optimising client care, and upholding fairness and equity. Their 'orientation to practice' and the 'three core practices' (see 3.7) of the HV-client relationship, home visiting and HV needs assessment (Cowley et al., 2013: 11-12) also remained steadfast and central to the way they strove to work. Most evidenced dedication to work in ways they knew through experience were most effective to deliver the best outcomes for their clients. They demonstrated allegiance to their profession and 'the normative values and ideological control aspects' 'from within', rather than 'from above' (external to the profession) (Evetts, 2003: online).

Wackerhausen (2009: 457, original emphasis) argues that professionals need to re-think traditional ways of practice to achieve the primary and constant aim '*to do what is best for the patient*'. Although the HVs held firm to the core dimensions of their professional identity, some commented that a possible re-shaping of how their mission could be accomplished would be welcomed. For example, greater investment and an overhaul of information technology would be beneficial to support them in their work in meeting future health demands. At the time of writing, this is already a popular research focus following the pandemic outbreak (The King's Fund, 2020b, 2020d). Post-peak pandemic, many agencies are now involved in establishing what can be learned from the Covid-19 'workaround' that came about through necessity.

Examples of possible future changes in how the service could be effectively delivered were commented upon. One HV stated that, having been restricted to making follow-up phone calls rather than statutory visits during the Covid-19 outbreak, some parents were reported to prefer this contact method. Working less face-to-face with clients and more online may have future benefits;

¹⁴The '4-5-6' approach for health visiting (0-5 years) outlines the four levels of service (community, universal, universal plus, universal partnership plus), five health reviews (antenatal health promoting visit, new baby review, 6-8 week assessment, 1 year and 2-2.5 year review) and six high impact areas (parenthood and early weeks, maternal mental health, breastfeeding, healthy weight, minor illness and accidents, health 2 year olds and getting ready for school) (iHV, 2016).

to potentially improve service accessibility, for example. The impact on health outcomes, however, is as yet unknown and will require close monitoring and evaluation if this is to become the norm (Conti and Dow, 2020).

In summary, the service changes experienced by the HVs did not alter their perceived professional identity. The HVs were resolute that the core dimensions underpinning their professional identity were essential for effective practice and positive public health outcomes. They considered that these constituent dimensions need to be maintained, and in some areas, strengthened, as part of their on-going 'identity work', as proposed by Ibarra and Barbulescu (2010: 137). For them, their 'attributes, beliefs, values [and] motives' were 'relatively stable and enduring' according to Ibarra (1999: 764) based on the work of Schein (1978). Returning to Sach's (2001: 154) view of professional identity as 'negotiated, open, shifting [and] ambiguous' in 'times of rapid change', the HVs understood their identity could be viewed as 'shifting' and at times, 'ambiguous'. They were aware that there were powerful influences external to their profession affecting, and at times, threatening their identity. Some changes as a result of the pandemic were accepted, but prior to this other externally-imposed changes were frequently and robustly resisted. The consensus was that only changes which were perceived to improve ways to accomplish their mission to '*make a difference*' in public health were deemed acceptable (Whittaker et al., 2013: 8, original emphasis).

Chapter 16 Review of the Research

16.1 Review of the Research

This chapter reviews various aspects of the research. It discusses what was successful, what could have been improved and what this researcher learned through the research journey.

16.1.1 Methodology and methods

This researcher investigated what it is like to be an HV living through a time of significant service change, and the effect of these on their professional identity. In reviewing the methodology and methods employed in this study, this researcher is confident that they were fit for purpose in answering the research questions and addressing the aims. Other options were considered, and although they may also have produced meaningful results, they were thought not to be in keeping with this study's aims, or readily applicable. The methodological framework and methods chosen were also reasonably flexible, helping to avoid the risk of 'methodolatry' (Janesick, 2000/1994: 390), and to allow for movement as the research evolved. For example, the interview questions were not fixed, and after each interview stage were reviewed and some revised following new learning and to adapt to the changing circumstances.

16.1.2 Interpretative phenomenological analysis (IPA)

Phenomenology is the study of the lived experience of phenomena (Creswell, 2014/1989) and at the core of IPA is the question, "what is this experience like?" and what sense do individuals' make of their experiences (Smith et al., 2009). The IPA framework is flexible and provided useful guidance to support this researcher as a novice. This was especially valued given the complexity of phenomenology and the contentious array of interpretations and methods (Caelli, 2001).

Through utilising IPA, this researcher was able to focus on individual participants situated in a specific context. The HVs were encouraged to present a holistic picture of their lived experience of change through their interpretations, thoughts, views, feelings and emotions. Interpretation is a key feature of IPA, not only for the participants, but also through the research findings being enriched through this researcher's own interpretation. This researcher endeavoured to interpret the HVs' own interpretation of their lived experience as faithfully as possible. Through attention to embodiment, this researcher noted each participant's body language, facial expressions, voice-tone and gestures, as well as her own, during the interviews. As IPA embraces the importance of embodied experience and emotion (Smith et al., 2009), this was in harmony with the art-based method chosen. As a result, the HVs' contributions were detailed, rich and textural.

16.1.3 One-to-one, face-to-face, semi-structured interviews

This was the most appropriate method to collect the data required. It provided the participants with time and quiet space to describe their lived experiences, and for this researcher to really hear their contributions through verbal dialogue. This researcher is aware of her novice status and limited research experience and she acknowledges that, with the benefit of hindsight and new learning, her interview skills left room for improvement. For example, the ability to think quickly and phrase follow-up questions clearly was sometimes lacking. Paying closer attention to her own bodily responses of affirmation, and calming down her tendency to nod and smile a little too frequently (however well-meant in aiming to put the participants at ease), are skills to be practised over time.

16.1.4 Visual art

Visual art as a method, such as collage, can communicate and express participants' lifeworlds beyond words (Mannay, 2016). Using collage as a data-gathering tool was another successful and exciting choice that surfaced a deep, insightful and nuanced understanding of the HVs' experiences. Further, a harmonious marriage between the IPA framework and a visual art-based approach was discovered, which may in all probability be a combination unique in research to date.

The collages illuminated visually what Dilthey and Rickman (1976) espouse, that individuals are distinctly different. Despite experiencing the shared phenomenon of change, the HVs' personalities, character traits and previous history and experiences shone out through the wide variety of their collage presentations (see Appendix E). However, viewed collectively, common ideas and concepts were often shared. These included some of the core dimensions of professional identity, such as the principles and values of health visiting, and the psychological effects of the changes. The majority of HVs enjoyed the experience of collaging and these visual artefacts proved good starting points for the discussion.

Roberts and Woods (2018) highlight that collaging, as a research tool, provides participants with agency. Apart from the prompt provided, this somewhat evened out the underlying power imbalance in the researcher-participant relationship. As this activity was at the beginning of the interview, this also helped set the tone and atmosphere of the session, aiming for a relaxed and shared experience.

16.1.5 Diaries

Only three (3/17) HVs, including those offering their responses in writing, used the diaries provided at the end of the Stage 1 interviews. When asked, participants' responses were very similar, in that, given their current circumstances, they had not had the time to keep the diaries. This researcher was already aware, prior to the study, of the time-constraints the HVs were experiencing, which was

confirmed during the Stage 1 interviews. In hindsight, closer consultation with the participants at the time of interview regarding their thoughts around this commitment may have been more productive. Using the word 'journal' rather than 'diary' may have implied a less onerous time-bound commitment. The word 'journal' may have indicated a more informal and sporadic use, possibly encouraging greater uptake. Additionally, emphasising that entries could have been open to freer interpretation, such as drawing doodles and sketches rather than only words, may also have resulted in higher levels of engagement. This researcher's awareness of this possibility was especially heightened after the participants' many expressions of enjoyment in creating the collages. As a result, this was a missed opportunity, as cross-referencing HVs' verbal and creative contributions with this third form of data collection was very limited. When diaries were completed however, the material helped HVs to focus and reaffirm their thoughts during the follow-up interviews, and their diary entries have been included alongside their quotes where appropriate.

16.1.6 Selection and recruitment

This researcher was conscious to avoid skewing the data by recruiting mainly HVs who held negative views of the service changes. As one participant commented, one tends to concentrate on the negatives more than the positives, as they affect oneself more. For this reason, unlike many studies that use online questionnaires to gather data, this researcher selected most of the participants herself, with only a very few participants self-selecting.

In hindsight, recruiting HV participants from further afield, but within the same NHS trust, would have enabled a broader comparison of data as they were exposed to similar changes. It may also have widened the ethnic diversity of the participants, as well as HVs' experiences of service change. Additionally, this researcher would have been unknown to the participants and viewed purely as an outsider researcher. This could possibly have added an interesting and different dimension to the study.

16.1.7 Analysis

The data were analysed in several ways. The HVs' experiences of the service changes were mapped against the core dimensions of the HVs' perceived professional identity. Emergent themes were also drawn out from these data and developed into super-ordinate themes (see Table 9) which formed a framework for analysing the data on the core dimensions. The effect of the changes on the HVs' feelings and emotions was also analysed. This proved complicated in practise, especially for a novice researcher, but she tried to ensure there was clarity and flow throughout the writing up of the findings.

Difficulties were experienced in comparing data across the interview stages. The changes to practice were ongoing, thus the working environment was not static between interviews. The final sub-sample were also working through the initial peak of the Covid-19 pandemic, bringing with it more radical change. The research questions were broad and the HVs chose to talk about issues that mattered to them at that time, therefore not necessarily commenting again on matters spoken about in previous interviews. That said, some interesting insights were gained, highlighting broad differences and commonalities.

16.2 Trustworthiness, Validity and Ethical Responsibility

In support of this study's validity, this researcher faithfully recorded the HVs' contributions through verbatim transcriptions and her own notes. The details of all aspects of the data collection and analysis have been made transparent in line with Yardley's (2000) advice. Other methods included on-going reflexive engagement, openness, cross-referencing various data sources, and prolonged engagement 'in the field'. Creswell (2014/1989) suggests that co-development with participants and/or member-checking may also support validity. Although co-development was not considered appropriate, HVs were provided with their transcriptions for verification and comments.

This researcher returned to the very complex, and in some ways intractable, ethical questions that she posed herself as this study unfolded. Asking how this study 'does good' and to whom, was in some ways easier to answer than how this researcher's ethical duty to 'do no harm' was ensured. Amongst other benefits, this researcher intends that this research will be a positive contribution to the health visiting profession. Tensions between the HVs and the organisation surfaced strongly in many of the accounts. This researcher's ethical responsibility was to faithfully report the accounts, but also be mindful not to discredit their employing organisation. She was careful to preserve the anonymity of the participants, their organisation and all non-consenting others.

16.3 The Research Journey

Reflecting on this research journey, this researcher is aware of significant professional and personal growth. This development took place in various ways. For example, through learning to navigate a complex methodology and apply various methods, and also through the practical research process itself; in considering how to analyse, document and distribute the findings.

Learning to be continuously reflexive throughout the research process was enlightening. For example, this researcher became aware of identifying with the attitudes of many of the more experienced and confident HVs, which often aligned with her own. She related to their generally calm and resilient stance, and how their experience led them to believe that change goes 'round in cycles', therefore taking a stoic response towards them. This awareness led this researcher to try to

set aside this affinity and assumptions when interviewing this experienced group. Likewise, when interviewing less experienced HVs, she was mindful to try to bracket her pre-assumptions and be open to their contributions, paying particular attention to her own body-language.

This researcher also grew in confidence and fortitude in managing unexpected changes of circumstance, especially in regards to the Covid-19 pandemic. Perhaps one of the most exciting learning experiences of all was the human journey of being alongside others in trying to understand their world as they experienced it.

16.4 Limitations

The researcher acknowledges that there are limitations to this study. An inherent limitation of phenomenological methods is that lived experience is elusive, losing depth immediately, and the 'now' has already gone (Smith et al., 2009). HVs' accounts were 'snapshots' of how they were feeling and making sense of the phenomenon of change, and although every effort was made to get as close to the experience as possible, its immediacy will inevitably have been lost.

HVs may have made conscious or subconscious efforts not to present as socially undesirable personalities. Also, the tone of their accounts was likely to be influenced by other factors, such as their mood on the day. These are natural traits, and therefore to be accepted in human and social science research.

Although the findings do not lead to generalisations, IPA offers 'theoretical transferability' instead (Smith et al., 2009: 51). There is potential relatability as 'recognisable insights' and the recommendations can be transferred to similar health visiting and other settings experiencing changes (Roberts and Woods, 2018: 3).

The management of the health visiting service has been devolved across the country. This researcher is aware of the diverse responses from different trusts to the current financial constraints in the NHS, and of late, to the Covid-19 pandemic. Interviewing a group of HVs from a different region to compare data would have been an interesting extension to this study. Time restriction and practicalities unfortunately precluded this option.

Chapter 17 Study Contribution, Conclusion, Recommendations, Disseminating the Findings and Future Research

17.1 Contribution to Knowledge and Practice

17.1.1 Health visitors' professional identity

One of the research questions was how have service changes affected HVs' professional identity. This was answered through focussing upon each core dimension of the HVs' professional identity and mapping their contributions onto these. To do this, since no current and comprehensive definition of HVs' professional identity could be found, the HVs' perception of their professional identity was initially established. This is the first original contribution of this study to knowledge and practice. In addition, Hotho (2008) considers how individual experiences of change combine collectively to shape the future of a profession, which also surfaced to some degree in this study.

17.1.2 Health visitors' self-knowledge

The interviews provided the participants with the opportunity, time and quiet space to engage with, and reflect upon, their experiences afresh. The majority welcomed this opportunity, and for many it increased their motivation and fortitude. For example, P3 L said of her experience:

“Quite cathartic [...] it's kind of given me time to reflect over the past few months, because when you're in 'that moment', you don't really take the time to 'check in' with yourself” (S20 L1-3)

adding:

“...it's good to reinforce why I became a health visitor [...] how I coped during tough times has given me a bit of strength as well that 'I can do it!'” (S20 L11-12, 15-17).

Although most valued the time to reflect, an 'incision into [their] world' was inevitable (Holt, 2012: 104). For a few, the interviews uncomfortably surfaced how they really felt. For example, for P2 F, the interview consolidated how she was feeling:

“...it's just making me see more that there's just no hope there.” (S18 L17-18).

17.2 Conclusion and Recommendations

This is the story of 20 HVs' experiences of working through over a year of transformational change in the NHS, and additionally for the final few interviewed, the Covid-19 pandemic. It describes the effects of change on their professional identity and working lives. Their accounts evidence what it is like to be an HV during a time of radical change. The use of IPA-informed interviews, creative visual art and, for a few, their diaries and written responses, enabled the HVs to share their lived experiences through their verbal and non-verbal contributions.

This researcher 'entered the scene' at a challenging time of service change for the HVs. She 'exited the scene' at a time when change was far more radical than at the outset due to the Covid-19 pandemic. Although many studies are now beginning to look into the effects of the health crisis on health professionals' identity, this research spans the time prior to, and during, the initial peak of the outbreak. The pandemic has brought about unprecedented changes of a magnitude and significance likely to influence and re-shape the future health visiting service as never before. Pre-existing challenges have been amplified through accentuating issues already present in health visiting, as evidenced by the HVs in this study prior to the pandemic.

Key findings are outlined below with associated recommendations. Many of the findings support and confirm those found in the extant literature, but there are also a number which are understood to be original. These findings link with the core dimensions of the HVs' professional identity, and/or the super-ordinate themes of communication, time, support and professional worth and recognition. The findings encapsulate what the HVs understood to be important for effective and efficient professional practice.

17.2.1 Core dimensions

The following findings and recommendations are linked to specific core dimensions of the HVs' professional identity and their practice:

1. HVs were concerned about their *accountability* when holding large caseloads, especially during the initial peak of the Covid-19 pandemic.

Recommendation: The government needs to recognise that the health visiting service requires greater and sustained financial investment to reduce caseloads to more manageable sizes in order for HVs to practise safely according to their professional Code (NMC, 2018).

2. HVs recognised that their practice is *complex, holistic and individualistic*. Assessing clients' needs is time-consuming. Continuity of care was considered important for effective practice and positive health outcomes.

Recommendations: HVs need to hold and manage their own caseloads. A greater recognition of the time taken to assess clients' needs and provide follow-up support is required. Health visiting teams need to be responsible for their own work allocation, in collaboration with others.

3. HVs' *autonomy* was the dimension of professional identity reported to be most negatively affected by the changes. HVs expressed the need to be able to exercise their autonomy and agency to practise effectively.

Recommendation: HVs need to be given license to practise with greater autonomy and agency to affect positive change.

4. HVs understood that their practice is too *complex* for its worth and value be fully reflected using questionnaire-style audit tools. The long-term benefits of HVs' input on public health were not being sufficiently recognised and evaluated.

Recommendation: A more appropriate system is required to monitor and audit the health outcomes of HVs' practice interventions long-term, as well as short-term.

17.2.2 Super-ordinate themes

The following findings and recommendations are linked to the super-ordinate themes of communication, time, support and professional worth and recognition:

5. The HVs needed face-to-face contact with each other to strengthen their sense of *collegiality*. This provides mutual *support*, emotional strength and motivation. An original contribution is that this need was amplified by restricted working during the pandemic. Team bases were often difficult to access and frequently lacked sufficient working space.

Recommendation: Adequate *time* needs to be built into HVs' working days for informal and unstructured colleague contact. Team bases should be made more accessible and provided with sufficient space for HVs to work together.

6. Excessive mobile working threatened a breakdown of *collegiality* and *support*, and increased isolation. HVs often worked excessive unpaid hours, threatening a healthy work-life balance.

Recommendation: Mobile working should be carefully monitored so it does not become the new norm, devaluing the importance of sufficient face-to-face colleague contact.

7. The HVs working through the pandemic were required to utilise remote means of *communication*. These included a greater reliance on 'WhatsApp' messaging and increased phone contact with clients. An original contribution is that this study captured the HVs' experiences of new ways of working during the initial peak of the pandemic.

Recommendation: This early data regarding the use of remote forms of *communication* should be captured and extended through further research in health visiting. The organisation, and national decision and policy-makers, should proactively engage with HVs and actively listen to their views and value their experience.

8. HVs believed that their expertise, skills and experience were all, to a degree, underutilised, undervalued or disregarded. This resulted in feeling their professional *worth and value* were largely *unrecognised*.

Recommendation: Develop a leadership style within the organisation that builds in genuine collaboration and consultation with HVs, especially when making decisions regarding service changes.

9. An original contribution is that HVs found the *excessive speed, confusion and contradiction* of the changes very challenging, and did not always appreciate the root causes of many of the changes, such as chronic underfunding.

Recommendation: Service changes should be appropriately paced, clearly communicated and streamlined. The organisation needs to raise the HVs' awareness of the wider national perspective.

10. The HVs were very proud to belong to the health visiting profession. Their professional identity, qualifications and clinical background, *worth and value* were mostly *recognised* and appreciated by their clients, but not always by the wider general public.

Recommendation: The organisation, the health visiting profession and the government need to raise HVs' public image and profile, in particular, their clinical background, role and value in public health. Measures should put in place to ensure their identity and NHS affiliation is clearly communicated to the public.

17.2.3 Feelings and emotions

The other research question asked what living through the experience of service change was like for HVs. This was answered through analysing their feelings and emotions revealed in the interviews.

The psychological effects of change on HVs are a significant and original contribution to practice.

The six most dominant feelings/emotions presented across all of the interviews were:

- work stressed
- pressured/overwhelmed
- undervalued/de-valued
- disrespected as a professional
- frustrated
- confused.

11. Most of the HVs thought that they had inadequate opportunities to express these feelings/emotions or that their impact was not adequately acknowledged by their organisation.

Apart from the more understandable level of heightened anxiety and confusion experienced by the HVs working through the pandemic, chronic underfunding and staff shortages in health visiting underpinned many of the issues that created changes which negatively affected their professional identity.

Recommendation: Linked with Recommendation 1., the organisation, and national policy and decision-makers need to recognise the significant effects transformational change has on its recipients, especially in light of the link between work stress and staff retention (The King's Fund, 2020e). To address this, effective measures need to be put in place. For example, adequate time should be set aside to openly explore HVs' feelings/emotions in response to service changes, led by the HVs themselves.

17.2.4 Summary

In summary, the health visiting service matters. The profession significantly contributes to the health of the nation (DH, 2011a). The HVs' role has changed and evolved from its origins as a 'mother's friend' through to today, and likely onward into the future (Davies, 1988: 39; Cowley and Frost, 2010; Baldwin, 2012). In this in-depth extended study, the HVs have presented their perception of their professional identity, and what they understood was required to meet increasing public health demands, reduce health inequalities and achieve their mission to make a positive difference in the lives of their clients and in the communities they serve.

This researcher agrees with Appiah (2020: online), that the personal lived experiences "...are to begin a conversation not end it". It is valuable beyond measure to have insight, understanding and knowledge as to what matters to HVs in order for them to work effectively for themselves and their clients, and what effect changes that challenge practice adversely may have on the health of HVs. This researcher agrees with The King's Fund Report (2020c) that it is time to address fundamental issues in nursing and midwifery, and create a compassionate working environment fit for the future.

Based on the evidence gathered, this research thesis is that HVs' perception of their professional identity, and their aspirations, remained strong and stable, transcending the service changes. This is in spite of the challenges of the changes and the impact of these on HVs and their practice. The professional identity dimensions identified in this study are important if HVs are to be able to practise effectively as public health practitioners. This is in accordance with their professional principles, values and mission to '*make a difference*' to the lives of their clients (Whittaker et al., 2013: 8, original emphasis).

Acceptance of, or resistance to, externally-driven service changes appeared to depend on the maintenance or disruption of a number of inter-related aspects of practice and how the changes affected HVs as professionals and persons. The various aspects of practice included the core dimensions of their professional identity, the 'three core practices' of the HV-client relationship, home visiting and needs assessment established by Cowley et al. (2013: 12), and their principles and values. Individual HVs reported that the effect of the service changes often meant that they were unable to enact their role as they aspired and therefore considered leaving the profession. Consequentially, HVs' professional identity and associated operational and aspirational factors need to be recognised and maintained by those designing and implementing service changes if they are to more readily accepted by HVs, especially in light of the link between chronic work stress, absenteeism and high staff turnover (The King's Fund, 2020e).

This researcher shares with the HVs in this study their heartfelt desire and determination to see the future of this valuable and unique service thrive. The spirit of hope and dedication is summarised for many through the voice of one HV reflecting on her choice of a rainbow on her collage:

P2 I "...there's always hope and there's always joy in the job [...] it's a nice job" (S12 L15-16).

17.3 Disseminating the Findings

In order to benefit practice and education this researcher's plan to disseminate the findings is as follows:

Articles for peer-review publication

It is intended that a number of topics in this thesis will be written up as articles for publication both for health visiting and professional nursing journals, as well as for a broader readership, including management and research journals. Topics include the psychological effects of service change on HVs, particularly pre- and post-initial peak of the Covid-19 pandemic, HVs' perception of their professional identity, and the use and value of collage as research method.

Collaboration with other researchers

This study's findings have a potentially wider value if combined with findings from other research inquiring into related topics. For example, by linking with professional bodies, these findings may triangulate with those of other research on the effects of the pandemic on HVs and health visiting practice.

Engaging in conferences, workshops and discussions

It is planned that this study's methods and findings reach a wide audience through electing to speak at professional conferences and contributing to debates. It is also intended to offer to present the

findings to other interested parties and stakeholders, such as trust managers, commissioners and service change implementers.

Teaching institutions

This study's findings are valuable for the education of student HVs, particularly regarding how HVs' perceived professional identity, with the principles, values, 'orientation to practice' (Cowley et al., 2013: 11) and mission embedded within it, is operationalised in practice. It is intended to present the findings of this thesis to educators for use as a teaching resource.

17.4 Future Research

This study ended after the initial peak of the Covid-19 outbreak. Unlike many studies that were initiated at that time, researching into how the health visiting service had been affected by the pandemic, this study also considered the effects of transformational change prior to, as well as during the initial outbreak. It would be of great interest to extend this study to further understand how all these changes will combine to affect HVs' professional identity in the future, especially given the fluctuating and uncertain situation of continuing to work through the health crisis.

The relatively large number of core dimensions of HVs' perceived professional identity meant that any analysis could only be presented as a broad sweep, and precluded an in-depth investigation into each one. Future research into any one of these could lead to further knowledge and fruitful insights.

An area not directly addressed in this research was how HVs' psychological responses to the changes directly affected their work with clients. This study has illuminated that emotional response to the changes was a significant factor when HVs explored their lived experiences. Many were conflicted between how they were expected to present themselves, and how they really felt. 'Putting on a brave face', and/or presenting as strong and coping when they did not feel that way, increased their work stress. Although it was discussed as part of the participants' contributions, further research focussing on this area would provide greater insight.

Another area ripe for research is to find out if the HVs who were experiencing difficulties in accommodating the changes had, given time, become more accepting of the new ways of working. This relates to them experiencing a mismatch in who they believed themselves to be, and their working arena (Bourdieu's 'habitus' and 'field'), which created disruption ('hysteresis') and discontent (Hardy, 2014/2008: 127, 139).

A further group of interest are the newly qualified HVs (NQHV) who may adopt a more 'entrepreneurial' HV identity in the future, i.e., with their affiliation residing more with the organisation than with their profession (Sachs, 2001: 155).

It would also be useful to follow up the HVs trained as part of the Health Visitor Implementation Plan (2011-2015) (DH, 2011a). Knowledge may be gained on whether they continued to feel that the health visiting service that they were trained to deliver had been greatly impoverished in the intervening years, or conversely, if the Covid-19 pandemic had ironically resulted in them adjusting to service changes more readily.

This study focussed on the experience of individual practising HVs to service changes. In the interests of balance, further research exploring the lived experience of policy and decision-makers and the managers who implement these changes would be valuable. Mutual and respectful understanding of each other's position may engender fruitful dialogue, and the 'mediation strategies' spoken of by Raelin over 30 years ago may bring about 'the ideal [...] that one day professional accomplishment will become consonant with managerial proficiency' (Raelin, 1991/1985: 270).

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Appendix A. Key Performance Indicators relating to health visiting

Public Health England (2020) (PHE) presents a commentary of annual data collected on health visiting services. The KPIs are summarised below, based on this document.

The health visiting service leads on the delivery of the Healthy Child Programme (HCP) (DH, 2009), which was set up to improve the health and wellbeing of children aged 0 to 5 years. This is achieved through health and development reviews, health promotion, parenting support and screening and immunisation programmes.

The health visiting service consists of specialist community public health nurses and teams who provide expert information, assessments and interventions for babies, children and families, including first time mothers and fathers with complex needs. The health visitor service delivery metrics currently cover the antenatal contact, new birth visit, the 6-to-8 week review, the 12-month review and the 2-2½ year review, and report on the following metrics:

- C1 – number of mothers who received a first face-to-face antenatal contact with a health visitor at 28 weeks or above
- C2 – percentage of New Birth Visits (NBVs) completed within 14 days
- C3 – percentage of New Birth Visits (NBVs) completed after 14 days
- C8i – percentage of 6-to-8 week reviews completed
- C4 – percentage of 12-month development reviews completed by the time the child turned 12 months
- C5 – percentage of 12-month development reviews completed by the time the child turned 15 months
- C6i – percentage of 2-2½ year reviews completed
- C6ii – percentage of 2-2½ year reviews completed using ASQ-3 (Ages and Stages Questionnaire)

These metrics are presented as management information and are reported by local authority, PHE centre and England level.

Appendix B. Extracts from health visitors' statements (2018)

The Health Visiting Service	The Nature of the Changes	Feelings/Emotions
<p>'...fracture of our service...' '...support from multidisciplinary teams are neglected'</p> <p>'...our service is being watered down to save money in the short term' 'HVs have extensive training [...] unqualified professionals do not' 'identity and recognition of [...] advanced training need [s] to be a priority'</p> <p>'I have always valued the profession and role until recently' '...recently advised to cut things 'short' be 'hard' on clients so that they understand that we can't offer them the Service once offered! 'I don't agree with this, it's always meant to be patient-centred and needs met...'</p> <p>'...the current service...is stretched' '...number and hours of HVs needs to be addressed' '...our service/care is not gold standard'</p> <p>'[in the last 3 years] Health Visiting has changed exponentially [...] not in a positive way' 'Morale is low...' '...we need to revisit what we signed up for in public health [...] measure the harm we avoid, by given space to carry out our unique role'</p> <p>'...really important that HVs embrace and emphasise parts of our job that [partner professionals] ...can't do, i.e. assessment...'</p> <p>'...morale is very low and stress levels very high'</p>	<p>'too many changes' '...those on top should apply changes slowly because it is becoming overwhelming'</p> <p>'Why change something that works well?' 'Do families really want this?' 'Money doesn't need to drive it all.'</p> <p>'... [partner professionals] are being given so much of the HV traditional role and HVs (and CPHVA*) are letting it happen' '...is the advice given by them always correct and up-to-date?' '... [partner professionals] do HV work [...] then dilute it [...] quality can suffer'</p> <p>'...the management...has agreed targets and KPIs without consultation of the health visitors...' 'Poor ratio of Health Visitors, poor retention of HVs...skill-mix and [partner professionals] leaving !!!'</p> <p>'Currently each day delivers fresh challenges which [...] are not client-centred merely some KPI* driven, box-ticking exercise'</p> <p>'...[management] have been secretive about how the bid was presented... decisions made despite...'</p>	<p>'...feel exhausted and nervous...' '...something needs to change [...] with all change comes apprehension'</p> <p>'...feeling tired of change [...] somewhat negative...'</p> <p>'I no longer feel valued, confident, supported or proud of my role [...] I endure work now...' 'This has been cathartic...!' (writing the statement)</p> <p>'confused [...] not really sure if I will have a job' 'should I go back into nursing'</p> <p>'I do not feel listened to by management...' 'I want to leave Health Visiting' '...I have lost my respect...' [in management]</p> <p>'having gone through many changes before feeling accepting...' '...not concerned personally but concerned about the impact on more junior staff'</p>

* CPHVA = Unite Community Practitioners' and Health Visitors' Association

* KPIs = Key Performance Indicators

Health Visitors' statements (2018)

The statements provided by nine HVs in response to the question, "how does it currently feel to be a health visitor?" were initially gathered to assess the potential significance of this study's focus. However, they also formed part of the earliest analysis. The statements were grouped under the three headings: comments relating to the health visiting service, the nature of the service changes and the psychological responses of the participants to these. From these data this researcher learned that the concerns expressed by these HVs were broader than the planned service change of the health visiting service a merger with the former Children's Centre service to create the Corporate Service. This led to a widening of the study's focus.

Appendix C. Art-making materials



Appendix D. Schedules for interview stages 1, 2 and 3

(Stages 1)	<u>Semi-Structured Interview Schedule 1</u>
	<p>1. Can you describe your experience of being a health visitor?</p> <p>2. Can you describe a recent event or situation where you felt affirmed as a health visitor; when being a health visitor mattered to you? When you felt like a <i>'fish in water'</i>?</p> <p>3. Can you describe the person you are at home, and at work?</p> <p>4. Thinking about the new Corporate Service and proposed changes:</p> <ul style="list-style-type: none"> - Can you describe your experience of being a health visitor <i>now</i>? - ...your thoughts as an HV in the <i>future</i>? <p>5. Can you describe your experience of support through this time of change?</p> <p>Any further comments?</p> <p><i>How did you find the art? Why did you choose this paper colour, items, objects...?</i></p> <p><i>What was your experience of this interview like?</i></p>
(Stage 2)	<u>Semi-Structured Interview Schedule 2</u>
	<p>1. Reflecting on your collage and diary entries, can you describe your experience as a health visitor during the service changes?</p> <p>2. Thinking about the Corporate Service, can you describe your experience as a health visitor <i>now</i>?</p> <p>3. Can you describe your experience of support through these changes?</p> <p>4. In respect of the changes:</p> <ul style="list-style-type: none"> - do you have any thoughts regarding the future of your role? - how do you see health visiting, as a profession, in the future? <p>Any further comments?</p> <p><i>How did you find the art? Why did you choose this paper colour, items, objects...?</i></p> <p><i>How did you find the use of the diary? What was your experience of this interview like?</i></p>
(Stage 3)	<u>Semi-Structured Interview Schedule 3</u>
	<p>1. Reflecting on your collage and diary entries, can you describe your experience as a health visitor during this time of change particularly in respect of being a health visitor working through the Covid-19 pandemic?</p> <p>2. What matters to you as a health visitor at this time?</p> <p>3. Can you describe your experience of being part of a wider team during these changes?</p> <p>Any further comments?</p> <p><i>How did you find the art? Why did you choose this paper colour, items, objects...?</i></p> <p><i>How did you find the use of the diary? What was your experience of this interview like?</i></p>

Participant P1 G (Stage 1 interview)

Collage prompt - 'Who are you as a health visitor?'



Participant's verbal interpretation of her collage:

Left-hand side representing 'what she does':

- Children = fostering child development so they can "reach their potential, so they can 'rule the world'" (S1 L5-7) / Mother and baby = fostering bonding
- Food = promoting healthy diets
- Banana skin = "depressed people (clients)...who've fallen on... 'banana skins' of life" (S1 L9-11)
- Sparkler = bringing "'dark places, light'" (S2 L9) / Heart shape on body = caring
- Couple on sofa = a frequent relaxed environment when she is with clients
- Slippery pole = encountering different situations with clients
- Mature smiling woman (*in centre*) = who she feels she is; "...a bright face" (S3 L7), maybe bringing a "bit of maturity." (S3 L10)

Right-hand side representing 'who she is':

- Drawer of items = she is one of a team
- Figure in the rain = "...this is what it's been like for the last two of three years... 'singing in the rain' you're still 'singing', but it's just 'raining', it's just really hard." (S3 L26-29)
- Runner = "...it's like a long-distance marathon, this job has been, to stay in it, it's like you need a lot of endurance." (S5 L6-8)
- Mobile phone = new IT systems are good, but personally challenging
- Smiling woman = represents her; "that represents me, so, still here, smiling, at the end of the day." (S6 L2-4).

Participant P2 I (Stage 2 interview)

Collage prompt - 'Thinking of this time of change, who are you as a health visitor now?'



Participant's verbal interpretation of her collage:

- Background colour: Green = trying to bring calm and comfort to clients
- Mountains and rainbow = a "battle" (S1 L3) but with hope and sunshine: "...there's always hope and there's always joy in the job" (S12 L15-16)
- Staircase = "... 'up-hill battle' of trying to get the job done"
- Crowds = "This is how many people I'm meant to see in a week" (*joking tone*) (S1 L5-6)
- Rugby team = her team colleagues, strong and united
- Target and clock = performativity; "...I think that will *never* go away, we're controlled and constrained by *targets*" (S2 L1-2)
- Light bulb and people = Initiatives from senior management "... 'bright ideas' of what we *should* be doing and us running around" (S2 L4)
- Baby swimming = work; 'paddling in water', but supported by colleagues and team leaders
- Contented children in centre = "...that is *absolutely* what health visiting is about" (S2 L 14)
- 'Superhero' with mortar-board = "...because that's what we are" (*playful tone*) (S2 L16) and ongoing professional development
- Blurred picture clipped to dark room = the speed of change in clients' lives, and "...trying to keep them on track" (S3 L9) and HV as the "... 'temporary clip'" (S3 L13) to enable clients to move forward. HV as "...the light in the darkness" (S3 L11) / Calculator = helping clients re-balance / Sugar and net = adapting to clients' needs
- Heart hands = kindness / Feathers = being a 'light touch' in clients' lives
- 'SUPPORT' and 'healthy' = central aims of being a specialist public health nurse
- Dark room = HV as a 'light in the darkness'.

Participant P3 O (Stage 3 interview)

Collage prompt - 'Thinking of this time of change, who are you as a health visitor now?'

**Participant's verbal interpretation of her collage:**

- Big waves = 'waves of change' = "Covid's changed everything." (S6 L12), as an HV working through the initial peak of the Covid-19 pandemic; changeable, unpredictable, unknown; "...similar to how it's been recently" (S1 L5-6)
- Boat = "Trying to... 'go with it'" (S1 L6-7) "Trying to 'bob along' really" (S1 L7-8)
- Beach = security "...little bit of sort of safety" (S1 L8-9); family and family life; her "...happy, safe place" (S10 L9).

Participant P3 P (Stage 3 interview)

Collage prompt - 'Thinking of this time of change, who are you as a health visitor now?'



Participant's verbal interpretation of her collage:

- Background colour: Green = As a contrast to last collage as "...things are completely different now...especially with Covid" (S17 L2-3)

Top to bottom:

- Happy 'pantomime' group with the word 'money' = "the 'powers that be'...making the decisions about all of the changes" (S1 L6-7)
- Coloured feathers = information being passed down to HVs
- Fighting dogs = Unfortunate situation: Immediate managers having to interface with HVs who do not agree with the changes

Right to left clockwise:

- Injured man = increase in work due to rise in domestic abuse during Covid-19 pandemic
- Women talking = increase in mental health issues due to isolation during Covid-19 pandemic
- Net and wire = "...entangled mess...how I think everything is at the minute" (S3 L1-2)
- Words 'Sorry' and 'TOUGH' = apologising to clients for different kind of service now
- Woman alone on sofa = herself, working on her own from home
- Rugby team = her team
- Small words: 'Working', 'difficulties', 'Tired' and 'DAILY CHALLENGES' = how it is for HVs "...on the ground" (S6 L14-15)
- Rawl Plug = HVs: "...behind the scenes'...fundamental" (S4 L7) Linking different professionals.
- Group of people = other professionals
- Dog chasing a ball = "...we're chasing everything" (S5 L22)
- Red string = "...we link everything together" (S2 L13-14).

Appendix F. Recurrence of themes in the participants'
accounts

Recurrence of Super-Ordinate Themes in Stage 1 Interview Accounts

Participant (n=20)	Communication	Time	Support	Professional worth and recognition
P1 A	X	X	X	X
P1 B	X	X	X	X
P1 C	X	NC	X	NC
P1 D	X	X	X	X
P1 E	X	X	X	X
P1 F	X	X	X	X
P1 G	NC	X	X	+
P1 H	X	X	X	X
P1 I	X	X	X	X
P1 J	X	X	X	X
P1 K	X	X	X	X
P1 L	NC	X	X	X
P1 M	X	X	-	-
P1 N	-	X	-	X
P1 O	No exposure to changes			
P1 P	X	X	X	X
P1 Q	+	-	-	+
P1 R	X	X	X	X
P1 S	-	X	X	X
P1 T	X	X	X	X
P1 V (written response)	X	X	X	X
Evidence in accounts	Total commented = 18 + = 1 X = 15 - = 2 NC = 2	Total commented = 19 + = 0 X = 18 - = 1 NC = 1	Total commented = 20 + = 0 X = 17 - = 3 NC = 0	Total commented = 19 + = 2 X = 16 - = 1 NC = 1

These four inter-related super-ordinate themes emerged as important in HVs' professional identity: who HVs' believe themselves to be, and in what they do (role).

Key

+ = Positive experience of the changes in some way regarding professional identity

X = Professional identity negatively affected in some way by the changes

- = Professional identity unaffected by the changes

NC = Not commented on

Explanation

Communication = between HVs, management, and clients

Time = with HV colleagues, clients, and work-life balance

Support = between colleagues, from managers, and for clients

Professional worth and recognition = from government, management, clients and the public

Recurrence of Super-Ordinate Themes in Stage 2 Interview Accounts

Participant (n=8)	Communication	Time	Support	Professional worth and recognition
P1 A	Unavailable			
P2 B	X	X	X	X
P2 C	++	+	++	++
P2 D	X	X	X	X
P1 E	Declined			
P2 F	X	X	X	X
P2 G	X	X	+	+
P2 H	X	X	+	X
P2 I	X	X	++	X
P2 K	X	X	X	X
Evidence in accounts	Total commented = 8 + = 0 ++ = 1 X = 7 - = 0 NC = 0	Total commented =8 + = 1 ++ = 0 X = 7 - = 0 NC = 0	Total commented =8 + = 2 ++ = 2 X = 3 - = 0 NC = 0	Total commented =8 + = 1 ++ = 1 X = 6 - = 0 NC = 0

Key

- + = Positive experience of the changes in some way regarding professional identity
- ++ = Improvement in some way since initial interview
- X = Professional identity negatively affected in some way by the service changes
- = Professional identity unaffected by the changes
- NC = Not commented on

Recurrence of Super-Ordinate Themes in Stage 3 Interview Accounts

Participant (n=7 + 2)	Communication	Time	Support	Professional worth and recognition
P3 J (written response)	X	NC	NC	NC
P3 L	X	X	-	++
P3 M	X	+	+	++
P3 N	X	X	+	++
P3 O	X	X	X	+
P3 P	X	X	-	X
P1 Q	Not interviewed			
P3 R	X	X	X	X
P3 S	X	X	X	X
P3 T (written response)	NC	NC	NC	NC
Evidence in accounts	Total commented = 8 + = 0 ++ = 0 X = 8 - = 0 NC = 1	Total commented = 7 + = 1 ++ = 0 X = 6 - = 0 NC = 2	Total commented = 7 + = 2 ++ = 0 X = 3 - = 2 NC = 2	Total commented = 7 + = 1 ++ = 3 X = 3 - = 0 NC = 2

These four inter-related super-ordinate themes emerged as important in HV's professional identity.

Key

- + = Positive experience of the changes in some way regarding professional identity
- ++ = Improvement in some way since initial interview (exclusively by clients)
- X = Professional identity negatively affected in some way by the service changes
- = Professional identity unaffected by the changes
- NC = Not commented on

Appendix G. Researcher's reflexive collages

Researcher's Reflexive Collage 1 - (22-01-19)



Who am I? Where am I?

- The vehicle for participants' lived experience to surface, take shape and be heard – 'flying the flag'
- Calm, 'porous', open – flowing intersubjectivity, blending
- Lived experiences taking form and shape through the study.

Researcher's Reflexive Collage 2 - (23-11-19)



Who am I? Where am I?

- Weighed down by emotional 'freight' from many participants' emotional accounts of stress, pressure and anxiety
- On-going changes like rocks falling
- Hope; professional identity remains strong, 'golden and shiny' for many
- Anxious to remain ethical, faithful to participants' accounts, yet not to discredit others, or make errors of judgement due to my inexperience
- Feeling torn and muddled, yet a feather of hope and the 'red blood' of real lives – HVs and their clients
- Aspiring to be the 'key' – to bring improvement and hope for HVs and the profession through my study.

Researcher's Reflexive Collage 3 - 12-04-20



Who am I? Where am I?

- The whole world turned 'upside down' by Covid-19: week 3 of lockdown and separation. Sad, angry and frustrated
- Vulnerable and anxious: the unforeseen and the invisible
- The 'bright thread' of receiving unexpected and unprecedented generosity, warmth and kindness from strangers
- Light at the end of the darkness
- Looking in a new direction with my study in a fast-moving situation
- Another turn of direction – of future significance and importance.

Appendix H. Examples of two (unworked) transcriptions

P2 C Stage 2 Interview Transcription
<p>Key: S n = section number</p>
<p>(Looking at collage) (See Figure 20)</p> <p>S1 Would you like to tell me about it? So...at the top I've got this man who I've put more it's like the commissioner, what a service and their agenda, which are these little things here. In the middle then we've got, so we've got the commissioner, what their agenda is. In the middle we've got us as the health visitors delivering the service. It is a <i>mix</i> of working as a team, here, well, a good team <i>here</i>; working like these are rugby players (<i>rugby scrum picture</i>) doing some tackles, trying to get through some of the changes, and then on the <i>ends</i> I've put...obviously there's still some things that this man's just pushing heavily against some of the changes (<i>man pushing heavy load picture</i>) or it could be ...like this one here, somebody having a hug (<i>people hugging picture</i>), those that feel...like the service <i>hasn't</i> improved since the changes, so we've got a mix of people that feel the changes have been positive, people that are still struggling with them, people that are working as a team to tackle through them together, and others that are feeling a bit on their own because I think it's quite a mixed bunch at the moment, which I think in terms of last time, the <i>overall</i> mood probably has improved the new teams and hubs. This is why I've focused on having some more team players in the middle but on the ends [of the collage] there are still people that are struggling, I think. (<i>calm, clear tone</i>)</p> <p>S2 So, where do you...where do you fit in? What's your experience? How do you feel? I feel at the moment more in this area (<i>indicates to the rugby team picture - working together</i>) which would be being part of a team, taking on the changes and feeling a bit more positive about it.</p> <p>Than before? (<i>previous interview</i>) Than before.</p> <p>When we first met? Mm.</p> <p>OK. So, you're working as a team with your rugby ball and you're powering through, but you're aware that not everyone's feeling like that? Not everyone.</p> <p>OK.</p> <p>S3 <i>But</i> I think there's a bit more positivity amongst the teams, and then obviously down the bottom [of the collage] what I've put is pictures of again, our service users, who are like your mums and your babies and we're still again, taking on what the Commissioners want, but it's not just as you can see <i>five</i> simple straightforward points; actually, what our work is, is quite complex so there's lots of different things scattered around as to what we do and how we do it. Things that still sort of need to be addressed, <i>but</i> there is a bit of a clearer picture.</p> <p>Right. Clearer than last time? Mm-hm.</p> <p>OK. And do you want to tell me a little bit about the colours and the objects you've actually chosen? Do they represent anything in particular?</p> <p>S4 Some of them just represent some of the challenges, more like the stones or the bundle of weed. Others are like the plug, obviously sometimes...umm...you know, we're just kind of 'plugging</p>

P2 C Stage 2 Interview Transcription

gaps' of other services still I think, but then I do feel like some of the changes have been quite positive so I've used a few brighter colours.

Yes. And the background colour you've chosen, any significance there?

Green which I think's...compared to last time, I *do* feel a lot calmer and I think among the team compared to last time, when I was sat here, it's...a calmer...it is a slightly calmer atmosphere, that's why I've gone for a green.

OK. And during all this, last few months of change, what about support, what's your experience of support?

S5

I think for *me personally* the support has *improved*, simply because I've now got a new team leader and I feel the new...I was quite sceptical and quite...I think because I'd been in a team where we'd been away from like the main hub and away from sometimes like the 'band eights', and even 'band sevens', we were kept 'out of the loop' on a lot of the decisions that were being made and information being passed on wasn't, I don't think was great, so the communication there *lacked*. However, since the *change*, which again I was sceptical about because I don't feel like I'd been given as *much* information as I probably *could've* been given, and also, I think because our team was just feeling so negative it brought down the whole team's sort of *mood*. I think since we've all actually, like I've been pulled out of that team and put into the new hub...

Right.

S6

I'm actually being based now more *centrally* into the *main* hub which I've not done before, therefore I'm actually seeing *more* of the 'band eights and 'band sevens', so instead of feeling like changes are just happening, that I'm actually able to speak to them a little bit more about it rather than it being a 'Chinese Whisper' service.

So, more...?

Finding out after everybody else, so I think I've tried to...knowing that the changes are going to happen, there's nothing I can do about it, I've tried to 'spin it' into a positive and make the central hub a point where I can go and be more face to face with people that are able to talk the changes through if I'm worried about it.

So, it's a change of team, it's a change of going from what sounds like more of a struggling team to a bigger, more cohesive team, but being in touch with middle management more?

S7

That's right. Yeah.

Right.

So, therefore you kind of understand what the commissioners want from you rather than it just feeling like 'you're gonna do this whatever' and not having any say about it. And I do think we've had some *positive* changes in terms of who our team leaders are.

OK, is that them themselves or just circumstance?

I think me having more contact with them on a daily basis, so that I feel if I need to go to them I can, whereas before we didn't see much of our team leader.

Right.

S8

And also, I just think maybe management style is a little bit more supportive.

(Sentence removed to protect anonymity)

Overall. OK.

Has improved.

Good, good.

I won't say everything's perfect, but I think there have been improvements with the changes, and it was difficult at the time I think when it was all very negative to be able to see the positives in it.

P2 C Stage 2 Interview Transcription

And like I've *said*, I think a lot of people are starting to feel the positives out of the changes, but there are still some people still struggling.

Would you have perhaps had that same experience of something more positive had you stayed in the place where you were?

S9

Um...I think that team, they've got new people in it, we've all been mixed around. However, from what I *hear*, it's...not quite as positive as the team I've been placed in.

Right. So, the change has really been circumstantial as well as...

Mm, and I think...*(Sentence removed to protect anonymity)*

I think for *me* feels, has felt beneficial.

Right, OK. Was it your choice to change your team or anything? It was the way it was.

S10

No. Um-hm. I was told and I think some people have found that *very difficult*. At first, I didn't really like it without being asked first and I guess if I'd gone into a team and I didn't feel it was supportive then I would have more of a negative overview, but because I've gone to a team where actually a lot more people are *positive* about the change, it's probably had a *better* impact on me.

So, the influence of your colleagues around you...

Definitely has made a difference.

Has made a difference.

Going from a team that's quite negative to maybe more of a positive team. They're just, we're able to support each other a little better.

Yes.

S11

But I'm aware that not everybody feels like that.

No, but this is your story. Yeah. That's...yeah. So, support-wise there you mentioned your colleagues, your leader. Anything or anyone else during this time of change that's been important or less important?

Um...I mean, obviously they've wanted us to...to come together a lot more with the Family Bases.

How's that?

I wouldn't say a huge deal has changed. I think before the changes we had a lot more face-to-face contact and support from the [Children's] Centres. But since the changes I don't feel we have the *same* relationship at the moment as we used to, and again, that's because their service has had a huge overview and a lot of new staffing, so it's getting to know them again and how they work, again, more like a hub, so you don't necessarily have a huge amount of contact with the staff and they don't accept a lot of referrals because they don't have the staff at the moment. So, I think in terms of *our* work I don't use them a lot and I think that's what the commissioners would like us to do, but I think we've found more strength within possibly just our health visiting service and coming together to try and 'battle through', but I wouldn't say that was necessarily together alongside the Family Bases which they're hoping for. I think in *my* line of work, because I haven't been able to use them as frequently as I used to, I've used other services instead.

Right.

S12

Which has maybe made me do a bit more wider networking and using services that I haven't previously used.

Can you give an example, can you give...?

So, a lot more of like different mental health teams, like 'Home Start' charities. It could be...for like children with additional needs using different services for those. We're using...we do have more community nursery nurses on board now so sometimes some of the parenting work we've...we're able to give to the community nursery nurses, rather than giving that piece of

P2 C Stage 2 Interview Transcription

work, like we used to, to Children's Centre and then having a named health visitor following it up; so, within our service really.

Right, right. So, your role if you think over this last year or when the changes started to be more significant, what's your experience of your role? Changed? Not changed? What's been going on with that?

S13

I don't think our role has changed. I still feel the core substance of a health visitor remains the same, and I don't think in terms of like advice-giving has changed my practice. Maybe how I construct my workload is slightly different, and, for instance we self-allocate now, so it's a bit more 'in-team' management and also I guess in terms of how I refer to other services for support, so I focus probably a bit more on what we're commissioned for in terms of new birth visits, or that sort of stuff and six or eight week check, and then if it's 'Universal Plus' or 'Partnership Plus' obviously we're still involved, but it might be that we're over-viewing more of that work through other services or other health professionals like...like the community nursery nurses instead...

(outside interruption) I'm just going to switch this off a second [audio recorder]...Apologies.

OK.

So, where were we?

Umm...I think that was...finished.

(further interruption)... Sorry. Apologies again. So, in terms of services, you were saying that you structure some of your work a little bit more to what the commissioners are asking for?

S14

And I guess having an awareness of other services that are available to us to take on some of that work, like knowing actually capacity-wise, we can't do it all. Which is, it's difficult sometimes to do that, but you kind of are more of a link sometimes rather than doing a set piece of work with the family.

How do you see the future at the moment? (*Sentence removed to protect anonymity*) How do you see the future of health visiting and your health visiting role?

I think...the *core* of it always seems to...that feels the same but sometimes how we...I think how we run the service is slightly different and I think that will be forever changing so...and they are trying to look at ways to, I guess, make our workload *easier*. I guess the problem is when they make those changes, it's difficult for us when we don't have a clear plan how that's going to be implemented which sometimes can cause a sense of chaos, which I think we were feeling last time (*previous interview*) and now the changes are *settling* I think that again, always *relieves* people before another big change happens, and if you can get a sense of positivity I think from a change then you do go into work feeling a lot better, but I think some people might have been lost in that transition.

Because?

S15

Because I still think sometimes, they prefer the 'old way'.

Right.

And I don't think you're always going to win everybody over on change, when you do a change process. People aren't willing to.

(thoughtful pause)

So I think...yeah, there are a few other things, you know, that we're being asked to do now like the antenatals, and sometimes working slightly later in the evening, or work Saturdays, but I guess they have come back on suggesting you know, for people that are full time, that's going to be difficult, that they could condense hours so that they're able to not be working six days a week but take off a day where they can, and it could be agreed that on Saturdays, you know, you are getting overtime paid for that. If they're expecting you to be doing it. Umm...So again, yeah,

P2 C Stage 2 Interview Transcription

there are a lot more changes. They're looking at... they've also looked at our templates for how we record all of our information and I went to a meeting yesterday and that was quite helpful, insightful, knowing that I'm going to come back and not be writing quite as much! (*smiles*)

It's going to be reduced?

S16

Heavily reduced on the templates. And because they looked at neighbouring health visiting services and looked at what information they need to be taken into account, and we collect sixty more pieces on our new birth.

Sixty?

Sixty.

Right.

Than neighbouring counties. So they've looked at how they can reduce that, and the new way of writing is very much you don't put anything in the record if it's normal unless it's abnormal, therefore just trying to make the record read... and so you have the basic stuff, what a normal visit is and if it's outside of normal, you record it, so it's *clear* for the next person what your focus is and I think that can *help* with a *clear* way of working to pinpoint, because I think we do waffle a lot, and have a clear reason as to why we're going in and actually could another service do that or you know, be more of a main person in that person's care.

Yes.

S17

So, they have looked at, because the record-keeping is, and is still at the moment until the changes happen, is very heavy, but they have also, we have Standards of Practice which are going to be changed to 'Guidance' so ...umm...is it 'Practice'? It's Standards of...

Procedures?

Procedures. And if you have 'Procedures' you should... do it 'by the letter' basically, whereas they've changed it now to 'Guidance' so, use that as a 'Guidance' so you don't have to be doing it quite as 'to the letter'. And therefore, you're covered more in Court and things like that and we have had some training on how to do the record-keeping going on, so it is, and I think for people that's a massive change because it's, I remember in my midwifery training, you write absolutely everything that you've done or it hasn't happened, whereas the new style of writing, which I *think* was probably how you used to write fifteen, twenty years ago, you only write what's abnormal. Which they've gone back to! (*laughs*) They were trying to cut the time down. So that's the positive, I think that's a positive change because it was *too* much, it was *too* heavy for everybody to think, I've got to do *all* of this, and they've actually listened, and they are trying to help sometimes cut down on time in parts that we shouldn't be excelling ourselves on.

And when you say 'they', are we talking middle management, higher management? Who are we talking...?

S18

A lot of this came from (*names manager*) and the 'System One' recording.

Yes.

So, they've...I'm not sure what they're under, but they've basically been pulled in as a service to look at all the templates and see exactly how much time is spent on it. It's *too* much, and they've worked out with the new templates, you know, they could realistically cut the time down by, you know, full-time equivalent each week in each team.

So...

A *huge* amount of time and that means that we can actually spend more time doing the visits that we need to be doing, the face-to-face contact with our clients, and so for *me* which was really *important* to this work, that's been, that is being reflected on what some of the changes that are going on which I prefer.

So, you see that as really positive?

P2 C Stage 2 Interview Transcription**S19**

I see that as positive, yeah. I don't see everything as positive (*laughs*) but I think that's a real positive! (*hearty laugh*) I don't think you can always have, I think there's never a *perfect* service. *But* that was a real positive yesterday seeing that and thinking, they've actually *finally listened!*

Finally listened?

Mm.

Anything else?No, I think that's it. Yep. (*calm, clear tone continued throughout*)

Well thank you.

That's OK.

Sorry about the interruptions in the middle

That doesn't matter.

(24-01 – end of recording).

P3 L Stage 3 Interview Transcription

Key: S n = section number

(*Looking at collage*) (See Figure 26)

S1

Would you like to tell me about it?

I would. (*cheerful tone*) So, since my last one, I've kind of...feel as though ... I've picked the dog, very excitable dog, because I feel actually, I'm feeling a bit more established in my role and I can kind of 'run with things' and with certain things like safeguarding I sometimes feel like I'm a bit of 'a dog with a bone' now! (*laughs*) To ensure the safety of the children, but I've put this little dog here (*indicates to picture on collage*) because I still know that I have some 'hurdles to jump over'...

Right.

...in order to become more established and fully integrated into my role as a health visitor. I'll start with the positive side first.

The right-hand side, yeah?

S2

Yeah. So, I've put this nice picture of the baby and the dad in this nice kind of sparkly area because, especially with covid and dads working from home, we've noticed such a good relationship development between babies and children. On the flip-side as well, because of covid, we've seen some more paternal mental health issues because of working and things, so it's being able to support them in that, so that's been like quite a big change of my role as a health visitor because it's mostly been the mums I focus on, but now I've had to shift my working to the dads as well. I think also, again, unfortunately with covid, doing more kind of...what's the term...advice by proxy, let's say! (*laughs*) And so things, a lot of things that have cropped up where I've had to really kind of establish my knowledge and experiencing these kind of, you know, introducing solids because they're not going to the [Family Bases] as much, or at all because the service has completely gone at the moment. All about kind of brain, baby's brain and development and bonding with baby and activities you can do with baby when kind of faced with lockdown issues, so that's kind of helped develop and hone my skills and knowledge-base in that.

S2

The 'Get Vaccinated', (*words on collage*) that's kind of again, I *really* focus on that when I talk to parents a lot more with, I think, with covid being around it's made them realise how, OK, there are actual *threats* of viruses and things now and it's kind of given them the realisation that yeah, this is *why* we have vaccines and kind of promoting that a lot more. The kind of, even though it's been quite difficult from, because it wasn't that long ago I did this first time (*making a collage*) and then we had coronavirus, it's been quite difficult to be there as much as I want with the families, but I've put 'I've been there' (*words on collage*), because I *have*. I've always made myself available and I've put 'Success stories' here because actually, people have been really appreciative of my time, so for me in my role as a health visitor it's just made me realise, compared to last time, actually we *are* needed and we *are* useful and the families do appreciate us. And that's why I've put here, 'We're thrilled to have made an impact', because I can see in my families how much my impact has made on their lives during a very unprecedented time. And you know, the 'bank' thing (*calculator picture*) that I've put here. Obviously, a lot of families have been financially impacted by this, so, being able to offer them food bank vouchers or give them advice about where they can *go* for financial support, you know, that whole *holistic* message that we can offer families and support, yeah, again a lot of people have been very appreciative of *that*. And the reason I've put 'Let's do this' and 'Tough' is because I do feel I'm tougher now in myself, and that I feel I *can* do this (*words on collage*). However, some of the stresses do cause me to have a 'Sleep crisis'! (*laughs*)

P3 L Stage 3 Interview Transcription

Right.

S3

And I do lie awake sometimes worrying about my families, making sure I have done enough and that they are supported and sometimes wondering if we *weren't* here, *who* would they go to for that support that we offer? (*sentences removed here to protect anonymity*) However, with all that, there is still the down-side of the role where I feel as though I'm having to say 'Sorry' a lot to a lot of people, (*word on collage*) a lot of our clients, because we can't offer the services that we used to, be that with our development checks, or you know, having a lot of recently, a lot of our development checks are shifting over to the [Family Base] because of coronavirus and the impact that's had and getting through the backlog, and I put the banana (*picture on collage*) underneath that because I just feel like there's going to be a big slip-up and something's going to be missed, where, by the [Family Base], not to say that they don't have adequate qualifications, but that is a health visitor role, to identify and refer and support families, and that kind of all comes in with like the 'daily challenges' (*words on collage*) and this is how the daily challenges make me feel, quite a lot.

The 'face'? (*picture on collage*)

S4

Yeah, the quite sad, solemn face, and sometimes when I *feel* quite like these challenges are 'getting on top of me', kind of see these two who are sat on the sofa, I kind of relate more to this lady...(*picture on collage*)

On the left?

Yeah. Because she's kind of like, right, OK. And the other lady's trying to talk to her and sometimes when all these daily challenges within your role are mounting up, it can make you feel a bit like, 'OK, I'm going to have to sit and try and support this woman even though mentally I'm struggling'.

So, who's the person on the right?

So, that would be a client.

Right.

S5

Because of *all* of the changes that have happened, not only with coronavirus but other changes that have happened, I feel like my brain is 'mush' and that's why I used the 'mush' there (*word on collage*) because we're constantly having to keep on top of emails, change the way we're working, making sure that we're still hitting our KPI target, which is why I put this target here in 'Productivity', which I feel just kind of takes away from the care of just looking at the numbers side of things and making sure the right referrals are open on the system and yeah, it's just...it takes away from it a lot when it boils down to keeping commissioners happy and then 'money', I put here for more of the health visiting side of things because I feel that the responsibility the health visitors hold is definitely not reflected financially, you know, a lot of the safeguarding, I think that we have to manage as well, and you're kind of used as a surrogate social worker in some instances, but we're not: we need to bring it back to and make children's services realise we are health-related. I think yeah, the lack of NHS pay rise, given the covid situation, was quite tough, and it's made me kind of question, you know, it's made me question, 'is this something I want to do for the rest of my life', if we're not going to be acknowledged for the hard work we do?

S6

However, I do enjoy it so much and I enjoy my role and I enjoy being there for the families and seeing them through difficult times and getting them to a really good place where they can enjoy life. And kind of, like, the 'heartbreak' and 'brotherly shove' (*words on collage*), I was kind of thinking more about during lockdown obviously we had a lot more relationship issues between parents because they were 'on top of one another' and they can't escape one another, so that

P3 L Stage 3 Interview Transcription

caused a lot of friction and the 'brotherly shove' thing obviously that reflects the domestic abuse instances that were raised, and I kind of linked that as well to the 'Tough', not only with me being tough, but finding it a tough situation that because of the restrictions with our changes in working, we *weren't* able to give as much support I feel to victims of domestic abuse, you know, but maybe a phone call, maybe a visit, it just, it wasn't very easy to know which was the best way to go: in my *heart* I'd want to do a visit to make sure the victim and children involved were OK, but doing over the phone, I found it quite difficult.

S7

So yeah, it's...it's been strange having covid as part of a challenge! (*ironic chuckle*) It's never anything I thought that I'd have to experience in my career, but I do think it's made me appreciate my role more, and how important we are, especially with knowing that we essentially were the *only* ones going in to see families in their home. The midwives had transferred their care to clinics, so I think we were *really valuable* in being able to go into that home, see the home environment, ensure the safety of the children and *just* be able to give, have that rapport with the families more so than you can do in a quick clinic appointment...

S8

...so yeah, and I have found that...I *feel* as though with coronavirus being quite a big thing for everyone, my phone has been non-stop because of families *wanting* to get in touch with us, *wanting* that support, wanting that reassurance, where usually they get it from other sources like family members and stuff, but I think our role has really been solidified with *this*, with this pandemic and people appreciate what we actually do and actually *know* what we do! (*laughs*) And you know, the wide variety of support that we can offer, so yeah. That's it! (*laughs, pauses*) **Thank you. So, if I asked you, thinking about yourself as a health visitor, what matters to you?** Being there for the families, and being able to care for them appropriately. Ensuring the welfare of the children and the kind of future generation, that's why I got into health visiting to begin with, because I thought we're in a very cyclic culture where you know, children of bad parenting will go on to be bad parents themselves and I wanted to be able to make that change, and educate people and break that cycle really, for the benefit of not only the family but society as a whole! (*laughs*) So yeah, that's my main thing, just to...*just* have more positive outcomes for people and their health and well-being.

And what about your experience to all of the changes of the team and the wider team?

S9

(*reflective pause*) I think...I mean, the wider team...I think in the beginning it was quite...coming in from it being qualified and then having, being told that you know, on a Friday, 'this is how we do things' and then starting my job as a health visitor on Monday and then being told, 'actually no, everything's changed' was very difficult. I do think the kind of *partnership working* with the [Family Bases], I *didn't see that* when covid hit. The [Family Bases] weren't around. They weren't accepting referrals as far as I was aware; I think I did one referral but they were doing remote things but it felt like we were carrying *everything*, and yeah, it's kind of looking back, it made me think right, well, if we *can* carry everything, why aren't we? If this is how we *used* to do health visiting, why can't we go *back* to that way? And because I think it can be done *well* and I think people would appreciate the health visiting service *more*, (*laughs*) if we did. But yeah, that partnership working just *wasn't there*, in my opinion and we didn't know, there were no *groups* other than on video call but if you've got a vulnerable family who don't have the luxury of a smart-phone or tablet, they're missing out, so it wasn't really catering for the whole wider population. Yeah.

So, your thoughts about what health visiting might have been in the past, and you're questioning, 'well, why don't we do it again?' What will it need?

S10

More health visitors! (*laughs*)

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Right.

More health visitors.

Capacity?

Yeah, *capacity*. Facilities as well; *time*, to be able to put on groups and I think education, the focus for the *training* around becoming a health visitor to focus *more* on the kind of basics of the job which I don't feel that they do. It's more all about leadership and research and things like that, whereas the actual 'bare bones' of the *job* is not really covered; there's a little smattering of safeguarding but you don't really, you don't know safeguarding until you're in the job and actually doing it. But yeah, essentially, more health visitors. (*reflective pause*)

Anything else about the team? About your immediate team? What's been your experience of all these changes, of the immediate team?

S11

I couldn't have got through it without them. They have been such a *bolster* for me *mentally* in the job. I mean, going back to kind of this picture, (*indicates to a woman alone*) during covid when we were told to work from home bar doing any visits and things, I found that quite an odd environment to work in; it's not what I'm used to and I'm used to having people and that social connection, and even just something as simple as if you *have* had a tough visit, a debrief with a colleague, just so you kind of reinforce your thinking and your working and your plan for the family and I, yeah, I '*cracked*' during covid, it was *awful* and it took me *phoning* a colleague in *tears* for them to say: 'I'm in the office, come in' and ever since that day, I went in every day, it was obviously *safe* for me to do so, but it really helped, I really couldn't have gone through it without them, and in the same token, my line manager, she was really good, understood how I was feeling because I had a lot of extra work added to me because I'm a full-time member of staff and people were deployed so I had to take on their caseload *as well*, as well as my current one, so, 'juggling *very many balls in the air*'! It's enough to make anyone '*crack*' really! (*ironic laugh*)

Yes.

S12

Especially when it's very *safeguarding*-heavy during a very difficult time when you can't *see* the children, as you would, and do a thorough assessment of the home and the family. But yeah, I wouldn't have gotten through it without the team.

So, it was the face-to-face?

Yeah, yeah. And the, you know, the *camaraderie* of it all as well, yeah, it was being able to see each other, you know, have lunch in the office, have a laugh, (*chuckles*) have a talk about what to do for a family and then yeah.

For you, that was essential?

Yes, absolutely. (*sentences removed here to protect anonymity*)

If covid hadn't have happened, would any of that have changed your thoughts particularly?

That's difficult to go back six months! (*laughs*). But in the year we haven't seen each other, when you talk about team or anything else, would anything have changed in your thoughts about *being* with your team?

S13

No. Not where I am at the moment because the team I'm in are hard-working; they're very conscientious workers, they will always go 'above and beyond' where they can for their clients, but they'll also go 'above and beyond' for their colleagues as well. It's what a *proper team* should be; they're *always* there for one another if someone is having a tough time be it work-wise or personally, they will pick you up, they will make sure you're OK, they'll 'check in' with you and that's so important. Not just to *me*, but for *everyone*, I think. And they're generally quite positive! (*laughs*) Unless they're having a bad day! (*laughs*)

Any other thoughts?

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It's hard to think *back* to a time when there wasn't covid, (*laughs*) work-wise!

Yes! What about the picture, did you mention the picture of the 'scene'? The 'country scene'?
(*picture on collage*)

S14

Oh yeah. So...this side kind of represents how I feel I'm flourishing in my career. This side where it's a little bit bare was where I feel I took a couple of knocks back.

The 'bare tree'?

Yeah, the 'bare tree'. It was 'pruned' a little, unfortunately because of covid, but I know it'll 'grow back' and the 'light bulb' as well is it feels as though I've 'switched on a light bulb'; it's also kind, of almost like a 'light to the end of the tunnel' in a way for my career because during all this *time*, at the beginning I was quite happy to be a health visitor, but now I think, well actually, maybe I want to be a *team lead* of a group of health visitors; maybe I want to improve the service on a higher *level*, but then I'm very conflicted; that will take me away from client-facing role which I really like, so yeah, it's kind of like a 'beacon' and a goal, (*slight laugh*) that I look for and to, if I was lucky enough to be able to 'climb the ladder' in ensuring that health visitors are protected and treated well from management.

And when you say 'management'?

S15

The decision-makers.

The decision-makers?

Yeah. And also, the commissioners as well. I think it's quite narrow-minded just to look at numbers on a screen, in terms of KPIs [*key performance indicators*], costs, and things like that. I appreciate that, you know, we've got to stick within a budget, but if ...if all health visitors were *valued* and you know, were *valued, appreciated* and *protected* enough to be able to *do the work* that we *need to do* for the future generations, these costs and numbers won't be an issue anymore, because all of these health needs and you know, emotional *well-being* and you know, the *amount of mental health* costs there are in the UK is *ridiculous*, but if we can *do our work* and *do it well* and not under pressure, we could, not *eradicate* mental health but definitely curb the incline of rates of people suffering with mental health, and then it would cost less on the NHS. It just makes sense to me! (*laughs*) You know, *that's* what health visitors are *for*; we're here as an intervention to *protect* people's health but also in a way to protect the financial side of things that come with healthcare services.

You're sort of talking about the 'long-game' of health visiting?

Yeah, absolutely.

What would it take for *something* to move on that, so the decision-makers, maybe understood what you're saying?

S16

I think they need to not necessarily think, right, 'we need to hit this amount of new births in a month', or you know, need to do 'X' amount of maternal well-beings'. I think we need to show a more *holistic* side of things, rather than it being a numerical way of data recording; have a more, I've lost the wording now...having more emphasis on *patient feedback*, and I know we give out the cards and you know, surveys and things, but I don't think it's enough. I think maybe some research needs to be done into the impact of the health visitor's intervention on the wellbeing of a family, like a longitudinal thing, but we need more health visitors to be able to do that!
(*chuckles*) So, yeah.

So, what about, when you think about the decision-makers and their *perception* of what's happening on the ground?

S17

I don't think they have a perception of what's happening on the ground. I've never heard of a commissioner or decision-maker coming out to the front line, let's say, with a health visitor

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spending a good [amount of] *time* with a health visitor to see what's going on. No, I've never heard of that being a thing. I think 'we're just numbers on a screen' that costs money. So, 'where can we save some money?' And I think the *general public's* kind of idea of what a health visitor does is quite skewed. Everyone remembers their midwife. They never remember really their health visitor in some cases! (*sentence removed here to protect anonymity*) (*hearty laugh*)
So...

But you were saying, with Covid, that you felt really appreciated?

S18

Yeah. Because we were the *only ones* really who were *going there* to the homes, *even* GPs weren't seeing them face to face, it was all telephone triage, and a couple of times I've been quite concerned with some GPs' decisions *not* to see a certain child and I've had to tell the mum, you need to get the face-to-face appointment, and luckily on a couple of occasions, that did happen because the babies were quite unwell. We've been the only...*consistent* service, I think, where we've still got the ability to go into the homes, should we feel there's a need, now that we've got PPE [*personal protective equipment*], which we didn't in the beginning, but we were still expected to go in, which was quite tough because we were putting our safety on the line, and the safety of the clients as well. Yeah, that was quite 'hard to swallow'. But we still did it because we enjoy the job. Or I do, anyway! (*laughs*)

Anything else?

S19

(*pause*) I think that's it really.

Anything about the choice of background colour?

Oh, it's just my favourite colour! (*hearty laugh*) Yeah, it's just my favourite colour. It's always one that reaches out to me, so yeah...

It's about, that's about 'you being you', the background colour?

Yeah.

Yeah. You've explained that beautifully.

Thank you. Thank you! (*She smiles*)

What was the, can I just ask you, be honest, what was the experience of making the collage like?

S20

Quite cathartic, again...yeah, very...it's kind of given me time to reflect over the past few months, because when you're in 'that moment', you don't really take time to 'check in' with yourself I think, and I think like kind of looking back, it's made me think, 'oh yeah, that was really tough' and 'oh yeah, that wasn't a great day', or 'oh yeah, actually no; we had a really, I had a really positive experience with that family and they're doing really well'. So yeah, it was, you know, nice to reflect back really and have that opportunity to do so.

And the interview overall?

Oh, lovely! (*smiles*) Yeah. Yeah, it is...it's good to reinforce *why* I became a health visitor, because I think sometimes when the stresses get you down, much like in any job, you do question, 'what am I doing?' 'What am I doing here?' But no, being able to kind of think back to families and think how I coped during tough times has kind of given me a bit of strength as well, that 'I can do it!' (*hearty laugh*) (*reference to words on the collage*)

'Let's do this'!

Yeah! (*laughs*)

Anything else?

No, I think that's it.

Thank you.

Thank you.

(30: 21 - end of recording).

Appendix I. Ethics application form and approval notification

UNIVERSITY OF HERTFORDSHIRE

ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS
(‘ETHICS COMMITTEE’)**FORM EC2: APPLICATION FOR MODIFICATION AND/OR EXTENSION TO AN
EXISTING PROTOCOL APPROVAL**

- 1 **Title of original application:**
Health Visitors' Experience of their Professional Identity and Core Values and how these relate to their work as Inter-Professionals: Comparing Professional Identity with Lived Experience in a Time of Change

Protocol Number:
EDU/PGR/UH/03549(3)

Is this the first modification/extension request for this study?**

No

If no, please include the most recent approval notification document with your application.

2 **Protocol holder details**

Applicant name:	Helen Seaman
Student/Staff number :	01028730
Applicant e-mail address:	helen.seaman@ntlworld.com
Work address (if appropriate):	NONE
Supervisor's name:	Professor Helen Payne
Supervisor's School & Department:	Education
Supervisor's e-mail address:	h.l.payne@herts.ac.uk

3 **Specify the nature of the modification/extension (please tick all that apply and complete Q4 & 5).**

Revised title of study.

Please state amended title here **Health Visitors' Professional Identity and their Lived Experience of Service Change**

Amend/extend dates NO CHANGE

From: [Click here to enter a date.](#) To: [Click here to enter a date.](#)

- Additional worker(s):NO CHANGE

Names and student/staff numbers for any additional investigators involved in this study

N/A

- Change of supervisor from: N/A to:Click here to enter text.
Please complete declaration below and give reason in Q4

Declaration by new supervisor:

I have reviewed the ethics protocol paperwork for this study and am aware of any conditions which must be adhered to.

Signed Click here to enter text..

Date: Click here to enter a date.

- Location of study AS BEFORE, IN NHS LOCATIONS

Detail new location here

- Other **Two research questions:**

1. How have service changes affected health visitors' professional identity?

2. What was the lived experience of service change like for health visitors?

-

Changes made to the study title and questions in the light of new learning

4 Reason for extension/modification request

In light of new learning and as preparation for final round of follow-up interviews.

5 Hazards

Does the modification or extension present additional hazards to the participant/investigator?

YES

NO

If YES, please complete a new Form EC5, 'Harms, Hazards and Risks'.

If you are required to complete a School-specific risk assessment (in accordance with the requirements of the originating School), it is acceptable to make a cross-reference from this document to Form EC5 in order not to have to repeat the information twice.

Signature of Applicant : Helen Seaman

Date: 16/10/2020

Support by Supervisor: Click here to enter text.

Date: Click here to enter a date.

** modifications include any amendment of documentation to be given to participants, for example Form EC3, Consent, Form EC6, Participant Information Sheet, survey document



SOCIAL SCIENCES, ARTS AND HUMANITIES ECDA

ETHICS APPROVAL NOTIFICATION

TO Helen Seaman
CC Professor Helen Payne
FROM Dr Ian Willcock, Social Sciences, Arts and Humanities ECDA Chair
DATE 20/10/2020

Protocol number: acEDU/PGR/UH/03549(4)
Title of study: Health Visitors' Professional Identity and their Lived Experience of Service Change

Your application to modify and extend the existing protocol as detailed below has been accepted and approved by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

Modification: Revised title of study and amendments to two research questions (as per EC2)

Original protocol: Any conditions relating to the original protocol approval remain and must be complied with.

Permissions: Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

External communications: Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

Invasive procedures: If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

Submission: Students must include this Approval Notification with their submission.

Appendix J. Researcher's e-poster for the Institute of Health Visiting (iHV) Conference (2020)

Who are YOU as a health visitor?

Helen Elizabeth Seaman, MSc, Cert Ed, PG Cert HE, RGN, RHV, CPT
University of Hertfordshire



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INTRODUCTION

In recent years the health visiting service has experienced a period of significant change and redesign. This presents challenges to its core ideology and mission to 'make a difference' to the lives of clients (Whittaker et al., 2013).

After over 25 years of practice and commitment to the profession, I was driven to explore with a group of health visitors their lived experience of changes to their professional identity over a period of transformation of their working practices.

My EdD study title is 'Health visitors' lived experience of their professional identity in a time of service change'. At the time of writing, the current externally-directed service changes are far more radical and unexpected than at the beginning of my study, due to the outbreak of the Covid-19 (C-19) pandemic.

AIMS

- To contribute to practice:
 - Through developing a deeper understanding of health visitors' perception of their professional identity
 - By identifying what, for health visitors, are the key features of externally-directed changes and the resulting effects on their professional identity
 - By identifying, through health visitors' experience of service changes, which elements of their professional identity are constant, and which are dynamic
- Understand health visitors' experience 'as lived through' during a time of service change: what it is like to be a health visitor at this time (van Manen, 2017)
- Offer insight to health visitors, other professionals and stakeholders including change leaders, policy and decision-makers, and implementers, and the public whom health visitors serve.

MATERIAL & METHODS

I adopted an Interpretative Phenomenological Analysis (IPA) approach which comprised semi-structured interviews with 20 practising health visitors. An art-based data collection method (collage) was used as visual art may express what is "hidden" beyond words. This data was complemented by the HVs' diaries. Two face-to-face interviews were planned approximately 12-14 months apart. Of the initial group of 20, 8 were able to attend the second interview prior to the pandemic. A further 7 are currently being carried out now restrictions have eased. The interviews have been analysed using a professional identity model that I created based on an extensive literature review. Social and role identities are key aspects of this model, defined from the participants' personal accounts and the literature.

ART-BASED DATA COLLECTION

Participants were provided with a common set of materials and invited to create a collage in response to the prompts:

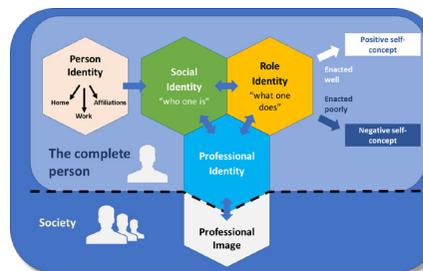
1st interview - 'Who are you as a health visitor?'

2nd interview - 'Who are you as a health visitor now?'

The collages formed the basis for a discussion on the health visitors' experiences and perceptions relating to their professional identity. Many commented that this was a positive, reflective and cathartic experience.



PROFESSIONAL IDENTITY MODEL



A health professional's social and role identities are integral to shaping their professional identity and influencing their positive self concept.

Role identity

- Core professional and personal values
- Emotional and personal commitment, attachment and psychological 'rewards' of practice
- Utilisation of personal experience
- Uniqueness / complexity of the HV role
- Interprofessional working (IPW)
- Public worth and value

Social identity

- Self-identification with health visiting through shared professional values, principles, attitudes, behaviour and ideology
- Sense of collegiality
- Affiliation with the NHS (or other care provider)
- A registered healthcare professional with a professional code
- Autonomy, agency, and caseload ownership
- Expertise and status through qualifications

Professional identity

The participants all evidenced that the two areas of professional identity that remain 'stable and enduring' (Ibarra, 1999) are:

- Their self-identification with the HV profession
- Their core values and mission to make a positive difference to the health and wellbeing of their clients

However, the way in which practice is delivered is 'open' and 'shifting' (Sachs, 2001)

INTERIM FINDINGS

The study participants were clear that to practise effectively, the following inter-related elements need to be balanced against the requirement to achieve efficiencies and targets:

- Communication** – Health visitors, clients and managers / decision-makers benefit from face-to-face contact, clear communication and collaborative decision-making.
- Time** - Face-to-face opportunities for holistic assessment of client need and continuation of care are essential. Also, time for face-to-face colleague contact, and for personal and collective reflection is required, as opposed to excessive administrative duties and data collection.
- Support** – Support is central to client care. It is also a very necessary requirement for HVs as professionals and persons.
- Professional worth and recognition** – A positive sense of professional worth and recognition is necessary for commitment, efficacy, motivation and mental wellbeing.
- The **psychological 'rewards' of practice** were evidenced as a source of great self-affirmation and satisfaction. However, the three feelings / emotions most commonly cited as a result of service changes were: **stress, feeling pressured / overwhelmed and not feeling respected as a professional** by those involved in planning service change. Respect issues relate to professional status, accountability, liability, experience, expertise, values, principles and mission.

Post-initial peak C-19 interviews and analysis are in progress.

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