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Abstract

There has been a scarcity of studies which explore transition to the health visitor (HV) role. This is in stark contrast to research into the transition from student nurse to a newly qualified nurse (NQN) role, which is known to be a difficult and challenging time, impacting upon overall retention in the nursing role. As a nurse lecturer, I have witnessed very similar difficulties and challenges as aspirant HVs undergo the transition to the HV role. However, this transition differs fundamentally to that of a student nurse to NQN, due to the prerequisite for a registered nurse/midwife status before entry into training for the HV role. The student HV is therefore moving from a role in which they are already established, often highly skilled and autonomous practitioners, into to a new professional role.

Using a constructivist grounded theory approach, this longitudinal study has explored this transition to the HV role, providing in-depth understanding of the experiences of the participants. It incorporated focus group and interview methods over a series of data collection points, throughout the transition. The aim to develop a substantive theory of the transition to the HV role.

The transition is multifaceted and is influenced by a range of factors including changes to role identity and community of practice, alongside individual resilience, and the support provided by the wider HV team. The three core categories of Role Identity, Way of Working and Living the Journey are encompassed within the developed conceptual model, which also provides a framework to support this complex transition process. The transition from qualified nurse/midwife to HV is a multidirectional process and is fraught with challenges. Hence, the greater understanding of the transition provided by this study, will help both inform and support future HV students, the wider HV team, practice assessors/supervisors, employers and education providers.

Recommendations include wide dissemination of the findings and conceptual model to allow exploration of the complexities of the transition with student and aspirant HVs, practice colleagues, educators and other stakeholders. Thus, enhancing the support for those undergoing this transition. There should also be greater recognition and valuing of individuals and diversity in the workforce and a focus on building resilient tendencies and wellbeing. Future research should include further exploration of managing multiple role identities, heightened definition of the HV role and the impact of difficult areas of practice (e.g., safeguarding). Other methods of entry into the HV role, rather than from a pre-existing registered nurse or midwife status, are recommended as this could alleviate some of the specific challenges faced within this important transition. There should also be further research to test this substantive theory in other role transitions, where there is a move from one professional role to another.

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List of abbreviations

A	Appendix
AEI	Approved Education Institute
AA	Academic Assessor
ACP	Advanced Clinical Practitioner
ASSIA	Applied Social Sciences Index and Abstracts
BERA	British Education Research Association
BPS	British Psychological Society
CC	Conceptual code
CHD	Coronary heart disease
CSP	Community Specialist Practice
CGT	Constructivist Grounded Theory
CoP	Community of Practice
CETHV	Council for the Education and Training of Health Visitors
CINAHL	Cumulative Index of Nursing and Allied Health Literature
CPHVA	Community Practitioners and Health Visitors Association
DH	Department of Health
DN	District Nurse
FG	Focus group
FHN	Family Nurse
FNP	Family Nurse Partnership
GMC	General Medical Council
GP	General Practitioner
GPN	General Practice Nurse
GT	Grounded Theory
HCA	Health Care Assistant
HCP	Health Care Professional
HCPC	Health Care Professional Council
HV	Health Visitor
HVIP	Health Visitor Implementation Plan
IHV	Institute of Health Visiting
Int	Interview
LD	Learning Disability (nurse)
MW	Midwife
MH	Mental Health (nurse)
NMC	Nursing and Midwifery Council
NQN	Newly Qualified Nurse
OHN	Occupational Health Nurse
P	Participant
p (lower case)	page number
PA	Practice Assessor
PHE	Public Health England
PS	Practice Supervisor
PT	Practice Teacher
NHS	National Health Service
NNRU	National Nursing Research Unit
RCN	Royal College of Nursing

SCPHN	Specialist Community Public Health Nurse
SLAIP	Standards for learning and assessment in practice
SN	School Nurse
SSAS	Standards for student supervision and assessment
T	Table
UoD	University of Derby
UKCC	United Kingdom Central Council
UKSC	United Kingdom Standing Conference for Specialist Community Public Health Nurse Education
WMA	World Medical Assembly

1.0 INTRODUCTION AND BACKGROUND TO THE STUDY

This chapter firstly describes the rationale for the study, including my personal interest in this area. It then provides an overview of the background to the health visitor (HV) role and a discussion of the entry route to becoming a HV. It also seeks to briefly explain important political influences on the profession and its development over time, highlighting key issues of the health visiting professions' role, particularly around its professional identity. The chapter also presents the aims and objectives for the study and lastly provides a synopsis of the structure of the thesis to assist the reader.

1.1 Rationale and motivation

The experiences of pre-registration nurses as they become qualified has been a personal interest for many years. It was during my involvement in a study exploring the preceptorship of newly qualified nurses (Whitehead et al 2013, 2016) that I started to think about the impact of the period of transition from qualified nurse or midwife (MW) to qualified HV. As a nurse lecturer at a UK university with commissioned places for the education of HVs, this transition had been observed countless times. However, even though it could be argued the issues facing the newly qualified HVs, as they moved into the profession, were likely to be similar to that of a newly qualified nurse (NQN), it was also apparent there were fundamental differences in this process. Essentially, the newly qualified HV is already a qualified nurse/MW, and hence is moving from a role in which they are already established, competent and confident, often highly skilled and autonomous practitioners, into to a new professional role in which they have to reconstruct themselves to become once again competent autonomous practitioners.

In witnessing this process, I had been struck by the difficulties many students experienced, to the extent that for some, the pressure led to them leaving the course despite clearly aspiring to the HV role. Appreciating why they found this so challenging and the question of how this process manifests itself, as they moved from one profession to another, was therefore particularly important to understand as it could help support the future nurses and midwives who strive to move into the health visiting profession.

Also, at the same time I became interested in the impact of the Health Visitor Implementation Plan (HVIP) 2011-15 – A Call to Action (DH 2011a), a four-year plan to increase the HV workforce by 4,200. This plan was in response to a key Conservative party pledge in their 2010 general election manifesto to increase the numbers of registered HVs. It encompassed an expanded and refocused training of student HVs and a high-profile national recruitment drive. In reality, this recruitment drive had to attract an additional 6000 extra new recruits to account for natural wastage, through retirement or career change, if it were to reach the planned target increase in registered HV numbers within the timescale (DH 2011b). A notable aspect of this 'call to action' was the relatively new appeal of health visiting as a career to a wider variety of nursing backgrounds than had formerly been the norm. Thus, to attract the numbers of student HVs required to meet the goals of the HVIP (DH 2011a), the recruitment initiative targeted all four fields of nursing (adult, mental health (MH), learning disability (LD) and children's), along with midwifery; resulting in a wider more diverse HV student body (Appendix 1).

Interested in the increasing diversity of the student body and the influence of previous backgrounds, especially the field of nursing, I undertook a small scoping study which explored the background of three cohorts of student HVs and its influence on their assessment results. Although the study provided evidence to suggest the original field of nursing made little difference to the students' assessment outcomes, there is a distinct uniqueness of these individual nursing fields, each having its own professional identity and knowledge base. Thus, the individual attributes of the nurses from each field can be very different (Burton and Ormrod 2020). This earlier study highlighted a number of themes which will be explored within this thesis. These include the motivation, status, knowledge and skillset of individuals and how these might affect the role transition.

1.2 The health visitor title

Early into the planning of this research I made the decision to use the term health visitor, or HV as its normal abbreviated form, within this thesis; the following explanation offers clarification and justifies this decision. Health visiting was regulated as a distinct profession from 1929 until 2001 when the Nursing and Midwifery Order (2001) regarded health visiting as a branch of nursing, removed the title from statute and rendered the title 'health visitor'

without any legal standing (IHV 2014). Currently therefore, HVs are registered as Specialist Community Public Health Nurses (SCPHN) on a sub-part (part 3, often referred to as the third part) of the register of all nurses and midwives eligible to practise within the UK. This is maintained by the present regulator and professional body; the Nursing and Midwifery Council (NMC) formed in 2002 under the aforementioned order.

Prior to the establishment of the NMC, the dedicated health visiting register was maintained by a number of organisations, including the Royal Sanitary Institute, the Council for the Education and Training of HVs (CETHV) and most recently the former nursing professional body; the United Kingdom Central Council (UKCC) for Nurses, Midwives and HVs (IHV 2014, CPHVA &Unite 2012). However, in 2004, the NMC, in introducing SCPHN as a separate registration, closed the existing statutory register of HVs and thus all HVs were transferred to the SCPHN sub-part of the register (mentioned above) (NMC 2004). SCPHN is the now protected title of the role (IHV 2014); however, the SCPHN title (and sub part of the register) encompasses other registrants (e.g., occupational health nurses (OHNs), school nurses (SNs) and family health nurses (FHNs) (Scotland)) (IHV 2013) and hence to distinguish the different specialisms the area of practice can be annotated on the NMC register and is often bracketed after the protected title e.g., Specialist Community Public Health Nurse (HV) (SCPHN/HV) (NMC 2017).

Despite this legislation, the use of the name 'Health Visitor' has continued, especially within the practice arena, by service users (IHV 2014) and in public documents e.g. The HVIP (DH 2011a). In fact, the Institute of Health Visiting (IHV) go so far as to claim that the protected SCPHN title is "*unpopular and meaningless"* (IHV 2014, p3). The combination of the SCPHN title being shared by other specialisms, and the potential confusion this may create, alongside the preference and familiarity of the name 'Health Visitor' has resulted in the decision to use HV, the accepted abbreviated form of this name rather than SCPHN throughout this thesis.

1.3 The health visitor – a brief historical and political perspective

The HV role and education has suffered from fluctuations and competing political and social influences since its inception. Historically the HV often found themselves between the demands of the training providers, the medical officers, who required effective health

surveillance and the Institute of Sanitary Visitors, who provided the final examination for HVs up until the 1960s (Twinn 1989, Brooks and Rafferty 2010). The professions' employers have also swung from local government to the NHS (Baldwin 2012) and recently back to local government (DH/PHE 2014). There has also been varying entry criteria for the profession at times, including, initially, there being no requirement to be either a nurse or MW (Adams 2012). Today however, the HV role is governed by the statutory requirement for a nursing or midwifery registration prior to entry, despite arguments the HV role is distinctly different and should allow entry from different routes, removing this requirement (Adams 2012, Cowley and Bidmead 2009).

Since the founding of the role, the responsibilities of HVs have swung between 'public health' to 'safeguarding' and across the whole spectrum of age groups from birth to the elderly, changing the scope, complexity and nature of the role (Peckover 2013). Additionally, at various times in its history the HV has been aligned to the role of the voluntary worker, social worker, teacher, MW and nurse (Baldwin 2012, Peckover 2013). One consequence of this is the creation of role ambiguity and resulting difficulties with the development of a distinct identity (Peckover 2013, Adams 2012, Baldwin 2012). This has continued up to the present day, as the role continues to be heavily politically and socially influenced (Brooks and Rafferty 2010, Baldwin 2012, Stansfield 2017) (see appendix 2 for further historical detail).

More recently the 'Vision for the future of Health Visiting in England' (DH 2010), launched a new service model to maximise the potential of the HV role to support children and families, build and empower communities (DH/CPHVA 2009, DH 2010) and to successfully implement the 'Healthy Child Programme' (HCP) (DH/DCFS 2009). This focussed service delivery on ensuring every child and family received a minimum basic standard of intervention and support and that each family and child's needs were adequately assessed and provided for, influencing again the direction of the HV role. This has since been revised to modernise the service yet again (PHE 2021). During the process of this research a further change to the management of public health and health visiting services for children aged 0-5 years has led to a return to local authority commissioning for health visiting services and away from commissioning by NHS England (DH/PHE 2014), further influencing the professions' direction (Fagan et al 2017). Currently the HV profession is also undergoing a review as part of the NMC

wider consultation on the Post Registration Standards of Proficiency (NMC 2021). The existing SCPHN standards (current since 2004) will be removed in 2023 and replaced with new standards of proficiency for the HV, alongside the other fields of SCPHN practice and associated programme standards. This is important to ensure the currency and competency of future HVs within the future health care arena. It is likely this will add to the uncertainty surrounding the HV professional role, as the new standards will apply only to HVs qualified after 2023. Importantly though, it also presents an opportunity to provide clarity and definition for the future HV role.

Historically there is a scarcity of literature considering the HV role and none which specifically explores the transition to the role in its entirety, especially post the 2011-2015 high-profile recruitment drive, (DH 2011a, DH2011b). However, in recent years there has been a growing number of works and studies, particularly exploring the political influence, recruitment, retention, the evidence base for, and components of, HV practice (Cowley et al 2013, NNRU 2013, Whittaker et al 2017, Brook et al 2019). There has also been a number of published texts focusing on the professional identity and the varied complex responsibilities of the role which have highlighted the ambiguity surrounding the professional identity of HVs (Baldwin 2012, Peckover 2013, Stansfield 2017). Additionally, there have been several writers that consider the transition into a profession are key to the development of professional identity (Adams et al 2006, Cohen 1981, Ashforth 2001). Hence, exploration of transition to the HV role may help to reduce present uncertainties and benefit aspirant HVs in their transition to the role and offers further rationale for my study.

1.4 Study aims and objectives

- The aim of this study is to provide a substantive theory for the role transition from nurse or MW to HV.

This should enable an in-depth understanding of the transition to the role, providing important knowledge to support future recruits and recruitment.

My principle research objective is therefore:

- To explore the transition of nurses and midwives to the role of a HV.

The transition is explored longitudinally over time to establish a clear understanding of the process, as it is experienced by the nurses and midwives undergoing the transition.

Secondary research objectives:

- To consider any impact of previous experience on the transition process.

During the exploration of the transition process considerable attention is given to the influence of previous experience of the nurse or MW on the process.

My study provides new evidence by providing a thorough understanding and substantive theory of the transition to the HV role, exploring in-depth, the process (including the barriers and limitations) in which new recruits become members of the profession. Through the process of exploring this role transition, a clearer understanding of the transition to a HV identity emerges, particularly of the new HV workforce at the time of the HVIP. The study also provides a clearer understanding of the investment needed to support this role transition. This will be useful for all stakeholders including potential new recruits, student HVs, HVs, educators and the work force development team.

1.5 Thesis structure

Chapter 1 has provided important context to this thesis and the HV role, including the rationale for the research and my personal motivation. It also states the research aims and objectives. To help navigate through this work it also offers an overview of the structure of the remaining 7 chapters.

Chapter 2 reviews the key literature, setting the scene and providing an overview and context of the evidence surrounding the process of transition, transition in health care, transition and identity, transition in nursing and the HV role. The current evidence base in health visiting is limited and there is a lack of research exploring transition to the HV role. There are a number of seminal studies exploring transition to the NQN and they have been useful in providing important insight and highlighting the complexity of the process.

Chapter 3 identifies and justifies the research methodology, constructivist grounded theory (CGT) that has been adopted for this study. The application of a design framework and

consideration of the philosophical underpinning of research alongside my research aim and objectives, facilitated this process. It also considers the tenets of grounded theory (GT) and their application in the design of this study. Finally, the enhancement of quality, rigour and reflexivity in undertaking this study are discussed.

Chapter 4 discusses the required ethical approvals and considerations of the study.

Chapter 5 presents a critical discussion of the research process, including the study design, the sampling strategy and participants. The data collection tools, data management and the data analysis process are also described.

Chapter 6 provides a summary of the findings of this study, presented within each of the six emerged subcategories. These are linked to excerpts from the transcripts and further evidence provided in the appendices (Appendix 16). The findings are gathered from across the data collection phases to illustrate and explore changes over time.

Chapter 7 provides discussion of the continuing conceptual analysis and the development of a conceptual framework illustrating the process of transition to the HV role. It identifies and critically discusses the three core categories alongside the application of the conceptual framework and hence, provides a substantive theory for the transition to the HV role.

Chapter 8 reviews the original aims and objectives of the study and draws together the key aspects of the previous chapters to present conclusions, emphasising the implications of the findings for practice and recommendations for the future based on the findings of this work. Study limitations are also discussed, and a dissemination strategy outlined.

1.6 Summary

This chapter has provided an introduction to the study and a background to the role of the HV. The health visitor title is discussed including the rationale for its use and subsequent abbreviation to HV. Important aspects of the development of the HV role over time have been presented as well as the role entry requirements. The study aims and objectives are stated. Lastly an overview of the thesis is given. The next chapter offers a review of the

literature in order to provide further rationale for my research and explore relevant literature in the field of transition pertinent to my study.

2.0 LITERATURE REVIEW

2.1 Introduction

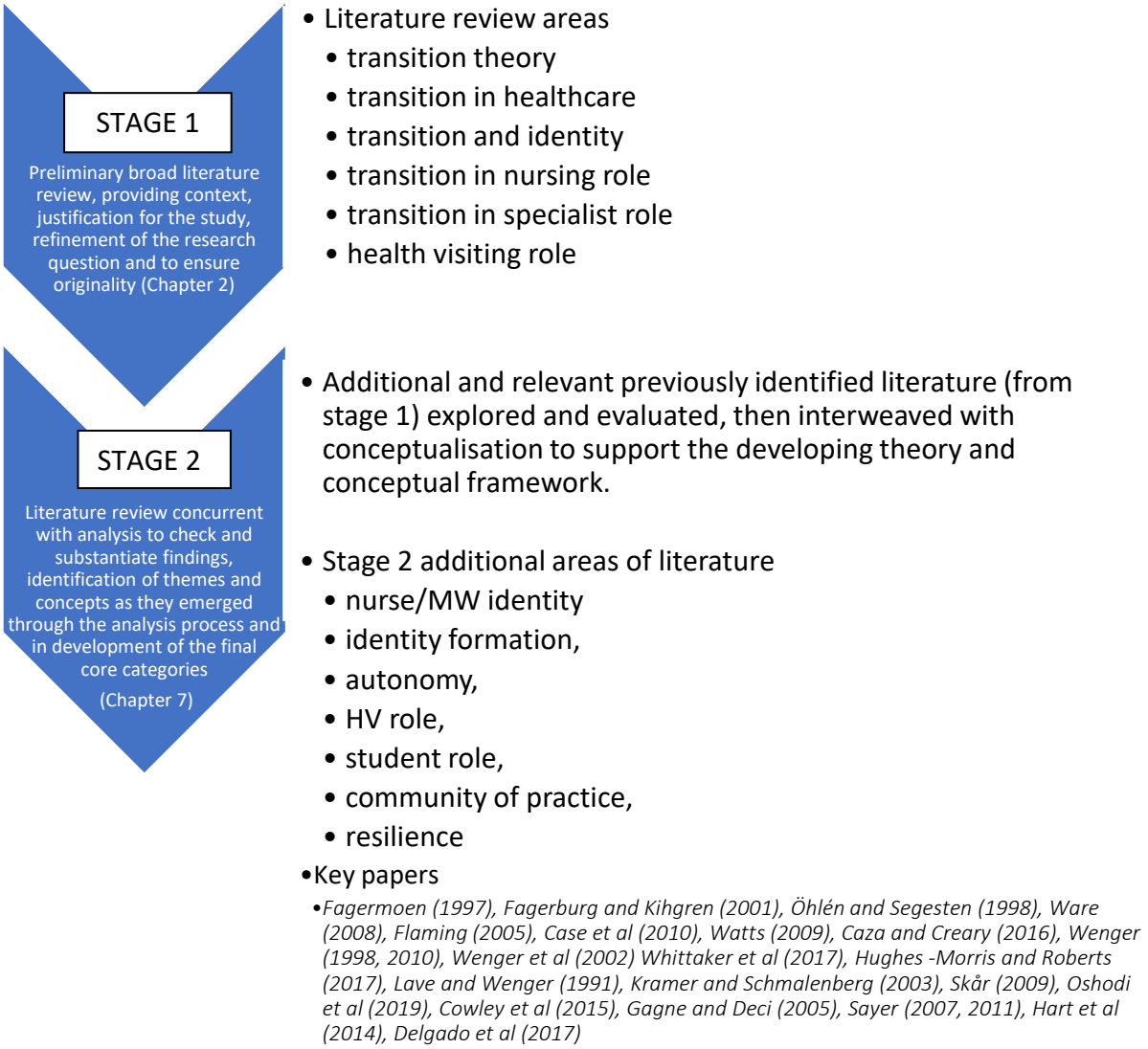
This chapter will review the seminal and contemporary literature to offer a background and context for the study. It will also provide further rationale and defence of the research question, identifying gaps in the evidence base surrounding transition, particularly in the context of the HV role. A preliminary literature review was undertaken in the early stages of the study and a more focused review of the substantive and relevant literature performed alongside the process of data analysis, as per the tenets of a CGT, my chosen methodology (see Chapter 3).

There has been a great deal of debate surrounding the timing and manner of the literature review in GT studies (Charmaz 2014, Birks and Mills 2011, Dunne 2011). Glaser and Strauss (1967), in their classic iteration of GT, believe the researcher should avoid the literature until after the analysis. This is so the researcher can enter the field with an open mind, without preconceptions. They do, however, support the notion of using the literature in the topic to ground the emerging theory but argue that to be immersed in this literature before this point will skew the researcher's view of the emerging theory.

Charmaz (2006) similarly believes that the literature review in GT should provide a context but that it requires a careful undertaking to create a discourse with your developing theory, suggesting they should be woven together. This can help in positioning your study within this literature and clarify its contribution to existing knowledge. Birks and Mills (2011) also suggest a limited review can help in the initial stages of a GT to enhance theoretical sensitivity in the researcher (Glaser and Straus 1967). Therefore, in line with the GT methodology, an initial broad overview of the literature was undertaken to provide context and to form the first phase of engagement with literature (Stage 1- see Figure 1, p10). This initial review presents what is known about key general transition theories, transition process and the process of transition in the context of health care professions. It also discusses concepts emerging from this literature to establish their relevance, in terms of role transition. After the end of the study (2016) and before the final completion of this thesis (2021) additional, newly published and relevant papers were added to this initial review as appropriate.

A further examination of the literature was also performed during and after the completion of data analysis and the identification of emerging categories and themes (ongoing from 2015-2021) (see Chapter 7). This lengthy second phase was used to check and substantiate the findings of the data analysis and the identification of themes and categories as they emerged. These were compared with the existing literature and thus, this allowed the discovery of differences and similarities to be woven into a dialogue with the emerging theory (see Figure 1).

Figure 1



Literature Review Process

For stage 1 of the literature review process the databases of Medline, the Cumulative Index of Nursing and Allied Health Literature (CINAHL) Plus and ASSIA (Applied Social Science Index and Abstracts) were initially searched using the search terms Transition AND (Nursing OR Midwifery), Transition AND Health Care professional and Transition AND (HV or Health Visitor OR Specialist Community Public Health Nurse OR SCPHN). Date limits were applied to restrict results to the last twenty years for searches relating to the nursing and midwifery role but expanded to no date for searches relating to health visiting (see Appendix 3 for example of a search strategy used in stage 1). This was to identify literature that had looked generally at the process of transition in health care professionals, but especially within nursing and midwifery and importantly, to establish if any previous studies had been undertaken which explored the transition to the HV role. From the results of these searches a number of studies were identified for inclusion in this review and hand searching of the reference lists of these studies identified further works. From my previous research and knowledge of the literature in related fields I was also aware of some key texts that would need to be considered for inclusion, on further assessment of their relevance to this work (Benner 1984, Kramer 1974, Duchscher 2008, Duchscher 2009).

Literature relating generally to the theory of transition was also scrutinised to identify important and seminal works in this field. Through the review of this literature an association between transition, identity development (Kralik et al 2006) and professional socialisation (Cohen 1981) was identified, hence studies highlighting this link have also been included in this review to establish the importance of these concepts in relation to this research.

Lastly in addition to the areas above it is also important to provide context for the HV role and a review of relevant literature in this area was also undertaken.

Stage 2 of the review of relevant literature was focused on pertinent emerging concepts and themes identified during the process of constant comparison analysis (see p44/45 and above p10 and Figure 1). Discussion of these papers is embedded within Chapter 7, incorporated within the discussion of the findings and the emerged categories.

2.2 Transition literature

Initially it was felt important to clarify and explore the concept of transition, to position the focus of my study in the existing literature. To achieve this, several key authors were included in this section of the literature review to offer a clear overview of the thinking around transition theory.

The theory of transition has a long history, especially in the disciplines of Sociology and Anthropology and it has been argued that the work of anthropologist Charles Arnold Van Gennep, from the early part of the 20th century (Van Gennep 1960), is closely related to transition (Kralik et al 2006) and provides us with an early theoretical framework. It is in this work that he describes a "*rite of passage"* (p10) and explains how the celebrations, surrounding the significant milestones of life, share fundamentally similar traits, despite the different cultural influences and nuances, across the world. Van Gennep relates a *rite of passage*, to life events where an individual leaves one group and enters another, leading to a change in status. The theory is easily demonstrated by consideration of the rituals surrounding significant life events such as graduation, retirement, and promotion or changing occupation, which despite cultural and geographical differences are similar across the globe. In linking this theory again to transition, Martin-Mcdonald and Beirnoff (2002) applied *rite of passage* to a variety of transitions including; developmentally, culturally, socially, in situation, of status and within relationships. Thus, implying a broad application of this *rite of passage* theory in our everyday world and lives and not just at significant life events. Van Gennep's theory identifies a linear three phased process for this *rite of passage*, as we move from one group to another as, rites of separation, rites of transition and rites of incorporation.

Reading the transition literature, it occurred to me that transitions of one kind or another have become an important part of all aspects of our lives. It is, thus, not a surprise that a number of authors across disciplines have sought to develop a theory to help explain the process. One of the most influential of these writers is William Bridges who said,

> *"Transition is not an event, but rather the 'inner reorientation and self-redefinition' that people go through in order to incorporate change into their life" (Bridges 2004; p. xii)*

Bridges first published his now seminal work ‘Transitions: making sense of life’s changes’ in 1979. In this work he discussed the importance of a successful process of transition in order to undergo successful change. This first book led to further editions (Bridges 2004, Bridges 2019) and works, ‘The Way of Transition: Embracing Life's Most Difficult Moments (Bridges 2001) and ‘Managing Transitions: Making the Most of Change (Bridges 1991, Bridges 2005). These build upon the initial concept, demonstrating the strength of the interest and relevance of this subject.

In a similar way to Van Gennep’s work, discussed above, Bridges (2004) defines transition as a process with three stages: an ending, a neutral zone and a new beginning. He claims all transitions must start with an ending, where the individual must leave something behind e.g., losing a family member, moving to a new house or job, and that they all conclude with a fresh beginning, as we emerge into the new state, whatever that may be. The neutral zone is the ‘in-betweenness’, a phase sandwiched between the then and the now or the ending and the new beginning.

There are obvious similarities between these two theories, but Van Gennep’s focus is the celebration of the *rite of passage* defining the stages of this process as way of explaining the eventual celebration on success. Whereas Bridges provides us with a framework to help us to manage the process of transition for different parts of our lives. Both identify the important middle stages or phases of the process similarly, as a space or a pause, or as Bridges puts it *the neutral zone*. Van Gennep called this middle stage the *rite of transition or liminal rites* and described the ambiguity that occurs when people are in this in-between state or as Draper (2003) called it *no man’s land* (Draper 2003, p63). To me, the resonance of these writings and descriptions of these middle stages with the journey from nurse/MW to HV is clear and it is this in- betweenness that will provide the focus of this research.

2.3 Transition in healthcare literature

The in-betweenness and the period of the new beginning described by Bridges (2004) provides a focus for much of the transition research within nursing and other health care professions (Kramer 1974, Gerrish 2000, Delany 2003, Duchscher 2009, Lindmark et al 2019) and key studies from this pool will be explored in another section of this literature review

chapter. It is worth noting, despite the abundance of studies in other areas of nursing and allied professions, within health visiting there has been little focus on this important issue. There are a small number of studies which explore related concepts, such as professional identity and socialisation to the role. The relevance of these studies will be further examined as this chapter develops but they are, Dingwall (1977) who explored the professional socialisation of HVs and more recently, Burrell (2011) and Machin et al (2012) who explored the professional identity of HVs in the fluctuating practice environment. These are, however, prior to the context of today's post HVIP (DH 2011a) workforce and they do not specifically explore transition to the HV role, leaving a substantial gap in the literature and the evidence base. Since the HVIP there has been research undertaken by Hughes-Morris and Roberts (2017) which will be discussed more fully later in this chapter. In short, they explore the impact of returning to a student status for their participants, both HVs and SN SCPHN students, and although this is an aspect of the transition to the HV role it does not encompass the whole process, which my research does. My study is intended to produce new knowledge and understanding surrounding the transition to a HV role and to reduce the gap identified within the evidence base. It is especially important to improve our understanding of the way the transition between the old role and the new HV role is experienced, including how this transition transpires and the influences on the process.

In the health and social care literature, transition is a concept that has been widely discussed and yet what is meant by transition is not always that clear, largely because of the different understanding attributed to the concept in its many different contexts (Kralik et al 2006). For example, Schumacher & Meleis (1994), completed a review and narrative synthesis of literature which focused on the concept of transition within nursing. Within this work they categorised four types of transition: developmental, health-illness, organisational and situational. Developmental transition is related to life cycle events, i.e., becoming a parent. Health-illness refers to how families and individuals experience the change between health and illness. Organisational transition describes changes that occur in the social, political or economic context of an organisation (i.e., change of leader, change of policy direction, or re-organisation) and Situational, which is transition as experienced by those changing profession or moving to another place or role, the latter being the area of transition relevant to my study. Schumacher & Meleis (1994) advocate for further research into the indicators of healthy

transitions, perhaps better thought of as the markers of successful transition. They note the factors of role mastery, wellbeing, in terms of how individuals feel experiencing the transition and well-being, in terms of the relationships formed or maintained in the transition, as important factors in success (Schumacher & Meleis 1994). Basically, if we understand what makes a transition successful, we can build this into the process in the future and in turn, promote transitional success. Supporting a successful transition to the HV role is an important goal of my research.

The textbook 'Transitions Theory Middle-Range and Situation-specific Theories in Nursing Research and Practice' edited by Meleis (2010) presents an extensive collection of 54 primary research studies spanning over 40 years, each exploring the concept of transition from within the four categories mentioned above, as well as an additional category Meleis calls, *Nursing Therapeutics*, which relates to the action of nursing care to manage transitions for their patients. This collection provides valuable additional expertise and insight and is a central resource for evidence relating to transition, encompassing each of the categories or types of transition. The majority of the studies included in the collection consider either health-illness transition or nurse therapeutics. Of the four studies included from within the category of situational transition (Brennan and Mcsherry 2007, Weiland et al 2007, Delany and Piscopo 2007, Sharoff 2006), only one has direct relevance to my area of study (Brennan and McSherry 2006) (this will be discussed later in this review). The breadth of evidence presented has allowed me to seat my research within this larger body of work. Thus, my study, by exploring transition to the HV role will provide additional evidence in the situational- education transition category and will also the explore healthy and unhealthy indicators faced during the transition, helping to add to and strengthen the body of knowledge in this area.

In continuing to explore the substantive literature surrounding transition theory it is important to include discussion of the work of Kralik et al (2006). Kralik et al, undertook a comprehensive literature review of *'The Theory of Transition'*. They included 23 qualitative studies, most of which were related to health-illness transition and were able to further define and refine the theoretical underpinnings for the concept of transition. They identified the importance of relationships and networks on the success of transition, in a similar way to that of Schumacher & Meleis (1994), and acknowledged a successful transition depends upon

positive relationships. Kralik et al (2006) also highlight the need to understand the transition process to help facilitate those moving through it, again supporting the earlier work of Schumacher & Meleis (1994) and providing evidence of the need for further research into the process of transition, which my research hopes to fill, specifically, within the transition from a nurse/midwife to a qualified HV role.

An interesting and important finding is the suggestion by Kralik et al (2006), that there is little consensus in the included literature on the nature of the transition process, with some authors claiming a linear, one directional and sequential process, with discrete separate stages, arguing there is a definite beginning and end to the process (Van Gennep 1960, Luborsky 1994, Froggatt 1997, Martin-McDonald & Biernoff 2002, Bridges, 2004). However, Kralik et al (2006) alongside other authors (Van Loon and Kralik 2005, Paterson 2001), suggest the process is more dynamic, being a multi directional and multifaceted process. Others suggest that transition is a recurring phenomenon, where constant adjustments are made to cope with many fluctuations in the process (Glacken et al 2001, Powell-Cope 1995). Clearly there is a need to continue to explore and refine the process of transition, to deepen and enhance the understanding of this important concept.

Kralik et al (2006), also describes a common theme within the literature is that transition results in a challenge to self-identity. Self-identity being disrupted, threatened and reconstructed during the process of transition, they note the similarities in papers exploring self-identity and redefinition with papers describing transition, clearly linking the two. Thus, I have included a section in this review which explores this relationship in more detail to establish the relevance for my study.

Kralik et al (2006) called for further research in the field, especially addressing the need to study transition longitudinally, over time, as time is identified as a key element of the transition process. It could be argued that time is a common factor in all transitions, over all categories and the need for research to explore transition in this way is essential. My research is longitudinal and was undertaken over a time period of 18 months (as the HV course progressed and into the period following). The intention being to fully explore the phenomenon of the transition to the HV role, providing important further detailed understanding of transition, its nuances and idiosyncrasies, narrowing the gap highlighted by

Kralik et al (2006) for research exploring transition longitudinally. The links established to self-identity, previously mentioned, also resonate with my study in which the participants will have new roles and responsibilities, exploration of this and the impact on the reconstruction of self and how this is experienced will also add important understanding to the transition literature.

What is clear from an examination of these texts is that the theories of transition have many applications and nuances. It is though, seen as a process; a way of travelling through from one place to another. The path travelled being affected by numerous factors including wellbeing, mastery (skill and competence) and self-identity. It is obvious, from the literature, that transition is a fundamentally important process for all of us, in all aspects of our lives and significantly must happen successfully for effective change. Therefore, the value in understanding it's process and how it is experienced cannot be underestimated. We need to understand what is happening to allow for better facilitation and support of those experiencing transition, to support them through this period of change. This includes the transition from nurse/MW to HV, as is the focus of my research.

2.4 Transition and identity literature

Identity can be described as the understanding of who or what we are, as seen through the perspective of the individual (personal or self-identity) or others (social identity) (Gecas 1982). Professional identity can be either or both, a social identity (group to which we belong) and/or a role identity (what we do and the meaning this provides us with) (Dutton et al 2010). Neary (2014) further defines professional identity as;

> *the concept which describes how we perceive ourselves within our occupational context and how we communicate this to others. (p14)*

Put simply, professional identity can be used to describe the collective identity of a professional group and/or how we construct ourselves as individuals within this group. However, for the purpose of this research, professional identity that is referring to the individual construction of our identity within the context of our work, will be known as role identity, except where it has been previously referred to as professional identity by other authors, where it will be continued to be referred to as such. For further clarity, it is important

to note, for this research, I consider role identity as the role in which we see ourselves, closely reflecting the definition provided by Neary (2014) above.

As previously mentioned, several studies have been found which align the theory of transition to the development of identity (Adams et al 2006, Pratt et al 2006, Cohen 1981, Kralik et al 2006) and socialisation to a profession (Cohen 1981, Brott and Myers 1999). This section of the literature review summarises key evidence in this area to provide a defence of how my research might sit within this field and how the focus of the research was developed considering these initial findings from the literature. It is not the intention of this thesis to unpick the theories surrounding professional identity or professional socialisation, but it is important to consider how transition to the HV role may influence the development of individual's role identity.

Within the literature concerning the development of identity in nursing and related professions, the discourse is split between the collective identity afforded to the profession, as professions seek to clarify their role boundaries and claim their area of expertise (Stronach et al 2002 , Thupayagale and Dithole 2005, Abbott 1988, Beaulieu et al 2008) and the development of a professional identity as an individual construct- a role identity (Fagermeon 1997, Fagerberg and Kihlgren 2001). This literature however will only be explored further, if it is required, as the direction of the study unfolds, integrating my findings, with relevant literature from this evidence base as part of the process of analysis. Literature relating to both identity and transition will be explored in this literature review.

Brott and Myers (1999), undertook a GT study to explore the development of professional identity in school counsellors, developing a substantive theory of the process, in which they stress the different ways participants internalised their role. They therefore, define professional identity in a way which is clearly tied to the notion of self-conceptualisation and is of particular resonance, they state:

> *"This self-conceptualization, which has been termed one's professional identity, serves as a frame of reference from which one carries out a professional role, makes significant professional decisions and develops as a professional."* (p.339).

The frame of reference they speak of is a meaning-making guide that allows people to interpret or make sense of their identity, in the context of their role. They also argue that developing a professional identity is a self- internalising experience, something that comes from within. This provides the opportunity to highlight the close association the process has with the concept of transition as Bridges (2004) said:

> *"Transition is not an event, but rather the 'inner reorientation and self-redefinition' that people go through in order to incorporate change into their life"* (Bridges 2004; p. xii).

Self-redefinition (as stated by Bridges) is surely strongly related to self-conceptualisation, as it would not be possible to redefine yourself without self-conceptualisation. Self-conceptualisation being how you think about or perceive yourself (Baumeister 1999).

Similarly, professional identity is in part linked to self-identity (Ashforth 2001) and in terms of transition, Kralik et al (2006) also strongly link the notion of self and identity to transition. Describing how identity is affected by change or as they refer to it "*a disruption"* (p326), they suggest the need to reconstruct identity based on new roles. Thus, implying that during a transition our initial identity becomes displaced and therefore is altered in order to conform to our new role. For example, during transition to parenthood, our identity is disrupted and reconstructed to encompass the new identity of being a parent.

There is also a further relationship between transition, identity, and professional socialisation. The earlier influential work of Cohen (1981) claims that professional socialisation is a key mechanism in the formation of a professional identity and relates this to the way skills, knowledge and characteristics of a profession are acquired.

> *Professional socialization is the complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristic of a member of that profession. It involves the internalization of the values and norms of the group into the person's own behaviour and self-conception*. (Cohen 1981, p14)

Furthermore, in the previously mentioned work of Brott and Myers (1999) (p10), they recognised that professional identity development starts in training and grows progressively as we enter a profession, continuing to develop as we identify with the profession. This strengthens, along with other writers, including Du Toit (1995), Melia (1987) and Burrell

(2011), the association between professional socialisation and professional identity. The similarity between the definition of professional identity provided by Brott and Myers (1999) (p10) and the Cohen's (1981) above definition of professional socialisation, in which both refer to self-conception and internalisation is clear. This connection is also seen in the work of Bridges (2004), discussed earlier in this Chapter (p18), in which he refers to inner reorientation and re-definition, further reinforcing the close relationship that can be seen between these concepts: transition, identity development and professional socialisation.

Furthermore, Adams et al (2006) links role transition to the formation of a professional identity, as the beliefs, attitudes and understanding about roles develop. They state:

> *'The professional socialization of an individual comes about through critical experiences where procedures and rules experienced by students or novice professionals trigger the construction of a professional identity.* (p57)

Other texts support this alignment between transition and professional identity, including the work of Pratt et al (2006) who studied, via GT, the professional identity construction of medical residents over a six-year period. Medical residents were chosen as subjects as the different specialties amongst them provided an opportunity to explore any variations between them. The detailed study comprised of 40 participants (29 medical residents and 11 faculty staff) who took part in four semi structured interviews over the course of the study, at predefined time points. This was useful to explore changes as the residents' specialist programmes progressed. The interviews were supplemented with surveys, observations and faculty records, providing a rich combination of data. Ultimately their study found the development of a professional identity was triggered by recurring conflicts between the individual participants self-concept and their work role. The work role changed as they became more knowledgeable and experienced within their speciality and this led to changes in the individual's self-concept. This in turn led to the construction of a new professional identity. In relating this to role transition, they believed that the transition between roles was motivated by an individual understanding what 'they' do (i.e., their actions in the role), to see more clearly what 'they' are (i.e. what the role is), and in doing so construct new identities, as they move into a new role. They advocate the need for this process to be managed and suggest the importance of role models in ensuring effective transition. Their work, although primarily focusing on identity construction and customisation, relates this process to role

transition. By doing so, their work supports that of Ibarra (1999, 2005) which also provides evidence of the link between socialisation, identity and career transitions. Stating that:

> *'new roles require new skills, behaviours, attitudes and patterns of interactions, they may produce fundamental changes in an individual's self-definitions.'* (Ibarra 1999, p765)

Ibarra has devoted much of her work to the field of work identity and career management. This work (Ibarra 1999, 2005), alongside that of Pratt et al (2006), demonstrate the strong association between transition and identity formation and helps provide a clear justification of the research questions I developed for the current research. That is, by studying the transition process when a nurse or MW 'become' HVs, it can also help us to understand the development of their identity as a HV.

Literature surrounding these concepts, linking professional socialisation, identity and transition, within the nursing and allied professions, include the work of Howkins and Ewens (1999) and Brennan and McSherry (2006) and more recently Kerr and Macaskill (2020).

Howkins and Ewen's (1999) research, although now dated, is important to acknowledge in this review as it shares some similarities to my research. They explored the way in which students become socialised into community specialist practice roles (CSP). The methodology adopted for this work utilised a form of factor analysis (repertory grid) developed by Kelly (1955), alongside one-to-one interviews. Kelly developed the grid to explore personality and although it is accepted as a useful research tool (Bannister et al, 1994), it is used here to measure changes in individuals' perceptions in role identity, rather than its original intended use and this may affect the tools validity. However, the use of interview data alongside this grid, make the study's findings a useful addition to the evidence base. The study included 26 students, from across the range of CSP students (district nurse (DN) and general practice nurse (GPN) students). Data collection was undertaken at the beginning, middle and shortly after the end of the CSP course. The emphasis of their research is the development of role identity and the complexities surrounding the socialisation process. Their findings suggest previous experience influenced the professional socialisation and role identity development. They also focus on the way that students see their role and how they perceive any role changes during a course of study. Interestingly they link the content and design of the

programme of education for the CSP student participants with positive developments in self-identity, recommending that educationalists should consider support for this process within their programmes. My research will investigate the influences of role perception in HV transition to make recommendations about how this aspect can be supported.

It is worth noting the similarities in the work of Howkins and Ewan's (1999) and my research: for example, similar participant group, longitudinal design and exploration of role identity changes. However, there are also distinct differences between the two, including the fact that my research is specifically related to the HV student. There are also significant methodological differences, with their research adopting, a type of mixed methods approach (combining quantitative and qualitative data), although they don't acknowledge this explicitly in their paper. My research, however, has adopted a purely qualitative methodology, which is discussed in detail in the next chapter. It is important to note that Howkins and Ewen's study was designed specifically to quantify and explore student views of their role change, rather than discover how they experience the process of role transition. In contrast, my research offers a deep understanding of the mechanism of the transition, specifically the transition to become a HV, through the eyes of the participants.

Brennan and McSherry (2006) undertook a qualitative study to explore the transition and professional socialisation from health care assistant (HCA) to student nurse. Their enquiry stems from a comment by a ward manager that a student nurse who had previously been an HCA was still behaving and thinking like an HCA a year into her course. They interestingly questioned how you stop thinking and behaving as you would in your previous role? Something which will be explored during my research. The study, a qualitative inquiry, utilised focus group interviews with 14 participants at various stages of their training. Their findings make strong links between the transition process and the professional socialisation of the role of student nurse, which they propose is influenced by the professional socialisation that has already occurred in their prior role as an HCA. This again demonstrates the importance of the process of professional socialisation as an aspect of transition. My research considers how transitioning to the HV role is influenced by their previous experiences and socialisation as qualified nurses or midwives.

More recently Kerr and Macaskill (2020) published a study which explored the role perception and professional identity development of advanced nurse practitioners. Using a narrative inquiry which collected data from 10 participants, they used the *habitu*s framework provided by Bourdieu (1990). They related the transition and emerging professional identities of their participants to a combination of factors including time, changes in practice context, learning, role modelling, sense making and acceptance by themselves and others. Linking both transition and identity and strongly alluding again to the influence of others in the transition process. Their work further supports the idea of a strong link between the concepts of transition, professional socialisation and identity alongside the influence of previous experiences, prior roles and the wider professional network. This adds further weight to my research exploring these elements of transition to the HV role.

2.5 Transition in nursing role literature

As mentioned previously there has been a great deal of interest over the last several decades on the transition that occurs as student nurses move into a qualified nurse role (Kramer 1974, Gerrish 2000, Delaney 2003, Duchscher 2008, Duchscher 2009, Whitehead et al 2016, Murray, et al 2019, Graf et al 2020, Wray et al 2020).

The seminal work of Kramer (1974) which explored the dissonance between nursing school and the reality of being a qualified nurse defined *reality shock*. Reality shock describes the conflict that arises between the values and expectations of the nursing role, gathered through the supportive environment of the nursing course and the often-stark reality of this role once they qualified. Kramer's rationale for the study was to explore why nurses were leaving the profession in the early period after qualifying. She established that if focused support was offered through this transition, then these early career nurses were much less likely to fall foul of the *reality shock* and leave the profession. The study had important implications for the profession, especially educators and students of nursing. Notably, Kramer suggested that this *reality shock* does not just belong to the undergraduate or pre-registered student but has wider implications across all of nursing. This obviously has relevance to my area of study and investigation of this concept during my research into the role transition of HV students will be important. This is especially significant due to continuing concerns surrounding numbers

of HVs in practice, despite the recent initiatives to improve HV numbers through enhanced recruitment (DH 2011a, DH 2011b, IHV 2019).

Significantly, the conflict and dissonance acknowledged by Kramer (1974) within the transition to NQN is widely recognised by numerous other researchers in the field (Duchscher 2008, Duchscher 2009, Gerrish 2000, Deasy et al 2011, Delaney 2003, Newton and Mckenna 2007, Ross and Clifford 2002, Schloessler and Waldo 2006, Whitehead et al 2016). Thus, demonstrating the relevance, longevity and impact of this element of transition. It will be interesting to see if this in felt in a similar way within my study.

Benner (1984), motivated, as was Kramer (1974), by the high NQN attrition rate, developed the 'Novice to Expert Model of Skill Acquisition' which enables an understanding of the progression nurses go through to transition to practice. Her work, which differs from Kramer, in that it is based largely around skill acquisition, has been widely employed within nurse education and continued learning support. She does, however, relate the acquisition of skills to the process of transition to the role, linking it to professional socialisation and clinical skills. Benner draws less on the influence of others for a successful transition, except in the need for experiential learning opportunities provided by more experienced nurses. Her model, although perhaps key in terms of insight of skills acquisition, is not as concerned with the detail and process of the transition as it is experienced by the NQN. In view of this it is not as pertinent to my own research.

Developing the seminal work of Kramer (1974) further, Duchscher (2008, 2009) created a theoretical framework for the initial transition for early career, newly graduated nurses. The *Transition Shock* theory (now subject to copyright) demonstrates that the NQN must deal with changes and challenges across all levels: physically, emotionally, intellectually, and culturally, as they grapple with the unexpected responsibilities and their new application of knowledge. Through this work Duchscher (2009) advocates the importance of providing education on role change theory in the preparation of student nurses for the realities of professional practice. Duchscher (2009) does not offer any guidance regarding the extrapolation of this recommendation to other groups (not just pre – registration students) but I would suggest, that as previously noted in the work of Kramer (1974), these issues are felt more widely and an increased understanding of the mechanism of this would be beneficial.

Confirming the stress of transition to the professional role, Deasy et al (2011) support the recommendations of Duchsher (2009) and acknowledge the importance of developing coping strategies in the pre-registration student. There are numerous other authors including Holland (1999), Etheridge (2007), Newton and Mckenna (2007), Rungapadiarchy et al (2006), Gerrish (2000), Delaney (2003), Kaihlanen et al (2013), Kumaran and Carney (2014), that have explored this issue. More recent additions to the body of evidence in this field include Whitehead et al (2016), who presented a case study of the transition to the NQN, exploring factors that influence this and Wray et al (2020), who undertook a rapid evidence review, evaluating the current evidence base surrounding the support for transition to the NQN.

Perhaps this large number of related studies is a consequence of the importance and significance placed on retaining members of the profession, which is interestingly also presently the subject of recent government proposals (NHS England 2020, Beech et al 2020). It also demonstrates the significant value of understanding the transition process, especially important for educators, employers and career advisors and of course those undergoing a role transition.

Graf et al (2020) completed a critical review of transition theories used to guide new graduate nurse transition. They contend that although the work of Kramer (1974), Benner (1984) and Bridges (2004) are still relevant today, they are less so when you consider the changes to the nurse role and education since they were developed. Duchscher's (2009) theoretical framework is less limited and is a preferred framework as it relates more to the challenges faced by recent graduates. It is useful to note the relevance of these transition theories are still current despite their age. This is echoed in the work of Murray et al (2019) and Arrowsmith et al (2015) who also present review papers in this field. However, it is important to continue to explore and research transition as a concept, as changes to health care roles persist, to allow us to provide further understanding and current and relevant guidance and support.

Graf et al (2020), echo Duchscher (2008) and Gerrish (2000) in their call for nurse managers and other senior staff to have a greater awareness of transition shock so they can adequately support the new graduates to the profession, reducing its impact and aiding retention to the profession. This bears relevance to my proposed study, as to date, there is a scarcity of

research relating to HV specific transition and hence, although there is anecdotal evidence of the difficulties this can present (Forbes 2016, Smith 2017), the lack of relevant primary research will potentially reduce the support and understanding of HV students and newly qualified HVs' requirements to facilitate a successful transition to the role.

2.6 Transition in specialist nursing role literature

There is a smaller body of research available that has explored the transition of the already qualified nurse to advanced and specialist roles or roles within nurse education (Howkins and Ewens 1999, Anderson 2009, Glen and Waddington 1998, Steiner et al 2008, Delany and Piscopo 2007, Holt 2008, Pleshkan and Hussey 2020, Heitz et al 2004, Ashley et al 2017, Kerr and Macaskill 2020, Stamps et al 2021, Brathwaite 2018, Begley 2007). Many of these works also share the sentiment of the Brennan and McSherry (2006) study previously mentioned that demonstrated previous experience and role can impact on the transition process.

In addition, Hughes-Morris and Roberts (2017) explored the return to a student role for nurses undergoing SCPHN courses (both SN and HV). However, the focus of this enquiry is the impact of student role on the participants rather than the transition from one role to another *per se*. There are of course similarities and they do relate this process to some of the transition theories (Melies 1984). However, this paper studied both HV students and SN students, and is partly retrospective, with participants having to rely on memories of their experiences rather than being synchronous, current and in real time with participants experience, which is an important benefit of my study. Hughes-Morris and Roberts (2017) study, although checked for duplications, has not been fully appraised at this stage to lessen the risk of bias from absorbing its content more methodically, as per the tenets of my research methodology.

This is also true of the work of Sayer (2007) who explored the role of the practice teacher (PT) in the professional socialisation of HVs and Holt's (2008) study, which produced a theory of role transition to advanced nursing roles. The focus of Holt's work, however, is, the move from one position to another (changing role or changes to the role they currently undertake, rather than changing profession), the emphasis on the change, not the process of transition over time. This study, particularly relevant due to its explicit purpose to understand the experience of a change in role, does not explore the role transition of HVs *per se*, rather they

studied the move to advanced and specialist nursing roles, providing an important niche in the evidence base.

It will, however, be important to explore these studies, and those also mentioned earlier in this section, in more depth as my research progresses, as they may share similar issues or findings and could offer useful evidence in support of the findings. In a similar way my research may support and strengthen some of the ideas and theories presented by other authors. This will be achieved through the process of constant comparison analysis, as part of the research process (p58).

These works, cited above, highlight the need to explore transition and the benefits of doing so, providing further justification for exploring the transition to a HV role. It is quite surprising that there has been little work done in this field specifically exploring the role transition to the HV which this research hopes to address.

2.7 Health visiting role literature

Health visiting has been a crucial part of the landscape of care for families and children since the early 20th century, providing an essential role in supporting some of the most vulnerable members in our society, and yet more universally promoting good health and well-being through advocating prevention and public health. Despite this historically significant role there has often been debate and controversy surrounding the HV role with a need for clearer understanding identified in the literature over many decades (Dingwall 1977, Twinn 1989, Billingham 1996, Brockelhurst 2004a, Brockelhurst 2004b, Smith 2004, Jewson et al 2008, Baldwin 2012, Adams, 2012, Peckover 2013, Stansfield 2016).

It is useful here to offer more detail of the work of Dingwall (1977), whose influential ethnographic study and subsequent book '*The social organisation of health visitor training'* (1977) offers seminal evidence in the field of HV education. Exploring how student HVs became socialised into the role at that time, Dingwall describes socialisation to the role, as a process in which new group members assume distinct types of knowledge and skills. This in turn, enables them to behave in a way that facilitates their acceptance, allowing membership into the established group. This strongly suggests the importance of other actors in the

process of socialisation, for example the wider HV community as the established group. It also suggests approval is required before socialisation can be achieved. However, Dingwall also claims the student plays a very active part in their socialisation indicating the process is not solely dependent on others but is also influenced by the students. Clearly, since 1977 much has changed in the education of HVs and the general landscape of the HV service, but it is nonetheless important to include this influential work here as this is related to transition and highlights important elements that may relate to the process. Within my research the influence of the qualified practitioners and HV team members, alongside that of the participants will be explored.

In 2007, Lowe undertook a review commissioned by the Department of Health (Lowe 2007) to define the key aspects of the HV role to offer clarity and direction for present and future roles of HVs. Lowe (2007) discussed the profession as "*lost and under pressure" (p 9).* A notion that is repeated more recently in other works suggesting that this remains as important today some years later. For example, in the work of Baldwin (2012) a descriptive review of the history of health visiting, there is a clear emphasis on the issues the profession had, and has continued to have, with its professional identity. Baldwin even disputes whether, in fact, HVs have their own professional identity, commenting on the multitude of related professions and their propensity to blur the HV role. Baldwin (2012) proposes this is due to the changing political agenda, which have prioritised different aspects of the care provided by the HV. Adams (2012), the co-founder of the IHV, shares this view and agreed that the profession is vulnerable to changes from political influence and pressure. These works also reflect the earlier study of Twinn (1993), who explored the change and conflict in HV practice in a doctoral thesis and provided an overview of the education and role development of HVs in the early part of the 20th century. The findings clearly suggested that the unpredictable development of HV practice has also added to the role ambiguity and future uncertainty of the role.

Burrell (2011) in her doctoral work also studied the professional role of health visiting and its professional identity, specifically within the period 2004-2009. The study is concerned more with professional identity as a collective group, rather than as an individual might construct this. However, the confusion and uncertainty in the role definition at that time is highlighted,

again relating this in part, to health policy driving the direction of the profession and further reflecting similar findings. Additionally, Machin et al (2012) via a GT research study that explored HV interactions, via interviews and direct observation of practice, is also concerned with the professional identity of HVs and the effect of changes to the context of their practice. The findings emphasise the need for a consistent approach to HV practice to allow a rebalancing of the professions fluctuating identity. Although they discuss the equilibrium of the HV identity this is not related to transition to the role.

Additionally, Peckover (2013), an established academic and HV, produced a paper examining the scope and complexities of the HV role from a 'public health' role to a 'safeguarding' one. Much significance was given to the influence of policy drivers on the way in which the role has changed shape and remit. The paper provided further evidence of the ever-changing landscape and ambiguous role boundaries echoing Twinn (1993), Baldwin (2012), Machin et al (2012) and Burrell (2011).

Peckover (2013), also expressed her concern for what she terms "*professional uncertainty"* (p 116) and argues this stems from deep seated confusion about the HV role, acknowledging that although there are challenges from policy there are *also,*

> *"a number of issues stemming from the ways in which health visiting is understood and represented to others in the academic, policy and practice worlds." (*p123)

This suggests some of the confusion and uncertainty stems from the way in which health visiting relates and fits with the people, agencies and services it works with and provides for. Although this HV *fit* is outside of the remit of my research it is important to consider these influences upon transition to the HV role. A key message of Peckover (2013) is the need for an increased scholarship and scrutiny of the health visiting profession. My research will help to provide some of this much-needed inquiry and contribute to the evidence base underpinning the profession.

Further evidence of the impact of role uncertainties can be seen in a recent study regarding HV recruitment and retention. Whittaker et al (2017) used an appreciative enquiry approach with both student and qualified HVs from across the UK and explored their professional values

and motivations. Their findings identified the importance of being able to uphold their professional values and aspirations in the role, asserting that if these are not fulfilled this affects job satisfaction and retention of HVs. Brook et al (2019) also found, in their survey studying retention of HVs, that characteristics of the HV role and low job satisfaction were amongst reasons given for leaving the profession. This could be due to conflict between the expectations and the realities of the role. With the lack of clarity and ambiguity surrounding the HV role it must be difficult for members and student members of the profession to be clear about the role definition, and therefore how it might meet their values and aspirations, creating conflict when these are not met. This could lead to attrition from the role, currently a major concern as professional groups lobby to enhance the number of HVs, once more (IHV 2019). I am interested to find out more about the impact of role ambiguity to establish additional evidence of its influence, as this may be important to reduce role disillusionment, leading to attrition.

There have been some attempts to address this issue, as in the work of Lowe (2007) already mentioned and that of Cowley et al (2015), who's wide-ranging narrative review of literature relating to HV practice, centred upon the implementation and delivery of HV services and in turn, analysed the skills, attitudes and values required for effective HV practice. Despite this, role ambiguity, uncertainty and fluctuation in scope continues to affect the profession (Brook et al 2019, IHV 2019) Thus, the importance of increased research into the HV role cannot be stressed enough. The more clarity and understanding of the role, the greater precision in its definition there can be.

In summary the role of the HV has been scrutinised by several authors and yet remains ambiguous and poorly defined. There are numerous influences and factors behind the professions ability to differentiate a robust professional identity. It is hoped that by increasing the knowledge base and understanding of the transition to the role it will help define the role further filling some of this gap in knowledge.

None of these texts have explored the way in which student HVs, as qualified nurses or midwives, transition to the role of the qualified HV in its entirety, especially in the context of the post HVIP (DH 2011a) workforce, something which is unique to my study.

2.8 Summary

Transition is a concept that affects all of us, throughout our lives at many different stages and in many ways. Maybe as a consequence of this, a number of seminal theories have been developed to explain this important concept, generally and in more focussed subject area specific fields. The transition theorists and associated literature defines transition as a process through which one goes through to incorporate change. There is however, differing views in the mechanism of this process, with some authors defining it as linear and one way, some as multidirectional and others as a circular process. This lack of consensus demonstrates the need to continue to explore and define transition and transitions, to add to the current body of knowledge and to improve our understanding of its impact in our lives. In the exploration of the literature related to transition, associations between transition, identity and socialisation were established. Therefore, it is important to explore this association as a line of enquiry within my research.

Additionally, there is a body of research which explores transition in a health professional context, most notably within nursing, where the process of transition from student to NQN has been the focus. This research highlighted important factors in a successful transition in this context, including, previous experience, skills acquisition and mastery, support and acceptance of others. It also emphasises the difficulties and challenges experienced during the transition process and advocates the importance of support during this time, to help retain NQNs in the profession. Based on this established evidence base, understanding the process of transition to become a HV is vital for the support of those undergoing the process and is likely to aid retention to the profession. My research will explore these influences and difficulties in depth and importantly, from the perception of those undergoing the transition to the HV role, to gain a deep understanding of the process.

There is a distinct lack of research which looks specifically at transition to the HV role. Although literature relating to HV role definition is available, this primarily explores the fluctuating professional identity of HVs and highlights difficulties caused by poor role definition and ambiguity. The resulting uncertainty creates conflicts with role expectations and role satisfaction. This could ultimately jeopardise workforce retention. Consequently, it

is important to undertake research exploring transition to the role, as this may, in turn, also help to define the role further, through exploring its individual traits and characteristics.

My research will provide a rich evidence base for the transition to the role of HV, addressing the deficit in the present research base. Therefore, making a significant contribution to knowledge in the HV field and providing additional understanding and knowledge of the transition process through a robust longitudinal study.

This literature has been examined with the purpose of clarifying and giving direction to the focus of this thesis and rather than an in-depth exploration of included works, the purpose of the review is to add important context to the direction of this thesis. It also serves to illustrate the amount of research interest in this arena and to help in providing a clear justification for this study and clarification of the unique contribution this research will potentially make to the evidence base. Further interrogation of the existing literature in this field was undertaken as the study progressed.

3.0 RESEARCH METHODOLOGY

3.1 Introduction

This chapter introduces and critically discusses the research process used to undertake my study; to explore the transition from nurse or MW to the HV role. It provides a detailed account of the many considerations to ensure the research design was the most appropriate to answer the research question. My own epistemological perspective is discussed, together with the reasoning behind the final research design. The development and evolution of GT is explored and the employment of CGT as the methodology of choice for this research is discussed and justified, alongside exploration of the fundamental tenets of GT. Finally, the role of reflexivity and the enhancement of quality and rigour within the research process is described. In considering the best way to answer my research question numerous factors were evaluated before arriving at the final study design, these are now discussed.

3.2 Research methodologies considered

An important factor was to consider how to study the process of transition per se, before considering specifically how to research the transition to the HV role. The literature reviews by Kralik et al (2006) and Arrowsmith et al (2016), which respectively, explore transition in health care and within nursing generally, were valuable here (previously discussed in Chapter 2) as the findings called for future research to be undertaken longitudinally, over time, rather than at one time point. This element was an important criterion in the final design process as you will see in Chapter 5 (p 55).

I also looked to the previous research surrounding the process of transition in the field of nursing generally, to explore how others had approached this. Predominantly, the research undertaken to date has used a qualitative design, adopting a variety of methodologies including ethnography (Barton, 2007, Sullivan-Benz et al, 2010), grounded theory (Dushcher 2008, Gerrish 2000, Holt 2008) and phenomenology (Etheridge 2007, Björkström et al 2006, Dushcher 2001, Dushcher 2009). In considering these different approaches for my study, to explore the transition to the HV role, individual qualities of each methodology were evaluated.

Ethnography is aligned to anthropology (Streubert and Carpenter 2011) and the study or

description of culture (Spradley 1980) and has been used to research a variety of subjects, important in nursing. However, it relies upon cultural immersion, seen as one of its unique characteristics (Streubert and Carpenter 2011), with researchers becoming part of the cultural environment (Atkinson and Hammersley 1998, Naidoo 2012). This was not something I intended to do, as although I saw myself being close to the research participant group, I was not culturally part of it. I am not a HV and remain outside the group, something which I felt allowed a greater freedom to interpret the participants views without preconception.

Ethnography is also used to explore a group of people with commonalities and seeks to identify the connections and shared cultural meanings (Naidoo 2012). This has some relevance to the intention of my research, which is to study a group of HV students undergoing transition to the HV role. It, therefore, contains both a common issue and a group. However, it is not the cultural meaning of this group that I sought to establish, rather it was an understanding of the process they were going through as they transitioned to the HV role. With these points in mind ethnography was discounted as suitable methodology for this study.

Phenomenology allows us to explore and describe lived human experiences (Finley 2009), its point being to derive a consensus of meaning of the lived experience being studied (Rose et al 1995, Moustakas 1994, Rodham et al 2015), for example, being a HV. However, although this would be useful for describing and understanding the lived experience of the HV role, it does not seek to explore social processes, which is the very nature of transition, (Chapter 2, p13) or to *"generate a theory from the individual level"* (Streubert and Carpenter 2011, p123), and therefore developing a theory from the data (Glaser and Straus 1967). As this is the intended product of this study and considering the nature of transition as a social process, phenomenology was considered unsuitable.

GT, whose primary purpose is to develop a theory, was adopted for use for my research and the rationale for this will be discussed further as this chapter progresses.

3.3 Research design

All research designs should be based upon an underpinning philosophy and theoretical perspective (Bowling 2009) as these provide a framework to guide the process and

procedures of the study, that are fundamental to the robustness and rigour of the research (Creswell 2003, Carter and Little 2007).

Crotty (1998) developed four questions to help make decisions about the practise of research and how each element of the whole process is related, enabling effective research designs (Figure 2). What appears important about this, is the way the questions are used collectively and should be seen and used as a whole, a process that should contain an answer to each. He labels these questions, four elements.

Figure 2

1. **What *methods* do we propose to use**? What are the techniques or procedures used to gather and analyse data?

2. **What *methodology* governs our choice of methods?** The strategy, plan of action, process or design lying behind the choice and use of particular methods.

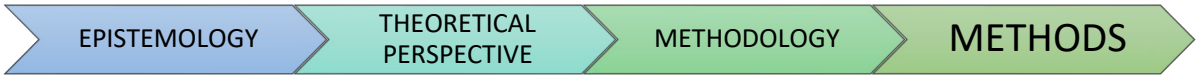
3. **What is our *theoretical perspective*?** The philosophical stance informing the methodology and providing context for the process and grounding its logic and criteria.

4.**What *epistemology* informs our perspective**? What is the theory of knowledge embedded in the theoretical perspective and thereby in the methodology?

The four elements (Crotty 1998 p2-3)

Crotty (1998) and Gray (2014) whose work is based on Crotty (1998), illustrated these elements and their relationship to one another, detailing the way in which each element influences the other. Crotty (1998) also proposed that these elements are dependent and inter-reliant upon each other (with one leading into and from the other) and this provided a structure on which to build an inquiry or research study (see Figure 3).

Figure 3



Structure of research based on the work of Gray (2014) and Crotty (1998)

Carter and Little (2007), developed a similar useful framework for planning and evaluating research. Their framework differs however from the work of Crotty (1998) and Gray's framework (2014), in that it excludes theoretical perspectives as a distinct phase and discusses instead the direct influence of epistemology on our choice of methodology and therefore, the adopted methods. They described epistemology as being an unavoidable theory of knowledge, which is adopted knowingly or unknowingly by a researcher, depending upon their degree of awareness (Carter and Little 2007). This theory of knowledge subsequently directly impacts on the choice and justification of a research methodology, as researchers are pulled towards specific methodologies. Both epistemology and methodology influence and contribute to the choice of methods. What stands out again, is the need to consider the design process as a whole, the melding of the different aspects influencing the final overall research design, incorporating the methodology and methods.

The guidance from both Crotty (1998) and Carter and Little (2007) have been used together to develop my final research design. I have carefully considered and planned each stage of the research process, mindful of the impact of each of the elements (Crotty 1998) and phases (Carter and Little 2007) and the requirement to answer the research question.

3.4 My philosophical position

When I began my research career over a decade ago, I had a tendency towards objectivism, positivist and post-positivist theoretical perspectives and the use of quantitative methodologies as a framework for truth (Henshaw 2006). This was partly because of my academic background in Health Services Research, which was often medically and therefore objectively driven. However, through personal growth and engagement with a wider range of research methodologies as a nurse lecturer, I began to see the need for the in-depth understanding that a more constructivist approach to knowledge (epistemology) can provide, moving away from a belief in a single reality. I now consistently question the legitimacy of the objective approach, leaning away from my previous reliance on the need to quantify and scientifically objectify concepts, to a need for the deep layering of knowledge that the constructivist and interpretivist theoretical frameworks provide. This personal shift to a constructivist epistemology and recognition of the value in the interpretivist theoretical perspective has led to the way in which I have chosen to pursue knowledge within this

research. What I now feel is important to know, is very different to what I once considered essential knowledge in terms of the truth and what constitutes reality. There is no doubt this perspective has shaped the way I approached this research, the inception of the idea for the enquiry and the way I chose to ask my research question; the emphasis on developing a rich understanding and interpretation of phenomenon from multiple viewpoints to establish emerging patterns and connections.

My study explored, in-depth, the process of transition to the HV role, identifying and investigating influences on this process, to generate a theory of the transition. This was achieved by examining, through the participants, the meaning and experiences of a group of student HVs as they undertook an NMC approved programme of education, to become qualified HVs. As established through the initial literature review, the area of transition is under researched within health visiting, despite there being a growing body of research exploring the process of transition in nursing more generally and this fact was taken into consideration when subsequently deciding upon the appropriate research design.

To fully appreciate how this transition is experienced it was important to hear and appreciate the voices of the participants, something which is emphasised within qualitative research methods, including GT (Mewborn 2005). The constructivist epistemology fits both with the purpose of this study and my own world view; that knowledge is constructed through interaction with, and exploration of, different experiences and perceptions of the subject to construct knowledge.

Constructivism is "*relativist, transactional and subjectivist"* according to Lincoln and Guba (2000 p168). Relativist being that truth cannot be wholly objective (Hugly & Saywood 1987) but is relative to its context, which can be very diverse; transactional because interactions between the contexts or situations and the individual's thoughts gives rise to the truth (Berlin 1987), and subjective in that it sees the role of the researcher as to construct a truth about the world as they see it, through the research participant account of their experiences of the world (Creswell 2007). My derived position, which is closely aligned to this philosophy, is that truth cannot be completely objective as different contexts can alter the perceived truth. These contexts then give rise to different multiple realities and the researcher acts as an instrument of research to assimilate these realities and interpret the researched to reach a

consensus of knowledge. In considering this and the need for the type of in-depth knowledge required to build a theory of the process of transition into a HV role, a constructivist position (Guba & Lincoln 1998, Gray 2014) was adopted.

3.5 Theoretical perspective

A theoretical perspective *"provides a way of looking at the world and making sense of it*" (Crotty 1998 p7), suggesting that to understand something well it is important to choose the right theoretical perspective from which to view it. Interpretivism is a theoretical perspective linked to constructivism (Gray 2009, Schwandt 2001, Creswell 2007, Chen et al 2011). It advocates that the social world cannot be investigated by observation and verification of facts, but instead it focuses on scrutinising, unpicking and understanding phenomena (Gray 2014). The endeavour of interpretivist research is to uncover how people feel, perceive and experience the social world, aiming to establish a rich meaning and understanding (Creswell 2007, Parahoo 2006). This clearly resonates with the aims and objectives of my study to explore the experiences of those undergoing the transition to the HV role. This exploration being through the eyes of the participants, to understand how they feel and perceive within the transition to the HV role.

Interpretivists also believe it is important to understand how people's interpretations of their world affect their view of their reality (Chen et al 2011). This reality is not fixed, it can be multiple and is developed together with the research subjects rather than independently; the interactivity being seen as a strength (Parahoo 2006, Creswell 2007). This resonated further with my intention to explore, in partnership with my participants, how they viewed their transition to the HV role and how, as an instrument of this research, I could bring together the patterns and meanings of their experiences to develop a rich understanding of the process.

Additionally, interpretivism is synonymous with understanding something in context (Holloway 1997) where people create their own meanings as they interact with the world. My study sought to explore and probe the thoughts and perceptions of individuals who were experiencing the transition to the HV role, capturing their different experiences and insights, to provide a deep understanding. It therefore aligned well with the interpretivist framework

and consideration of this, and the factors discussed above led to this as my choice of theoretical perspective.

It is important to note that within an interpretivist approach the researcher cannot be divorced from the perceptions and experiences of the participants and the researcher should be mindful of their assumptions and views and their potential impact upon the research products (Charmaz 2014) (see further discussion Chapter 3, p48).

By applying the previously discussed, four elements (Crotty 1998) to my study, I therefore chose to adopt a constructivist epistemology and an interpretivist theoretical perspective. Using the frameworks of Carter and Little (2007) and Crotty (1998) in conjunction, these decisions must also influence the choice of methodology, this will now be discussed.

3.6 The chosen research methodology

Interestingly, GT was originally aligned with the positivist and post positivist view, my previous philosophical and theoretical position, and this did create some original interest in this methodology. This link is mentioned in the approach advocated by Glaser (1978) to GT as according to Glaser (1996) cited by Cohen et al (2007, p 491) *"it arose out of quantitative methods"*, it seeks to identify multiple variables, examining how they are connected in order to establish the complexities of a situation. Bryant (2002) also discussed the prominence of positivism in the earlier iterations of GT.

Despite this epistemological alignment however, GT differs, in that it generates theories that emerge from the analysis of data rather than testing theories through collecting data (Cohen et al 2011). GT also shares some traits of quantitative approaches in that it is systematic, following a rigorous methodical data collection and analysis method (Cohen et al 2011). Additionally, the classical iteration developed by Glaser and Straus (1967) and Straus and Corbin's (1990) evolved GT methodology, strives to maintain the objectivity of the researcher through distinct methodological actions. For instance, by not engaging with literature in the field of interest prior to data collection and analysis (Ramalho et al 2015). Although these attributes drew me towards GT initially, this did not form my eventual decision to adopt a GT methodology, justification of this is detailed below.

GT is one of the most popular qualitative research methods used within the social sciences (McCallin 2003) and has, for many decades, been a popular choice of methodology within nursing research, largely because it is valued as a way to contribute to the professions body of substantive knowledge and as an effective way to explore concepts and phenomena important to the profession (Struebert and Carpenter 2011). It is also very useful for exploring key social processes (Wertz et al 2011, Charmaz 2014, Mills and Birk 2011). GT, therefore, appeared very suited to the exploration of transition to the HV role.

The GT methodology uses the concept of *inductive reasoning* (Charmaz 2008) which is type of logic used when different forms or sources of evidence are scrutinised for connections and patterns and combined to form a conclusion or a theory (Polit and Beck 2012, Neuman 2003). It is a very open ended and exploratory process, moving from exploration and analysis of the wider complexities of evidence, narrowing at the end of the process, to link them together to a conclusion (Lodico et al 2010). Most theories generated through GT are specific to defined focused fields of inquiry or substantive areas and are not able to be generalised to other fields as a formal theory would (Glaser and Strauss 1967, Birks and Mills 2011). However, the reasoning of the developed substantive theory can sometimes resonate to other areas and with further application and exploration, refinement may lead to a formal theory, connecting with other areas (Birks and Mills 2011, Kearney 2007, Charmaz 2014).

The aim of a GT is to explain *"what is going on"* (Glaser 2002 p2), in the field of inquiry. It can be used to "*discover new dimensions of social processes at play in people's lives"* (Strueber and Carpenter 2011 p 123) and is very effective when the intended consequence is the creation of a theory, combined with explanation and exploration of inherent processes (Birks and Mills 2011). The aim of my study is to develop a substantive theory, specific to the transition to the HV role, explaining *what is going on* in the transition from a nurse/MW to the HV role. It also aspires, through detailed exploration of the transition process, to uncover the innate processes at play. Thus, GT fitted closely with my intended aim and objectives to explore the transition and the influences on this process. The description of the reasoning used in GT is also intrinsic to my final research design. Therefore, this and the close fit to other characteristics of my research discussed above, led me to adopt GT as the methodology for my research.

GT is also considered valuable where there is little known about a subject already and therefore no known theory to test (Glaser and Straus 1967, Bryant and Charmaz 2007, Chun Tie et al 2019). This again closely matched my research characteristics, namely: the lack of previous studies specifically exploring transition to the HV role (see Chapter 2).

3.7 Further defence of grounded theory methodology- refining my choice

The GT view places high regard on individual experiences and seeks to explore this viewpoint (Struebert and Carpenter 2011, Birks and Mills 2011). In fact, Glaser and Strauss (1967) claimed that when a GT is generated from the data of people who have lived the phenomenon, the researcher knows *"in his bones"* (p225) the credibility of the findings. I want to explore the individual experience and perspective of the transition to a HV role, and hence, a GT approach provides a clear benefit. GT also contends that theoretical processes are always at play, despite not necessarily being obvious to the untrained observer. GT thus provides a method to uncover them (Struebert and Carpenter 2011). The theories built from GT originate directly from the participant data, the researcher identifying relationships and connections within this data to explain what is happening, eventually forming a theory which is 'grounded' in the participants experiences. This is a further benefit of a GT study since findings grounded directly in the participants experiences must add a richness and candour to any theory generated. Clearly the role of the researcher is also important in this process and as a nurse lecturer who regularly taught HV students, I did bring knowledge of my past experiences with this group into the research data, and this has to be acknowledged. However, this familiarity also helped me to understand the context of the participants transition and enabled an open relationship with the participants, based on their interactions with me.

There has been much written about the emergence and evolution of GT (Bryant 2002, Bryant 2003, Charmaz 2014, Tan 2010, Jones and Alony 2011, Struebert and Carpenter 2011, Birks and Mills 2011, Timonen et al 2018). It was originally developed by the two sociologists Barney Glaser and Anslem Strauss in 1967, (Glaser and Straus 1967) and draws upon field work, or research undertaken in naturalistic settings. The assumption being that theories can be discovered through field interaction with the participants (Streubert and Carpenter 2011).

There were subsequent developments by Strauss, one of the original founders. These have led to divergent forms of GT; the classical or traditional GT approach, based on the original work of Glaser and Strauss (1967), in which it is thought data and theory are revealed through the process of analysis, and the evolved Strauss (1987) (Strauss and Corbin 1990) approach, in which it is believed theory is constructed rather than discovered, through interaction with the data. However, it has also been adopted and sometimes modified by other scholars both inside and outside of its original sociological field. These adaptations and modification of GT has led to further contentions and conflicting views about what constitutes GT.

Some of this contention has arisen from criticism for, what is seen as, a lack of philosophical underpinning in the original form (Birks and Mills 2011, Annells 1996). There are many scholars that argue it should be seen and used more as group of methods, rather than a methodology (Bakker 2019, Timonen et al 2018). However, this has driven further developments of GT, as researchers endeavour to establish its philosophical basis, taking into account the larger qualitative research arena (Denzin and Lincoln 2005). Three approaches are now acknowledged; Glaser (viewed as positivist), Strauss and Corbin (post-positivist) and Charmaz (constructivist) (Wertz et al 2011). The key differences are in the procedures and positionality of the researcher used with the collected data; Glaser, waiting for theory to emerge, the researcher being an objective observer; Corbin and Strauss, imposing patterns to construct a theory rather than simply waiting for it to emerge (often criticised for forcing data to *fit* concepts), and Charmaz, where theory is developed through data gathered during interaction between the researcher and the researched. The researcher being seen as central to this process, as part of the research, whilst at the same time emphasising the voice of the participants (Birks and Mills 2011). Charmaz (2006) also advocates the data should be allowed to shape the emerging categories and eventual theory, rather than being forced to fit any preconceived ideas about what the data might reveal (from prior knowledge of the field for example) (Charmaz 2014).

Charmaz (2006) re-positioned GT to take account of the constructivist paradigm. CGT places emphasis on the phenomenon being studied along with its context and considers the creation of data and its analysis as arising from the sharing of experiences with the research

participants (Charmaz 2014). It clearly acknowledges the researcher part in the process. Charmaz (2006) states,

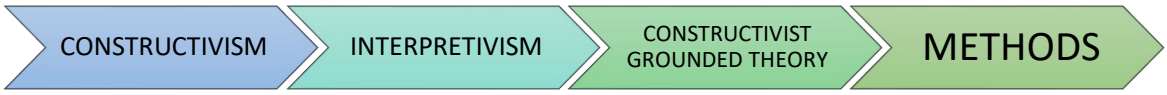
> *"constructivists study how and sometimes why…… we do so from as close to the experience as we can get."* (p130)

It is this closeness that I want to use within my study, whilst at the same time constructing a theory based on a sound methodological framework. Placing the researcher (myself) within the research to create knowledge with the participants and allowing the researcher to experience the participants world, through shared interactions, is essential in this study. Thus, CGT is an appropriate methodology (please also see Appendix 4).

This exploration of GT facilitated my decision to adopt a CGT methodology. It fits with my own philosophical perspective and my need to ensure the voices of the HV students (my participants) are accurately heard, but it also recognises my part as researcher cannot be removed from the research process (discussed further, please see p48).

Thus, my research is founded upon a constructivist epistemology, an interpretivist theoretical perspective and utilises a CGT methodology as illustrated in Figure 4, based on the previous discussed framework (p34) (Crotty 1998).

Figure 4



Framework for my study

3.8 Grounded theory methods

There are several unique fundamental components within a GT study (Dunne 2011) which are integrated in the design of my research, I will now explore these in some detail.

Although this has already been previously discussed within Chapter 2 (p9), I have included additional consideration here of the important issue of reviewing the literature in GT research as I feel it is important to further clarify my position. Most other research inquiries start with a thorough review of current and previous knowledge in the field of interest, deeming it to be essential (Dunne 2011, Ramalho et al 2016). However, in GT the key question is *when* the literature should be used (Birks and Mills 2011, Dunne 2011, Ramalho et al 2016).

Charmaz (2006) and McCann and Clark (2004,) believe an early literature review in GT is important for context and in providing rationale (McGhee et al 2007) and also in highlighting gaps in the present evidence base (Hutchinson 1993, Charmaz 2006). Birks and Mills (2011) and Charmaz (2006) suggest a limited review can help in the early stages of a GT study to enhance theoretical sensitivity (Glaser and Straus 1967). This is important in GT as theoretical sensitivity reflects the ability of the researcher to generate meaningful concepts from the data that fits with the emerging theory (Glaser and Holton 2004). Therefore, in the early stages of this study the initial literature review explored relevant context and the of theory of transition in other fields, deliberately avoiding an in-depth exploration of studies relating to transition to a HV role; although to avoid the risk of duplication a search was undertaken to identify their existence. A more focused review of the literature was then undertaken during the process of analysis, integrating it within the process (see Figure 1, p10). This helped to position the study within this literature and clarify its contribution to the evidence base.

Concurrent data generation is a key tenet of GT, it is what makes it different to other research designs (Birks and Mills 2011). Data generation should be simultaneous with analysis, both working hand in hand to, a) produce data for analysis and b) analyse the data generated. Thus, establishing where additional new data is required to address the resulting inquiries and follow emerging concepts (Emmel 2013, Birks and Mills 2011, Glaser and Strauss 1967). Additional data is provided using theoretical sampling, another of the tenets of GT, whereby choices are made about who to include in the sample, and what questions to ask depending on the needs of the inquiry (Birks and Mills 2011, Sbaraini et al 2011).

Theoretical sampling is complex (Wertz et al 2011) and often used differently by different researchers (Charmaz 2014, McCrae and Purssell 2016) and yet it is seen as fundamental to the emergent nature of GT (Mills and Birks 2011). The researcher is key to this sampling

technique, as they make decisions about what cues or ideas need to be followed and interrogated further as the analysis occurs. This sometimes results in additional participants being required to investigate an idea (Hallberg 2006). Within my study this was facilitated by consenting several participants who I could theoretically sample from as required, but who were not included in the initial purposive sample. It can also mean the existing data collected needs to be reinterrogated or a different line of questioning is used with existing participants (Coyne 1997). This honing of questioning, sampling and analysis continues until the researcher feels full saturation of the emerging concepts and categories is reached, this is known as theoretical saturation. Consequently, it is not feasible to know the full details of some characteristics at the outset of a GT study; sample size, all data sources, all timings and exact methods of data generation (Birks and Mills 2011). Therefore, the design of a GT study is flexible by its very nature.

Linked to theoretical sampling, GT also requires the use of constant comparison analysis which is fundamental to the research design and intrinsic to concurrent data generation (Birks and Mills 2011). Here the researcher compares the generated data to all existing data as it arises. When patterns emerge, further generated data is then compared and concepts and categories identified. The researcher continues to gather data until saturation (as above) is reached. The process is cyclical and relies on the researcher analysing and identifying concepts or codes (coding) and categories within the data.

The opening analysis of collected data identifies initial codes to encompass the findings. Further rounds of analysis refine these initial codes to focused and conceptual or theoretical codes, which are ultimately honed further into categories. From this an emerging theory develops that connects and incorporates the relationships within the data (Sbaraini et al 2011). This process eventually culminates in a theory which holds all the generated data. At this point in my study the data analysis techniques developed by Charmaz (2006) were used as a guide, alongside the work of Sbaraini et al (2011) whose detailed account of the process provided me with a useful insight of the application of analysis in GT.

Coding is the pivotal link between collecting data and developing an emergent theory which explains the data, referred to as generating "*the bones*"(Charmaz 2006 p45) of the analysis, the whole of the raw data is broken down into parts (Jones and Alony 2011). These parts are

then progressed into a "*working skeleton"* (Charmaz 2006, p45) through a detailed process of sifting and sorting the data into patterns or categories. The more significant and dense categories then become the sub and core categories, as they are further analysed, explored conceptually and theorised to form the GT (Jones and Alony 2011). This clearly highlights the significance of the coding process in the overall outcome of the study. Using CGT in my study thus, involved a deep exploration of the data, rather than just looking at the surface, alongside participant/researcher shared data production (Mills et al 2006, Charmaz 2014). This co-production of data incorporated the reflection and recording of my thought processes, in a form of memoing, during and after interaction with the participants and the data. I saw myself as part of the research and as sharing the creation of meanings and experiences, together with the participants.

Memoing is another of the key tenets of GT (Sbaraini et al 2011), crucial in the exploration and conceptualisation of relationships in the data (Charmaz 2014, Birks and Mills 2011) and in the co-construction of data. In my study, memos were used to record my thinking and perceptions at each stage of the study and allowed reflexivity on the data set and subsequent analysis. Memos help consider what is happening in the data, making explicit the comparisons and patterns that emerge. They should be spontaneous, stemming from the thought processes of the researcher as they help to move the findings into a GT (Birks and Mills 2011) (See example memos Appendix 5). This memoing and intensive data exploration was used in conjunction with the constant comparison analysis method described previously. Using the participants as the keystone and adding my reflections to their voice, to build meaning and develop codes and concepts.

3.9 Quality and rigour

Quality and rigour are an important consideration in any research study with good research resting on a good research design (RCN 2009). Flick (2006) offers an exploration of criteria relating to quality of qualitative research which enabled me to consider these approaches in depth. The criteria attributable to the work of Guba and Lincoln (1985) of trustworthiness, credibility, dependability, transferability and confirmability resonate closely with my thinking. Charmaz (2005) also suggests the criteria of credibility, originality, resonance and usefulness are key quality indicators of CGT. Hence a combination of the two approaches have been used

to inform my research. Charmaz (2006) implies the resonance and usefulness of my research will be increased via sound credibility and originality of the research. Both criteria I have embedded within the research design.

Through careful planning and close adherence to the methodological principles I have been able to ensure quality criteria are appropriately met. Birks and Mills (2011) assert,

> *It is the quality of your data and how you apply grounded theory methods in its collection, generation and analysis that will determine if your research will be deemed a quality study* (p147).

In particular the following actions were taken:

- The collected data were digitally recorded and then transcribed soon after, this allowed closeness with the data as I became further immersed, enhancing credibility (see p64).
- The transcripts were then analysed via initial coding as soon as possible and before further focus groups or interviews took place, thus enabling theoretical sampling via follow up of lines of inquiry as they emerged (see p64).
- Notes were taken during data collection to record key points and used as a form of respondent checking (Appendix 10). Previous findings were also discussed with participants at the start of the next round of data collection, checking and clarifying points to support my interpretations and enhancing credibility and trustworthiness.
- The data collection methods used together have served to triangulate findings and to further saturate emerging concepts, increasing credibility (Silverman 2010).
- Data analysis has been thoroughly recorded through the use of detailed auditable trails to document and illustrate the methods and results of coding and categorising concepts (please see p68). The presentation of this data analysis (see Appendix 11 & 12) provides evidence of the procedural rigour used within this study (Birks and Mills 2011) enhancing quality and assessment of ' fit' (Glaser 1998), a further quality criterion within GT.
- Originality is promoted via defence of my theoretical sensitivity. I restricted my interaction with focused literature (as already discussed) until after initial data collection (also see discussion re reflexivity below). Importantly, I am not a HV and have therefore not experienced this transition for myself. So, to some extent I am

approaching this research as an outsider or as an etic researcher (Morris et al 1999) or at the very least "*an outsider who also has some insider characteristics*" (Grace 2020 p542), reducing the risk of importing preconceived insights and diluting originality (Eaves 2001).

3.10 Reflexivity in the research process

Reflexivity is the process of careful, conscious appreciation of the researcher's influence in the process of research. It does not look back on what has been done, as in reflection, but rather it is the "*process of self-awareness and scrutiny that is bi-directional"* (Engward and Davis 2015 p 1352). It offers transparency of the why and how decisions are made during the research process, opening up the limitations of the research to review. During this study I have used the work of Alvesson and Skolberg (2009) to help guide this process. Reflexivity is achieved by offering transparency surrounding the decisions made throughout my research, at each level, and through my own questioning of assumptions I might apply in the process and of continual self-appraisal. This reflexivity is entwined into the research throughout and assists to enhance the rigour of the research in doing so (Engward and Davis 2015, Ramalho et al 2016).

A difficulty for the researcher in using GT and in my case, the most difficult area, was to remain open-minded as the theories emerge. Despite recognising, as Charmaz (2014) does, that the researcher is integral to the process of developing a GT, I feel it is important to acknowledge the risk of preconceived ideas regarding what theories could develop. This stems from undertaking previous research in related fields (Whitehead et al 2013, 2016) and as previously mentioned, from first-hand witnessing of the transition to a HV role, as a nurse lecturer. I therefore realised the need to reflect upon my thoughts and feelings as I collected and analysed the data, whilst acknowledging that my personal values may affect my interpretation of the participant voices (Birks and Mills 2011). Thus, memoing was used as a form of filtering, to help separate out any preconceived ideas and beliefs from the data collected through personal reflection and self-critical reflexivity (see Appendix 5) (Overcash 2004). These memos become part of the data for analysis (Birks and Mills 2011). The process of memoing, reviewing and revisiting them in conjunction with the participant data, allows ideas to evolve into concrete concepts and brings the process of co-production of data alive (Charmaz 2014).

3.11 Summary

This chapter has explored the research approach used to undertake my study. It explained how the research design was finalised and explored important considerations to allow the research question to be best answered. After discussing my philosophical position and its relevance to my study, the reasoning behind the final research design was offered. The development and evolution of GT has also been reviewed and the choice of CGT as the methodology for this research was discussed. Lastly the fundamental tenets of GT methods were considered. In addition, within this chapter, I have included discussion of issues relating to quality and rigour within my study and the steps taken to promote these important aspects. Lastly, the role of reflexivity in further strengthening the rigour in my study has also been reviewed. The ethical considerations when undertaking this research, along with the required ethical approvals are discussed in the following chapter, prior to exploration of the research methods adopted in Chapter 5.

4.0 ETHICAL CONSIDERATIONS

4.1 Introduction

The previous chapter defended and discussed the use of a CGT methodology as the theoretical framework underpinning my study, the central tenets of this approach and steps taken regarding the quality and rigour of this research. I will now discuss the important ethical considerations essential when undertaking research and how these are applied to my study. This is followed by an explanation of the required ethical approvals.

4.2 Ethical considerations

During the planning and undertaking of this study ethical guidelines and principles relating to the undertaking of research were carefully considered (DH 2005, RCN 2009, WMA 2018, BERA 2018, NMC 2018). Their aim is to protect all research participants from harm or maleficence. Many of these ethical principles and guidelines were developed as a direct response to historically unethical studies (Beecher 1966, Pappworth 1967) and provide assurances that the welfare of the participant is protected, respect for the dignity and rights of participants upheld and scientific validity is maintained (Allmark 2003).

It is important to acknowledge that there are always ethical concerns and considerations within any research project and that researchers have a responsibility to their participants (Gillham 2008). These can be addressed with careful planning and adherence to sound ethical principles. Beauchamp and Childress (2013) provided useful ethical principles on which to base research designs. They identified four key ethical principles, beneficence, maleficence, autonomy and justice which can be applied to research. These principles are implicit within the design of this research project. In practical terms, this is applied to my design in a number of ways, and this is discussed below and for associated documents please see Appendix 6.

I was aware that there was some risk to the participants in my study because of the nature of the in-depth interviews which explored the feelings and thoughts surrounding their experiences. This is something they might have found difficult, especially if it uncovered sensitive issues, such as difficulties with assessments or relationships (DiCicco-Bloom & Crabtree 2006). I was mindful the interview process may also provide advantages to the

participants as they increased their own awareness and reflectiveness by processing their feelings to communicate them to me, as the researcher. In addition, they may have felt more valued and respected as a contributor to the research field (Oliver 2010). As it happened there were no incidences where participants became distressed or upset, despite revealing often challenging situations. If this had happened support mechanisms were in place, including the university student support team and the personal tutor of the student.

It was important to ensure the participants were aware of my role as the researcher and the precise nature of the research and any potential impact of participation, making clear any my expectations (Gillham 2008). This was achieved, initially, through an introductory letter asking for expressions of interest to participate, with time given for deliberation (Appendix 6). To address the issue of potential coercion due to my position as a lecturer (Ezekiel et al 2014, Hawkins & Emanuel, 2005) this initial request came from a colleague who was completely independent of the research. It was not until responses to this call were received that I contacted potential participants directly and provided both a written and full discussion of participation information (Appendix 6) prior to asking for consent.

Participants were reassured throughout this process that participation was voluntary and there would be no consequences if they decided not to consent. Potential participants were given further time to ask questions and fully consider their choice before finally making a decision. Fully informed consent was obtained from the participants at the outset of the study and this was re-established prior to the subsequent focus groups or interviews (Appendix 6). Informed consent is a central component of the research allowing participants to be in possession of all information relating to the study before the decision to participate (Oliver 2010).

In this research, the precise nature of the interview questions for the duration of the study was unknown and so to ensure potential participants understood the process, I was careful to explain the grounded theory and constant comparison analysis and how this might shape future questions. The full disclosure of the purpose and process of the research and the method utilised (as above) alongside the time allowed to make a decision to participate was fundamental in reducing potential effects of a power imbalance in the relationship between myself and the participants.

Participants were also informed that their participation was entirely voluntary, and they could withdraw from the study without giving a reason. It was made clear that this should be prior to either, their participation in any of focus groups, or before interview data was analysed, as it would be impractical to remove an individual voice from a group discussion. In the case of interviews, due to the nature of constant comparison analysis it would not be possible to remove their data once any analysis was undertaken (Oliver 2010).

Anonymity is "*a cornerstone of research ethics"* (Oliver 2010 p77) and allows the identity of those participating to be concealed. There are occasions when, especially within qualitative research, this anonymity is at risk due to the nature of the in-depth and rich data and its reporting (with verbatim quotes). These may make it feasible for someone to identify elements of the study, including the participants, through either their own knowledge of the research field or academic institution (Oliver 2010). In view of this only data which was needed for the research question to be addressed are included in this study with only minimal demographic data provided for the sample characteristics (p58). Participants were also given a numerical code to represent their data to protect their anonymity.

Confidentiality (Oliver 2010) was maintained for all participants with no personally identifiable information included in the transcripts, researcher memos or any of the research products. To maintain confidentiality the proper and correct storage of research data is crucial and this study has adhered to the Data Protection Act (1998 and 2018) and the University's Good Scientific Practice (UoD 2008). All the research data is held securely on a password protected desktop personal computer and as a backup, on an encrypted and password protected data storage device. It is anonymised as discussed above. Data stored within the study database will be deleted from encrypted devices after a minimum period of six years (but up to ten) as per university guidance.

The audio recordings of the focus group and interviews were transferred to an encrypted and password protected data storage device and transcribed by me, as the researcher (reducing the risk of accidental identification of participants by a third party), before being analysed. Prior to subsequent interviews and at the end of the study, time was taken to discuss previous responses with participants to ensure they were happy with my interpretation of their

contribution, allowing them the chance to check for accuracy and to increase the credibility and trustworthiness of my interaction with their data.

4.3 Ethical approval

Ethical review and approval for the study was obtained from the University of Derby, School of Health Research Ethics Committee. A copy of this approval can be seen at Appendix 7. The study adheres to the Research Governance Framework for Health and Social Care (DH 2005) and with the Governance Arrangements for Research Ethics Committees (DH 2011c), which was current at the time this study commenced. It states,

> *"Research involving staff of the services listed in paragraph 2.3.1, who are recruited by virtue of their professional role, does not therefore require REC review…"* (p13)

This provided guidance and clarification about the requirement for NHS ethical approval. I also contacted the regional NHS Research and Development Department for advice, who confirmed with Trent Clinical Research Network (CRN) that this is the case (Appendix 8). Since this time, the regulations regarding research approvals have been revised with the introduction of the Health Research Authority (HRA) and I was aware that the approvals required for my study may have changed. Hence, this original advice was supplemented with the decision support tool provided by the Health Research Authority (HRA) (Appendix 9). As this study recruited participants from within a university setting, because of their role as a student undergoing transition to a HV role, neither NHS ethical nor NHS Research and Development approval (now known as HRA approval) was required. The study, therefore, adhered to the University of Derby Code of Practice on Research Ethics (UoD 2011) and in doing so the Data Protection Act (1998) and the University of Derby Good Scientific Practice (UoD 2008), all current at the time of the study. It also adheres to the research ethics guidance provided by the Royal College of Nursing (RCN) (2009) and the NMC (2018). I am aware the rules for handling information relating to research participants changed in May 2018 when the EU General Data Protection Regulation came into force alongside The Data Protection Act (2018) which is now law and can confirm my study adheres to this latest version of the act.

4.4 Summary

This chapter has discussed the ethical approval of my study, together with consideration of ethical principles in research and how these have been incorporated within the research process. This included the methods and processes employed to protect the participants within the study. The following chapter describes the research methods utilised during the study.

5.0 RESEARCH METHODS

5.1 Introduction

The previous chapter discussed the considerations regarding the ethical conduct of my study. This next chapter will now discuss the research methods implemented in-depth and offers clarification and details of the research process, including the research design and how it aligns to a CGT methodology. The sampling strategy employed, participant demographics and the adopted data collection methods of focus groups and interviews, are also discussed. The latter part of this chapter details the procedural aspects of the data collection and analysis methods. The three data collection phases, the timing of these and their relationship to each other are also explained.

5.2 The study design

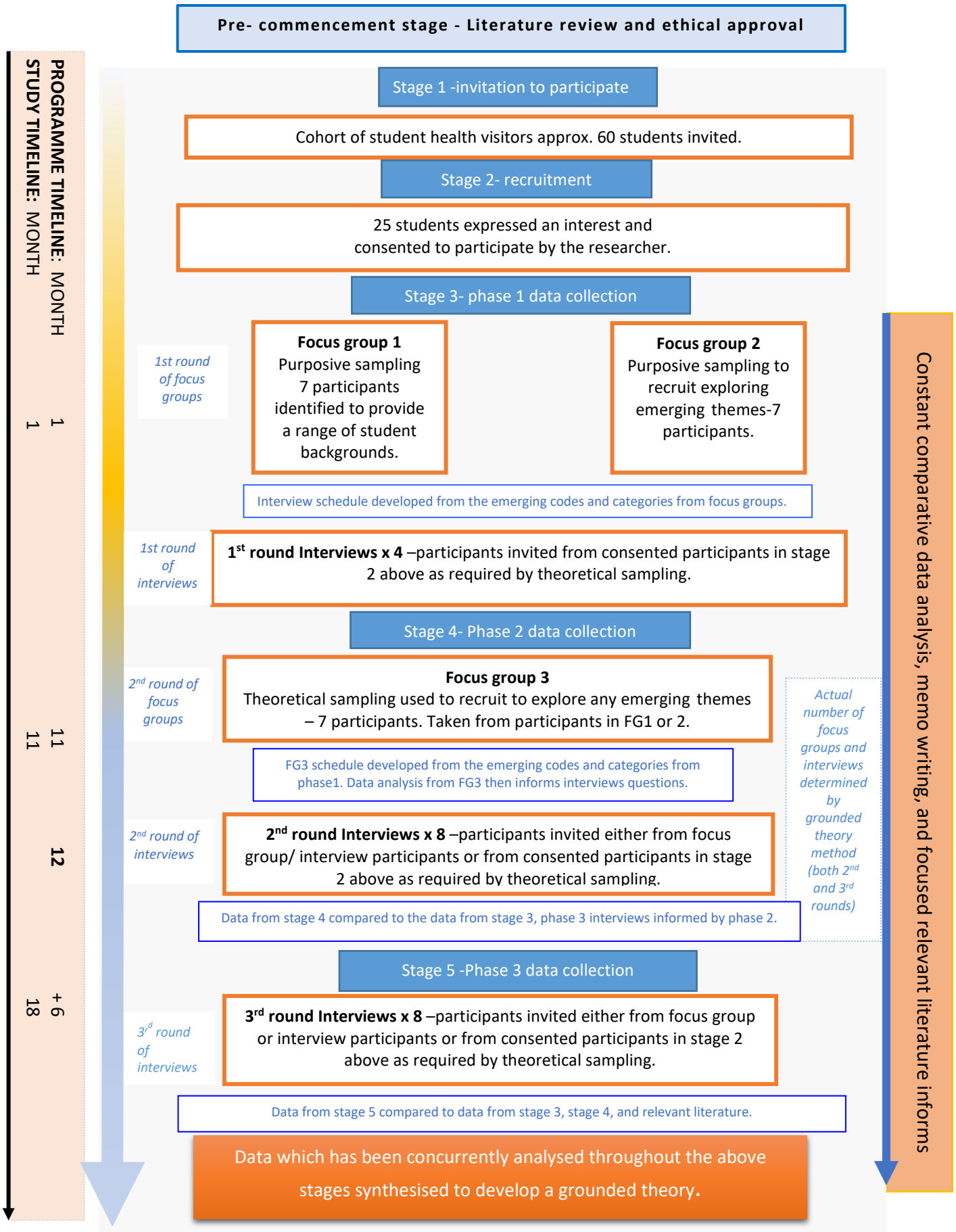
The study design can be seen in Figure 4 (p56), the study timeline (left of diagram) has been aligned with the HV programme timeline to appreciate the overall time context. The individual stages and elements of the whole design were carefully considered, and this will be discussed as the chapter develops. For further information regarding participants in each stage please see Table 2 (p67) and Table 3 (p71).

5.3 Sampling strategy

To enable the collection of relevant, rich, in-depth data from the student HV population a purposive sample was initially selected. Purposive sampling is described as the process of selecting information rich cases (Patton 2000) or a form of selective sampling (Coyne 1997). I therefore selected a group of student HVs who could share their experiences and perspectives surrounding the transition to the HV role.

This purposive sample consisted of participants who had to be either a registered nurse or MW (a statutory requirement for entry into the profession, see Chapter 1 p4) and who were at the start of their programme of study, leading to a HV qualification, and therefore, engaging in the process of transition to the HV role. As such, I initially approached a full cohort of student HVs through an invitation to express an interest in taking part in the study (see Appendix 6).

Figure 5



Study Design

There were 25 student HVs who returned an expression of interest form and subsequently consented to take part (from a possible 60). As a study objective was to consider any impact of previous experience on the process of transition, I was careful to include participants from each of the four fields of nursing (LD, MH, Adult and Children's nursing), alongside midwifery, in the initial purposive sample. This heterogeneity, I hoped, would help identify similarities and differences in their experiences and enable me to uncover any possible connections between their previous experience and the process of the transition. These were then followed up as the study progressed.

Theoretical sampling (see Chapter 3 p44) was then used as the iterative process of data analysis revealed the need for more information to saturate the developing categories, and therefore further participants were invited from the original consenting 25 as needed. The proposed number of focus groups and interviews had to remain flexible in view of this. A total of three focus groups took place, two in phase one and one in phase two. This was alongside 20 one-to-one individual interviews: four at phase one, eight at phase two and a further eight at phase three of the data collection strategy (see Table 2, p67).

5.3.1. The participants

The participants all adhered to the inclusion criteria as previously mentioned. Table 1 (p58) details the background demographics of the eventual sample. The sample, who were all female, represents midwifery and all fields of nursing. The all female sample is not unusual for a research study in this arena and is representative of the wider population of HVs. With an approximate 10/90% male to female split on the wider nursing register (Health Foundation 2016, West et al 2017) and a smaller approximate 1/99% male to female ratio as registered SCPHN(HVs) (DH 2012). The participants were split over the BSc or masters level programme of study approximately 50-50. The mix of background field and academic level in the study sample is comparable to other HV student cohorts during this period of the HVIP as can be seen in the study undertaken by Brook et al (2019) to explore retention and career progression in health visiting post 2015 (discussed Chapter 2, p30). My study sample demographic differs very marginally from those in the Brook et al (2019) study, in that there are slightly reduced participants from a children's nurse background and slightly increased

numbers of MH nurses. However, all fields are represented. As previously mentioned, (p52) these details are kept to a minimum to project the participants.

Table 1

Original field of nursing or midwifery of participants	Number
Midwife	4
Child field	2
Adult field	6
Mental health field	4
Learning disability field	2
TOTAL	18

The background demographics of the sample

5.4 Data collection methods

The decision to use a CGT approach (see Chapter 3) to undertake this research allowed the interrogation of a variety of research methods to enable the appropriate richness, quality, and nature of data necessary to develop a GT. There is not one particular method that is specific to the CGT methodology (Birks and Mills 2011, Charmaz 2014). However, it was important to allow data to be collected in an unhindered and as open approach as possible, thus, allowing a theory to be generated (Denscombe 2003). To achieve this, it was essential to capture the authentic voices of the participants, whilst exploring their thoughts, feelings, perceptions and experiences. Consequently, I considered a range of methods to decide the best way to gather the rich data required to really hear the participants voice and provide the quality of data needed. The participants had to be able to determine what was important and to convey their own story and experiences in the way they wanted to. After considering the pros and cons of various approaches, I chose a combination of focus groups and in-depth interviews. I will give my rationale for these choices in the following sections.

5.4.1 Focus group interviews

Focus group interviews, sometimes known as group interviews (Gillham 2008), formed the first method of data collection for my study. These offer a valuable method to access a number of participants at the same time (Happell 2007) enabling the gathering of data from groups of participants who share certain characteristics, such as, in this case, becoming a HV (Williams and Katz 2001, Gillham 2008). They provide a collective voice and can produce a large amount of useful data via the groups dialogue and interaction, (Morgan 1996, Bryman 2008) helping to understand and explore experiences focused on a topic (Bryman 2008, Curtis and Redmond 2007). Having used focus groups in a number of previous studies, I am aware of the drawbacks in their use: namely, the effects of group dynamics (Morgan 1996) and the *groupthink* concept (Turner and Pratkanis 1998). These can minimise conflicting views and opinions within a group, masking alternative perspectives, with some members opting to keep quiet, influenced by other stronger views (Turner and Pratkanis 1998). This required my careful management as facilitator.

A strength of focus groups is that they enable participants to interact with each other, creating energy and generating conversations which can lead the research into new areas (Myers and Macnaghton 1999, Bryman 2008, Silverman 2011). As a facilitator I needed to be sensitive to this flexibility whilst maintaining a degree of control over the group discussion, keeping the conversations on topic, yet allowing the conversation to follow a new path (Birks and Mills 2011). Facilitation is something of a balance in this respect, with the facilitator leading the conversations onto "*safer ground"* (Barbour and Kitzinger 1999 p14) if needed. Barbour and Kitzinger (1999) suggest, however, that it is quite typical for the participants to be able to manage difficult situations that arise themselves, assuming the role of moderator if needed. This is something I anticipated the participants would be able to do as qualified nurses and midwives, with the negotiation and communication skills expected of their profession.

Another important consideration was that focus groups are inappropriate for capturing the voices of the individuals from within the groups (Gillham 2008). The point of a focus group is the interaction between the participants, which generates the discussion amongst the group members, rather than a round-robin of question and answers between the facilitator and participants, hearing just one voice at a time (Wilkinson 2011, Smithson 2000, Gillham 2008).

It is the role of the facilitator to actively encourage this interaction. The group context is also important in the analysis of the data, which should be seen as a whole and within the backdrop of the group and not simply from individual group participants. It is therefore collective in its method (Smithson 2000) with all group members supported to contribute to the discussion, providing insight into their experiences (Silverman 2011). This seemed slightly at odds with my need to hear the individual voices, but I also realised the collective voice is extremely important and needed to be included. A collective voice gained through the interactiveness of a focus group, allows the exploration of understanding and opinions and "*are particularly suited to study of attitudes and experiences around specific topics"* (Barbour and Kitzinger 1999 p 5). Focus groups thus, provided a good starting point for the development of lines of inquiry for further data collection and subsequent analysis by generating new directions for study, particularly important in the early stages of a GT study (Gillham 2008, Birks and Mills 2011).

Two focus groups were completed at the beginning of the HV programme. These captured the participants voice early into the course, when they were still rooted within their previous roles. In addition, although they would have an early view of the HV role, they would not yet have any depth of experience. This was important because I needed to explore the transition process from the beginning, from early into their programme of study, so that I could compare and contrast and recognise patterns and changes in the data over time.

Originally the intention was to complete further focus groups at each planned phase of data collection as the study progressed; however, at phase two the decision was made to undertake just one further focus group rather than two and from that point forwards no additional focus groups were undertaken. The reasons for this will be discussed more fully as this method chapter unfolds (p64).

I facilitated the focus groups alongside a co-facilitator/moderator (an independent skilled researcher), who took live notes using a flip chart (Appendix 10). This is considered as good practice in focus group interviews (Kidd and Parshall 2000, Halcomb et al 2007). It was useful for two main reasons; firstly, they could help record emerging concepts as they happened, offering a summary, which was then used as a form of respondent checking at the end of the focus group, validating the findings (Gillham 2008) and secondly, the initial discussion and

interpretation afterwards between myself and the co-facilitator, served as a check to inform reliability (confirmability). The focus groups were recorded using a voice recorder and I transcribed them shortly afterwards.

I piloted the initial focus group questions with a group of qualified HV colleagues to test the ability of the questions to generate useful data with individuals who were familiar with the role and would understand the context of the study (see Appendix 13). Piloting of interview schedules is a useful way to test their effectiveness and improve the quality of the study (Gillham 2008, Baker 1994). In this case the wording of the initial questions were amended very slightly after piloting, allowing me to change the flow of the question and reduce the possibility of them being misunderstood.

5.4.2 Semi-structured interviews

To account for the lack of individual voice so far and the possible disadvantages of a focus group (previously discussed), I also undertook a series of semi-structured, in-depth, one- to-one interviews. These also helped to provide triangulation (Caillaud and Flick 2017) and permitted a deeper exploration of emerging codes and categories from the analysis of the focus group data, moving towards theoretical saturation. In some cases, where I felt further exploration of evolving concepts was required this was with individual focus group members, choosing the participant who I anticipated could provide the relevant data. This is not unusual, Birks and Mills (2011) suggest you can select the same participants from the focus group/s to interview individually or you may recruit new participants to explore further. I did both, the point being, to collect more data, to look at the ideas from different angles and enable follow up of evolving concepts and categories. All served to generate new data to explore and develop emerging categories.

The participants were asked to take part in either or both the focus groups and interviews as part of their consent to participate. There were some participants who only took part in one-to-one interviews. These participants were recruited as part of the theoretical sampling strategy in phase one and interviewed again in phase two and three. Of the 25 participants who consented to take part, 18 contributed to the study. The remainder were held as a contingency to meet the needs of theoretical sampling, if required.

Focus group interviews and one-to-one interviews are often combined within a study for several reasons. For example, as in this case, early exploration of initial themes and perceptions for further follow up with in-depth interviews (Lambert and Loiselle 2008). It also allows enhancement and confirmation of the data, through a form of triangulation and enriches the research findings (Adami and Kiger 2005). However, it is important the rationale for the combination of methods is consistent with the underpinning research methodology (Lambert and Loiselle 2008). In this case, GT allows for a variety of data collection methods, with both interviews and focus group interviews advocated, either integrated or alone (Birks and Mills 2011).

In-depth or intensive interviews can provide rich detailed data (Berry 1999, Tollefson et al 2001, Dicicco-Bloom and Crabtree 2006). Involving a one-to-one conversation and interaction with the interviewee, the interviewer uses probing questions, to obtain valuable information (Kvale et al 2010); this includes the essential skill of "*careful listening"* (Gillham 2008 p29). This deep level of data is important in the development of a real understanding of the interviewee's experiences. Interviews are also especially suitable for GT as they remain open to growth of the emerging codes, are flexible and yet can be controlled as needed (Charmaz 2014). However, an inherent risk in interviewing stems from them being led by the researcher, who makes a judgement about which information is important and consequently this could introduce a degree of interviewer bias (Berry 1999). To reduce the likelihood of this type of bias in my research and allow the interviewees the freedom to use their voice, to tell their own story as they see it, I needed to find a suitable approach to these interviews.

I considered the use of narrative interviews which are known to be helpful in gathering rich intense data and allowing the participants the freedom to talk of their experience without being led by the researcher (Kip 2003). Narrative interviews use a passive approach, eliciting stories from the participants to illustrate their experiences and perceptions with minimal interaction from the interviewer (Flick 2006). For my study, I required some structure to enable the directability of the interview if there was a need to probe further into developing lines of inquiry. I was also mindful of my place in the research, co constructing data through my interaction, as previously discussed in chapter 3 (p 38), and therefore felt I should be more involved than narrative interviews allowed. Birks and Mills (2011) support a more active

interview approach where *the "interviewer acts as a coordinator of the conversation"* (p75), as the preferred technique in CGT. I could see this *active* approach was a better description of the interview technique I needed, it allowed me to give some direction to the interviews, enabling exploration of the emerging concepts. However, I did feel the need to borrow from the techniques of narrative interviews to promote freedom for the participants and they were encouraged to tell their story in their own voice, thus providing rich in-depth data. This was supplemented by prompting or delving questions to encourage the interviewee to expand on their experiences.

It is generally accepted that interviews do not replicate reality but that they can serve to establish the story from the perspective of the participants (Charmaz 2014, Mason 2002, Silverman 2010). They are however reliant on the participants' ability to articulate and recall their experiences (Mason 2002). My study explored the very recent and current experiences of the participants, all qualified nurses or midwives and therefore it was reasonable to expect they could articulate these experiences effectively. It was also not reliant upon a distant recollection but in the memories of very recent events. As such, allowing a truer reflection of the participants thoughts.

Ultimately, the semi structured intensive interview approach that is supported by Charmaz (2006) was adopted for this study as it allowed a degree of freedom for the participants but also allowed me to direct the interview if needed. The structure was in the form of a simple interview outline, used at the beginning of the study to give initial focus. Whilst allowing participants to speak freely in their responses, further questions were developed to explore emerging themes and categories (see Appendix 14).

Initially a pilot interview was undertaken with a colleague to explore the process in more detail and evaluate the effectiveness of the interview technique, including recording and transcribing (as per focus groups). Piloting the interview recording, and transcribing was a useful exercise in allowing me to gain further insight into the process and explore my technique. Reflecting on this process helped me to realise I needed to listen more and to allow participants to finish their dialogue before I probed further, allowing the interviews to be more in keeping with the participant voice.

5.4.3 Evaluation of focus groups

At the second phase of data collection, it became clear that the data generated by the one-to-one interviews was more beneficial in terms of its richness and the ability to follow up lines of enquiry as they arose. The focus groups had been useful in establishing early lines of inquiry and for capturing patterns in the large amount of data generated and helpful for identifying initial emerging categories in the study (Birks and Mills 2011). However, I decided that to allow me to probe further, following up concepts more efficiently, no more focus groups would take place. Moving to further one-to-one interviews in phase two and only one-to-one interviews in phase three. This also helped provide triangulation (Adami and Kiger 2005, Stewart and Shamdasani 2014).

5.4.4 Recording and transcribing

Each of the focus groups and interviews were audio recorded using a digital recorder and then transcribed. As they took place, the richness and relevance of the data being produced was considered, thus, allowing me to refine the questions to enable representation of the transition process being experienced. Any need for further data or follow up of leads generated were incorporated into the subsequent or following round of interviews, allowing me to be reactive to the generated lines of inquiry, in keeping with theoretical sampling. Over the three points of data collection in my study I refined the questions to explore potential changes over time. So '*What skills do you have now that you think will help you in the HV role'*? became '*Do your previous skills help you in the HV role?* (See Appendix 14). Having the focus group and interview recordings was extremely beneficial, providing the opportunity to explore relevant data in more depth during the analysis and to reflect on the direction of questioning and where I needed to probe further.

Transcribing was also an important aspect of the process (Silverman 2011, Charmaz 2014) and by doing this myself I was able to immerse myself in the data which helped develop my early ideas. Transcribing was performed to include punctuation, tone and pause information, using guidance from Gillham (2008). The verbatim transcripts were not shared with the participants (Forbat and Henderson 2005). However, the participants were asked if they agreed with my interpretation of the recordings by sharing this with them at their subsequent interviews and

focus groups. Hence, giving them an opportunity to add anything they thought I had missed, or to say if they were not happy with my interpretation (Witcher 2010).

5.5 Data management

5.5.1 Overview of the data collection process

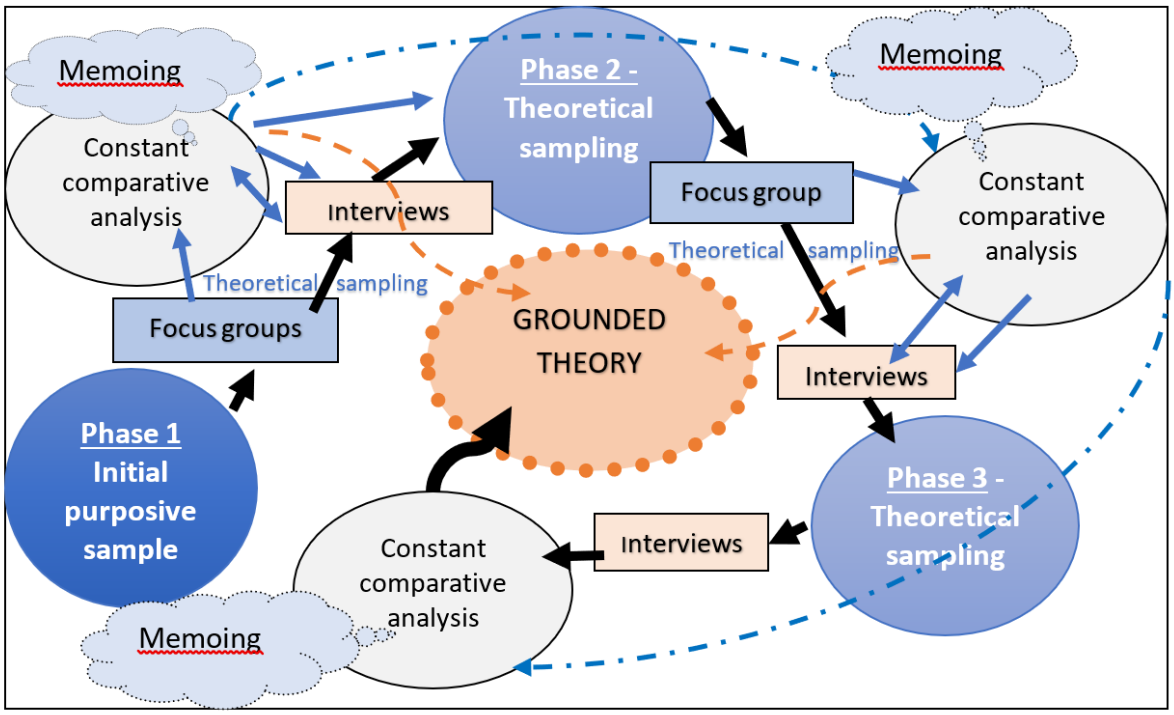
Data collection and analysis took place in three phases, maximising the tenets of the GT methodology (Chapter 3, p43) as I was able to employ these between and during each phase (illustrated in Figure 6 p66). I undertook all the phases of data collection and analysis. As previously discussed, the data collection began (phase one) at 1 month into the HV programme, with two focus group interviews, these each included seven participants. The intention was that this purposive sample would identify initial concepts for further exploration. As such, four further participants took part in in-depth, one-to-one interviews in this phase, shortly after the focus groups. These served to further examine the identified concepts and emerging categories from the earlier focus groups, facilitating theoretical saturations of concepts at this initial phase.

At 10/11 months into the programme, a further focus group and eight interviews took place (phase two) and, at the last phase of the data collection (phase three), at six months post completion of the HV programme, a further series of eight one-to-one interviews took place (Figure 5, p56). As such, I collected data over an eighteen-month period, at specific junctures as the participants moved through the programme and hence, their transition into being a HV.

The first and second data collection phase were timed to coincide with, 1) the start of the programme; being as close to the beginning of the programme of study as I could facilitate pragmatically, (this was at approximately one month into the programme) and then, 2) at 10 to 11 months into the programme, within the statutory period of consolidated practice. Consolidated practice is a regulatory requirement of all HV programmes (see standard 3 of the standards of proficiency for SCPHN (NMC 2004)) and consists of a minimum ten-week period at the end of the HV programme, during which the students move full time into the practice area to consolidate their HV skills. At this point student HVs are able to take responsibility with supervision (NMC 2004), providing my rationale for seeking further data

from them at this point, as they were now fully immersed in the role and close to the end of the programme of study.

Figure 6



Overall process of the study- adapted from the work of Birks and Mills (2011) p 71

Due to the character of GT studies as emergent designs detailed descriptions of a research design are inconsistent with its nature, and changes to the study design had been anticipated and planned for (Appendix 6) (Charmaz 2014). Thus, shortly after collection and analysis of phase 2 data, a third and final stage of data collection was added (to be undertaken at 18 months into the study), as it became clear, that at that time the transition was largely incomplete. I therefore adjusted the timeline and duration of the data generation and collection period to include a final phase of one-to-one interviews at approximately six months post qualifying with the existing participants. This helped to ensure I met the study's aims and objectives and reached theoretical saturation.

5.5.2 Relationship between the data collection phases.

In phase one, the focus groups were analysed sequentially, using a constant comparison analysis technique, to identify initial and focused codes and to inform the subsequent one to-

one interviews. Each of the one-to-one interviews were similarly analysed in sequence, prior to completion of the first phase of data collection (see Table 2 below).

Table 2

Data Collection Phase (timing)	Data Collection Method	Analysis	Analysis Method	Final analysis
One (one month into HV programme)	Focus group x 2, followed by one-to-one semi-structured interviews with 4 additional participants.	Transcribed and analysed using constant comparison analysis to identify open/initial coding	Sequential constant comparison analysis over the course of the data collection, (always prior to next interview or phase)	Develop final categories and grounded theory
Two (10/11 months)	Focus group x 1, followed by 8 interviews.	Transcribed and analysed using constant comparison analysis to identify open/initial coding		
Three (18 months/ post six months qualification as HV)	8 one to one interviews.	Transcribe and analyse using constant comparison analysis to identify open/initial coding		

The timing and relationships between the data collection phases of the study.

The sequential constant comparative analysis pattern used in phase one, was then repeated in phase two of the data collection, identifying initial and focused codes. The final stage of data collection, analysis and synthesis involved a process of considering the longitudinal experience of the participants and their transition into the HV role. It encompassed working backwards and forwards within the data sets, at the different time points, comparing and contrasting to explore the experience over time. Each phase of analysis was carefully compared to the next, drawing out connections and themes, thus developing categories

within the data through refining and focused conceptual analysis. The findings of this phase of analysis are detailed in the next chapter as the subcategories are discussed in depth.

5.5.3 Data analysis process

Analysis began shortly after the first focus group and continued sequentially as each data collection took place from this point forwards. As previously discussed, within GT coding forms the foundation of the analysis (Chapter 3). For the first phase of coding, the initial coding phase, I coded the full focus group and interview transcriptions, as advised by Charmaz (2014), to enhance the closeness of the analysis to the participants. To assist and to help focus the analysis to my research aim, I used the following questions, which are based on the work of (Allan 2007). This work strongly recommends the importance of focusing on the purpose of the research and staying centred on the point of the data to maximise fulfilment of the research aim (Allan 2007).

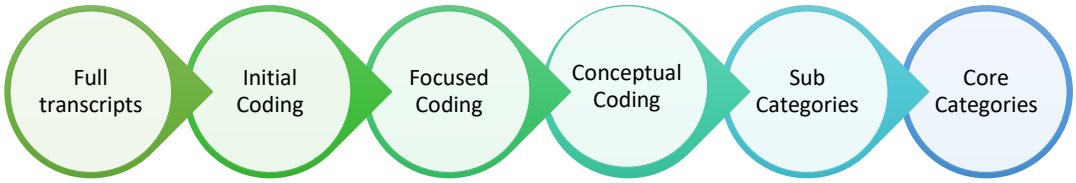
- What is happening now or has happened?
- What has changed or is changing? Are things being renegotiated?
- Are there any influences on what has happened?
- Is this relevant to the research topic?

I opted against solely using line by line coding, which is often used within GT analysis, as this seemed to fracture data excessively and felt as though meaning or context was being lost. As such, I encompassed a segment of text with an initial code, rather than each single line, as this reflected the data more closely and was a better fit to the participants experience (Charmaz 2006). An example of this initial coding can be seen in Appendix 11. Memoing (Appendix 5) was used throughout this process to help record my thoughts as I performed this analysis and to enhance my reflexiveness (discussed in Chapter 3, p48).

The second phase of coding, known as focused coding, incorporates progressing the initial coding through a further analysis and synthesis to explain larger sections of the data. The more significant initial codes are used to re-explore the data to determine if they can adequately represent the whole data set. To illustrate the method used and to facilitate openness, I have provided an example of this initial - focused coding (Appendix 11 +12).

This honing and refining process continued, with the significant focused codes being further conceptualised and subsequently led to the identification of conceptual codes (Appendix 12) (Charmaz 2014). At this point in the process of analysis the relationships between the identified categories are conceptualised, bringing *"the bones"* (Charmaz 2006 p45) or the fragments of data, split during the initial coding, back together and thus, moving towards a theoretical explanation of the area of study (Glaser 1978) (see Figure 7 for visual explanation).

Figure 7



Process of coding within the study

Within my study this led to the identification of 61 conceptual codes (Appendix 15). Further theorising culminated in these being refined to six subcategories. These will be explored in full in the following chapter.

5.6 Summary

This chapter has presented a discussion of the research methods implemented in my study and provided further details of the research process, including how it aligns to a CGT methodology. A diagram of the study design to illustrate the research process over the study timeline is also presented for clarity (Figure 5).

The sampling strategy employed, including details of the participant demographics, were explained before the adopted data collection methods of focus groups and one-to-one interviews, were then critically discussed.

Finally, this chapter explained the data management procedures employed within the study, incorporating the process of analysis used and detailing the initial, focused and conceptual coding methods. The timing and relationship between the data collection phases was also described, highlighting the application of the method of constant comparison analysis to the

data collection strategy and the process of coding methods employed. The following chapter will present the findings of my research, prior to the final GT being developed in Chapter 7.

6.0 FINDINGS

6.1 Introduction

This chapter presents the findings of the iterative, constant comparative analysis generated by the constructivist approach to GT (Charmaz 2006), the methodological framework for this study. The collaboration between researcher and participants, a central tenet of this approach, has actively generated data, clarifying meaning through joint analysis and negotiation. This led to a co-operative and shared construction of knowledge (Mills, Bonner and Francis, 2006).

As previously discussed, (Chapter 5, p68), analysis began with a reading of the individual transcripts and initial coding of segments of text as the text meaning or content altered (Appendix 11). The initial coding was followed by focused coding (Appendix 12), before further theoretical coding and the development of conceptual codes (Appendix 15).

6.2 Subcategories

From the 61 conceptual codes, developed via the process above, further analysis and refining led to the development of the following subcategories which housed all identified conceptual codes (Appendix 15 & 16):

1. Motivation and reward
2. Shifting perceptions
3. My old self
4. Changes in me
5. Role identity
6. The journey

The 'storyline technique' (Birks et al 2009) is used to present these subcategories enabling and protecting the integrity of the research, whilst providing an engaging and interesting story for the reader. To promote transparency with the processes used and to illustrate how these six sub-categories are related to the conceptual codes, the following chapter subsections should be read with the tables presented in Appendix 16 which provide further detail of the incidence and strength of each of the conceptual codes within the findings. It is interesting to

note that as the study progressed the conceptual codes changed, reflecting the experiences of the participants as they moved through the transition from qualified nurse/MW to HV.

In the following presentation of the findings, I refer to the interviews as Int1, Int2 etc., this is to identify which phase of data collection the interview took place. Focus groups are denoted FG1, FG2, FG3 etc. Please refer to Table 3 below for further details of the phase and timing of the data collection points. Participants are referred to as P1, P2 etc.

Table 3

Data collection phase	Data collection method and participants	Analysis	Analysis method	Final analysis
One: at one month into health visitor programme	**Focus group x 2** *FG1: P1,P6,P11,P12,P13, P14,P18* *FG2:P2 P3,P4,P5,P15,P16, P17* Followed **by 4 one to one, semi-structured interviews** *Interviews: P7,P8,P9,P10*	Transcribe and analyse using constant comparison analysis to identify initial coding	Sequential constant comparison analysis over the course of the data collection	Develop final categories and grounded theory
Two: at 10/11 months into health visitor programme	**Focus group x 1** *FG 3:* *P3,P4,P5,P6,P14,P15,P16* **Followed by 8 one to one, semi-structured interviews** *Interviews:* *P1,P2,P7,P8,P9,P10,P11,P13*	Constant comparison analysis to identify initial coding		
Three: at six months post health visitor programme	**8 one to one, semi-structured interviews** *Interviews:* *P1,P3,P5,P7,P8,P9,P10,P11*	Constant comparison analysis to identify initial coding		

Data Collection Phases

6.3 Motivation and Reward

Motivation for the HV role is clearly significant, being present in 10 of the 61 overall conceptual codes (Appendix 16, Table 1). It was intentionally explored during the focus groups and interviews as I considered it important to understand the participant's inspiration for becoming a HV. This helped to fully appreciate the reasons and incentives of the participants

who entered this journey and why they chose to leave their previous nursing or midwifery role. The goal was to explore how motivation impacted upon the outcome of the transition and to provide important insights of the experience. This was explored at each stage of data collection to look for any emerging patterns and themes.

The reasons for choosing to become a HV were wide-ranging but clearly, as can be seen in Appendix 16, Table 1, conceptual code 1 (Please note for cross referencing purposes a shortened version will be used from this point onwards, A= appendix, T=table, CC= conceptual code i.e., A16,T1,CC1), most of the participants were motivated by a desire to work with families and to have an impact or to *"make a difference" (FG1)*, through empowering and enabling. P7 for example stated:

> *Advocacy was the thing I was interested in and getting to work with families.*
>
> *(P7,Int1)*

These were typical sentiments, and many participants reflected this desire to work with others to improve their lives:

> *I wanted to make a difference [to people's lives], I wanted to work with people beforehand. (FG1)*

The transcript excerpt above comes from a participant with experience in working with perpetrators and victims of crime and illustrates her belief that the HV, through their interventions, could improve outcomes for families and indicates a strong motivation for the role.

Other motivations came from participants first-hand experiences with HVs (A16,T1,CC2), either as previous service users or in a professional capacity in their former roles. These experiences provided both positive and negative role models for the participants:

> *I had my first son when I was only sixteen and the health visitor I had then was fantastic and I just wanted to follow suit and be like her. (FG2)*

> *I think I had a few reasons really; I had quite a negative experience with my health visitor. (FG1)*

The negative experiences of HVs held by some of the participants, although in a definite minority, seemed to provide an incentive to be a HV that would somehow be different to their own experience and wouldn't, for example, "*talk at you and… be nosey" (FG2)*. The majority,

however, reflected very positively on their experiences with HVs, especially in their former role and these have provided strong role models and an inspiration to be a HV:

> *I spent a lot of time working alongside specialist health visitors and the more time I just kept looking at them, I just kept thinking I want to do what you're doing. (FG1)*

> *I spent a day with a health visitor as part of my [initial nurse] training and enjoyed that and thought; this is somewhere I can see myself. (P7Int1)*

A large number of the participants also discussed the opportunity and challenge becoming a HV provided them (A16,T1,CC3). This was often because of the need for a change in their work role, career progression and professional development. This is typified by the participants in FG 2:

> *I wanted a change, a challenge! (FG2)*

> *I felt stagnant……I wasn't being me, I felt like I wanted to do more. (FG2)*

P9, although further demonstrating the need for a change to her work role, also identified the move as a significant change:

> *I'm a mental health nurse …….so it's a big transition for me but I really did want to come out of mental health and do something a bit more general … with a different group of people. (P9,Int1)*

Important for many of the participants (A16,T1,CC4), public health, health promotion and preventative working were cited as a key aspiration to practise as a HV. The participants awareness of this element of the HV role was obvious. This is illustrated well by the conversation in FG1:

> *I have always thought about public health, always thinking prevention is better than cure. (FG1)*

> *I wanted to get to them [families] before, be upstream rather than downstream. (FG1)*

Initially all of the participants also considered their old roles and previous experiences would be a good basis for the HV role (A16,T1,CC7) and shared many commonalities. They either felt they would be able to apply these in some way or that health visiting aligned itself well to their background and/or field of nursing:

> *I just thought the way I was working in mental health fitted very much the model of health visiting, the sort of taking things forward, implementing and looking at things from different perspectives really (P8,Int1)*

I like that fact that it [health visiting] is holistic and relevant to all (P9,Int1)

This did diminish as the study progressed with only three out of the eight interviewees in the final data collection (phase 3) feeling that their previous experience still had an impact on their new role. This was unexpected as I had thought time would actually reinforce the usefulness of the former role.

It was also evident that, at first, there was a very genuine surprise felt by many of the participants that they were eligible to apply for the student HV role. The HVIP (DH 2011a) had widened the recruitment strategy to include all fields of nursing and midwifery, however prior to this the awareness of health visiting as a potential career prospect had been largely confined to the more traditional MW, adult and children's nurses. Comments included:

> *I didn't realise that mental health nurses could be health visitors; I had seen the adverts and just flicked by them. (FG1)*
>
> *The trust that I worked for advertised it and I thought you always had to be a midwife or a paediatric nurse… yeah and I just thought it was fixed – that was how it was, so I was really surprised to see it [the advert]. (FG2)*
>
> *I thought at first it would just be for paediatric nurses, but it isn't at all. It isn't at all…. I feel-it's a bit of everything. (P9,Int1)*

This was interesting because it became clear many of the participants had previously not considered health visiting as a career choice.

Memo (analysis after FG1 and FG2) **Data collection phase 1**

Eligibility for the role

The mental health and learning disability nurses especially are surprised they were able to apply for the role of student health visitor. They hadn't previously considered the role and for most it hadn't been a long-term aspiration. This might mean they understand less about the role at the outset and they may not have been well prepared. I will need to explore how their level of knowledge and awareness of the role changes over time.

It wasn't only these nurses who felt surprised- some of the more traditional students (adult nurses and midwifery) were also surprised they had been accepted because they felt they lacked relevant community experience. The HVIP had meant the recruitment net was widened across a number of factors and this was, in my experience, impacting in a number of ways- especially lack of insight, perception of HV role and confidence in themselves. This will also need to be explored.

In this first data collection phase, a minority of the participants, across both focus groups, articulated that 'being' a HV also held some importance in relation to the status of the role and this became part of their motivation. A participant in FG1, when referring to her decision to apply for the student HV role, clearly demonstrated that the HV is seen as an improvement in status by her friends and colleagues who supported her with the decision:

> *They were saying to me "do it, better yourself". (FG1)*

The other members of the focus group showed their agreement with this idea by nodding and validating using positive verbal responses, suggesting this is a shared perspective; it also similarly also occurred in FG2. This was something I hadn't anticipated, although anecdotally being a HV was always a sought-after position and attaining a place on a HV programme was always very competitive.

The motivation for becoming a HV began to change for many of the participants as their understanding of the role and perceptions started to change with increasing experience (A16,T1,CC31). At 10 months into the programme participants reported:

> *I think mine's changed [motivation], I think I've seen the bigger picture….. So, I thought, ooh! That'd be an interesting job and it would be a good career progression and things like that! But I think now I've seen the bigger picture, I'd say yeah, my reasons are different. (FG3)*

The sense of understanding the role complexities and seeing the bigger picture is described by many of the participants and along with this they began to acknowledge the challenges they faced within the role (A16,T1,CC5):

> *It's pretty much the same as [name removed], but for me, the reason still stays the same. I'm going to be a health visitor but then it's knowing the bigger picture, there's actually more to it than I thought it was about….. and although it is challenging, it's still something I want to do". (FG3)*

> *I was idealistic, and I think I have realised the complexities. In nursing I naturally understand the things I have been taught… now I understand them in a whole different direction. (P8,Int2)*

And in acknowledging the emerging challenges of the role further:

> *I think it's very hard work and a very hard job. Without the bigger picture and without the passion would I still be here? (FG3)*

> *I suppose I was a little bit naïve….. I guessed there'd be some safeguarding but the amount that you see ……I was in my own little bubble you know, and these*

people were living outside… It doesn't mean that I want to do less it's just been a bit more of a challenge than I thought it would be. (P11,Int2)

Despite the challenges most participants remained positive and enthusiastic and held onto the goal of completing the programme and becoming a HV:

I think I'm probably more passionate. I was passionate to begin with, but my passions grown even more. (P11,Int2)

I feel that I'm still motivated but its changed and …. I wanted the challenge and I wanted to change and I wanted to help people, wanted to feel like I was making a difference and yeah that's why I want to be a health visitor! (FG3)

For some, however, their motivation faltered and they contemplated a move back to their original field (A16,T1,CC31). For P9 this was principally due to becoming disillusioned with the lack of opportunity to use her field of expertise:

Well, I actually want to go back into mental health more now than I did in the beginning. I thought there would be more mental health and things that I could take part in and there really isn't. (P9,Int2)

This change in motivation persisted for a small minority of the participants and was significantly affected after they qualified. In my experience the level of motivation in students undergoing the HV programme does seem to fluctuate as they progress through the challenges of both the academic and practise elements. Those that were successful, however, did practise as a HV once qualified. Interestingly in this study, by six months post the end of the programme, two of the 18 participants had chosen to return to their previous roles, one other decided to remain as a HV but had spent a long time considering this: P8 discussed the return to her previous role:

About three weeks before I qualified I had a sudden "I'm not sure about this" which is normal transition which I did normalise ……I thought sensibly I'd take unpaid leave and during that time two weeks into the unpaid leave I thought I am not putting my life on hold to do something to please others. (P8,Int3)

For this participant the diminished motivation to become a HV may have been, in part, due to her experiences during the course as she really struggled with her confidence and self-esteem.

In the same interview she states:

I forgot that I was a qualified nurse, I completely forgot that I was qualified. I'm actually very experienced…. I shouldn't be feeling like that. (P8,Int3)

Memo (Interviews round 3) Data collection phase 3

Loss of Value

The experience of participant 8 has been very difficult, she feels valueless and her confidence has taken a massive knock. She is very low and this has also made her doubt her ability and suitability to do the HV role. She had the insight to understand the experience had tainted her view and tried to take some time out to reflect on the decision to stay as a HV or to return to her previous role but in the end chose to return to her old role. This participant reflects the feeling of many of the others over the course of the study.

Many describe plummeting confidence and feeling useless and deskilled to the extent that they doubt their ability to use even their established skills. Others also found the lack of opportunity to use their skills frustrating and limiting, which also seems to impact upon motivation.

It seems acknowledgement of their previous skills, expertise, knowledge etc is important- recognition of their value by others is significant in maintaining and establishing confidence and motivation for the role.

Similarly, P9 also eventually decided not to stay in the HV role in the long term but rather than feeling valueless, she also considered the role did not really use her skillset and expertise, commenting:

> *If I could set up my own post- natal support group or a baby massage group maybe I would find it a bit more rewarding than just doing the same old visits over and over again- there's no scope. (P9,Int3)*

In contrast, the majority (13/18) of participants spoke of the reward they felt in completing the programme and the sense of accomplishment and pride they had in becoming HVs, despite the challenges it presented (A16,T1,CC8). P1 reflected on the course and summed up the feeling of many of the participants as they qualified as HVs. She felt the HV programme had enabled both personal and professional development despite acknowledging the challenges faced in the process:

> *So, the course, it's the best thing I've done. It was hard but I enjoyed it all. What we are talking about is fulfilling my potential, if it was going to be easy, I wouldn't have fulfilled my potential. (P1,Int3)*

Participants also felt very proud to have succeeded in becoming a HV and wanted to ensure this was acknowledged. Clearly being a student HV had been difficult and being able to step away from that role was very gratifying:

> *I feel quite proud to be a health visitor. When I go out and knock on somebody's door, I always make sure my name tag is facing the right way*

round and the first thing I did when I qualified, I went and got my name badge changed so it no longer said student. With just the word student off I felt about six foot taller. I mean it's a flipping hard course. (P5,Int3)

For the participants, the motivation to become a HV, had clearly fluctuated throughout the process of becoming qualified and for some the motivation significantly waned as they doubted their ability or inclination for the role. Despite this the majority of participants maintained their motivation and negotiated the challenges and experiences they faced as they understood more about the role. The resulting reward, pride and sense of accomplishment as they completed the programme successfully was obvious.

6.4 Shifting Perceptions

This is the largest of the subcategories and constitutes 16 of the conceptual codes, suggesting that a shifting perception is a significant element of the transition to be a HV. It is clear that as the study progressed the perception and insight of many aspects of the role develops and changes, the details of this are discussed below.

A particularly strong theme was the early shared perception and consensus surrounding the key attributes and skills of a HV. To begin with, communication and relationship building skills, which participants linked also to being non-judgemental, were identified as important qualities of the HV (A16,T2,CC14). P10 illustrates the importance given to this aspect of the role amongst the participants:

A good health visitor has to be non-patronising, to be understanding, and open minded and a key support for that family. I guess communication that's the key thing (P10,Int1)

Also recognised as a significant trait of the HV is the ability to empower, enable, and motivate others (A16,T2,CC16). FG1 clearly demonstrates this:

Letting them [families] discover for themselves change and educating them to better themselves. You can't make them change they've got to do it themselves. (FG1)

You're empowering someone to do something, aren't you? You're empowering somebody rather than disabling them. (FG1)

Similarly, being a source of support and advice for the whole family was also seen as a vital element of the role by all the participants (A16,T2,CC17), who strongly acknowledged this as

significant, seeing it as fundamental to offering a good HV service and identifying it as being key to many families. This is exemplified in the conversation below:

> *I think we are the ones they [families] ask questions to, about housing benefit, school, immunisations …. They use you as a fountain of knowledge. I think as a health visitor you're the one person they see more than anybody else. So as a health visitor you've got the privilege of being their support network. For some people, the health visitor could be their only support. (FG2)*

As the study progressed the perception of these attributes and elements of the role are further developed by the participants and they began to connect them together, building on their understanding by adding complexity. For example, by phase 2, they began to assimilate the qualities of trust and honesty (A16,T2,CC15). The following sums this up well:

> *Enabling trust and building relationships with them [families] through communication so they feel they can trust and be honest with what they are saying (P10,Int2)*

> *You have to be honest, you have to be you…. the family knows that you are human and sometimes walking in and talking to them and you're on your airs and graces, that doesn't work, that rubs people up the wrong way, you've got to be approachable you have to be honest, even in the bad times. (FG3)*

Advanced and skilful communication was considered especially important by many of the participants, and they discussed the need for this to be sensitive and appropriate, suggesting this is fundamental to relationships:

> *So, you know yeah, they [families/parents] can talk to you and be honest with you and you're not talking at them and giving them information, they don't want, you know people aren't always going to do what you tell them to do. A lot of it's about how you talk to the mum and how you talk to the family and communication skills and being non-judgmental. (P9,Int2)*

> *Good listening skills and communication skills, to be able to communicate on different levels, empathy, empowerment. (P11,Int2)*

Their awareness of the HV role continued to grow and by the final phase of data collection assessment skills, alongside management and prioritising skills, were also identified as fundamental attributes of the role:

> *To realise what's not right, to have your basis, child development and things like that and then recognising anything out of the norm. (P1,Int3)*

P11 reflects the perceptions of the majority of the participants and identifies in the excerpt below the significance of prioritising skills in the HV role:

I think for a health visitor you need to have really good time management skills, however on your case load you've got to be flexible and you've got to understand that sometimes case management goes out the window- you are constantly risk assessing your caseload all the way through and I don't think people realise that's what health visiting is too- juggling all sorts. (P11,Int3)

Depth was also added to their discussions around empowering and enabling families. This illustrates a heightened appreciation and understanding of the concept as they discuss applying empowerment in practise. P3 and P11 epitomise this when they reflected on working with families:

So, you're taking them on a journey, along with you. So, they actually feel part of it, they don't feel like they're being dictated to and actually they might come up with some suggestions that you've not thought of. (P3,Int3)

So, you're doing you're the job well if the family doesn't think that you've done anything as a professional because families shouldn't feel you're interfering. And I think part of that is about accepting that actually if we are working to the family's beneficence, then that's about what they see as goals for themselves- not what we see- and so we're working to do them no harm, but to do good. (P11,Int2)

Memo (analysis of FG/Int) Data collection phase 2

Changing perception/ enhancing attributes

I notice they have begun to understand that communication, empowering, enabling, truth and honesty are all interconnected in the role- for example communication is affected by their relationship building and that this is influenced by trust and honesty. The depth of understanding of these concepts appears to be heightened. They are building a deeper appreciation of the role. The connection between these attributes although seen as separate concepts initially begin to be acknowledged as the knowledge of the role changes. Their perception changes as they see this as a specialist skill of the health visitor.

The participants also initially discussed the idea of the multi-faceted nature of the role and the way in which the role combines the differing fields of nursing and social care. Many of the participants felt the HV role calls for a wide-ranging knowledge base and blend of expertise (A16,T2,CC18) and identified that a mixture of professional backgrounds and expertise would be beneficial for their practise as a HV. In support of this P7 summarises the feelings of the wider group of participants:

I don't know but it's a combination, isn't it? I almost feel like I have to be an expert in paediatric health, nursing and education and early years and social care. (P7,Int1)

P8, a MH nurse, also reflected on the desire for midwifery experience, recognising her developmental needs but at the same time understanding that these need to be encompassed, along with her current expertise, in the HV role:

In one respect, I wish I was a midwife and a mental health nurse, like I think you could be all of them in one person. (P8,Int1)

This idea is revisited and expanded in phase two of the data collection with participants further recognising the nuances of the role and how it encompasses many aspects of both health and social care (A16,T2,CC18). The following excerpts illustrating how participants perceptions of the nature of the role has changed.

It has changed [my perception] because I didn't realise there was a lot of social work involved and following up and looking at the broader picture……I think we need to realise were actually a bit of everything, were not just health visitors we are nurses, we are a bit of social care and all that. (P1,Int2)

You're a support network and that's what it is…… for mum and for baby. You're part of a network as well, school, police, so you're all linked up together, whereas I don't know I used to think health visiting was- go and weigh the baby- see if they are alright developmentally….. but actually, you know, it's much more than that, bigger yeah (FG3)

The way in which a HV must be able to react to situations and to pull upon their resources was also recognised. As the transition progresses participants saw the broad scope and boundary-less nature of the role. This is demonstrated by the following transcript excerpt from participant 11 and represents the feelings of the wider group particularly well:

Health visiting – you can't put that in any little tin and say this is specifically what you do because you are an advocate, you are a counsellor whether that be grief, debt, marriage counsellor. You are financial help, you are emotional help, you are everything, you are whatever that family needs you to be at the time. Health visiting is not just weighing a baby and having a nice little chat, its far more than that. It's the bigger picture and that's for every family. As a health visitor, you don't know what you're going to face when you knock on that door and whatever it is you do face that's what you become. You can either become a mental health nurse, you become a general nurse, you become everything. (P11,Int2)

Many of the participants also speak of feeling shocked or upset by some of their experiences as they became more aware and immersed in the difficult issues experienced in the role (A16,T2,CC19). This includes the demanding nature of working with families with problems involving safeguarding or domestic violence. They also felt they had underestimated and were unprepared for this aspect of the role:

> *You know it's there but until you're actually doing the job and going into people's houses and just what you see…it's opened up my eyes, it's shocking and you come out thinking oh my god is this how people live. (FG1)*

> *To realise that people, live their lives differently- it was a bit of a shock. I've become more untrusting..... I am a bit like [names removed], I was a little bit naive about the world. (FG3)*

These feelings continued into the programme as the participants were further immersed in the HV role, but by now (phase two data collection) some of the participants were beginning to develop coping strategies, to protect themselves and thus, enabling them to manage their experiences better, this is illustrated well by the following:

> *As long as I know that I've done what I can do, then you have to kind of learn to protect yourself. It's kind of a survival mechanism. If I went home at night and thought, oh my god! I could have done this and I haven't done that, then yeah I'll beat myself up, but as long as I've done what I agreed I was going to do. You then have to pull back slightly. But, just literally one day it just clicked. You can only do what you can do! You can put in resources. You know with some people, you can throw everything at them. And they'll still make the decision that don't - you know, what you've tried to help them with. (FG3)*

Many of the participants related these aspects of the role to it being difficult and challenging (A16,T2,CC32+38), referring to their changing view; they discuss it being "*hard work" (P13,Int2)* that is emotionally demanding:

> *It was the biggest shock to my system……and I realised it's not perhaps as I thought it was. I think I originally had this sort of rose-tinted picture of a health visitor -it's all sweet and sunlight because that's what I thought it was, the reality is; it's not. (FG3)*

> *The difference now is that it's much more involving than I thought it would be initially. It's quite a lot more emotionally, you get a little bit more emotionally involved, you get attached to the family, you get to know the children and sometimes it's a bit difficult to go home and leave it. (FG3)*

At the same time, they also began to realise the HV role limitations as they became more familiar with its nuances, understanding that the HV often has a limited impact (A16,T2,CC39).

Importantly, they also acknowledge the positive difference the HV can make to the families they work with:

> *You know there are some times you can't stop and help everybody and sometimes you are left in limbo and you're thinking what else can I do? I've done this, I've done that- but they don't want the help. (FG3)*

> *You can only do what you can do- Yeah and I suppose with me coming from a hospital setting to a community setting, well it's something- that goes on regardless of whether you are there or not! Do you know what I mean? (FG3)*

> *There's the potential to change somebody's life, but then again if they're not going to heed the advice what is… it's what more can I do? ……so yeah I am making a difference and I am glad I'm doing that but it can be very frustrating and you've got to know how to deal with that and what you've- you can't do it in everybody's life but you've still got to try haven't you. I still want to make a difference, still think that you can, but it's the realisation that – you know you can only do so much? (P11,Int2)*

Another clearly emerging theme and shared consensus was the uncomfortable feelings that misconceptions surrounding the HV role created. These often included the impact of a negative image of the HV. With the majority of the participants commenting on this, it is obviously a significant issue, provoking a strong reaction (A16,T2,CC20). The following excerpts from the first phase of data collection reveal discussions around the public's view of a stereotypical HV and their need to change this.

> *A lot of people don't understand the job of a health visitor, or the role of it, they think it's someone to talk at you- it's not- or to just weigh babies- or to look round your house and be nosey. (FG1)*

> *We are there for people who haven't had a good experience with health visitors to show them we are not there to take your kids off you- yeah because of that image that's been portrayed- just come and have a nosey- you're going to take my kids off me if I haven't done my washing up or there a pile of washing. (FG1)*

> *You shouldn't do that- you shouldn't do this- this is how it should be done, and it makes people- it gives health visitors a bad name. (P9,Int1)*

This concept was then further developed in the second phase of data collection, with emphasis now being placed on ensuring awareness of the qualified nurse or MW status of the HV, in both the clients and other members of the multidisciplinary team, even suggesting the title of the role should contain 'nurse'.

I think people are quite sceptical of what health visitors are actually there for- some people don't even know that we are nurses- that's the big issue. I'd say most people looked quite surprised when I told them. (FG3)

It's the title 'health visitor' I don't like it at all. I think we need to be called health visitor nurses because if you keep the 'nurse' in somewhere you might get more respect. (FG3)

I don't think other services know exactly what health visitors are. The problem is they probably think we are <u>just</u> health visitors. I don't think they know we are actually qualified nurses. (FG3)

This highlights the importance placed on being a nurse or a MW and how this links to their sense of respect and worth. This led into some discussion about the requirement to be a nurse or MW as a prerequisite for the HV role. This will be further explored later in this chapter (p89).

Memo (analysis FG3)	Data collection phase 2
Recognition of being a nurse or midwife	
The participants have highlighted their issue with people, clients, colleagues, MDT members, other agencies not recognising them as qualified nurses or midwives. This is really important to them, and they are very defensive of this and how much it bothers them that people don't seem to know this. They attribute being recognised a knowledgeable, of being able, of being valued to this.	
They also suggest that the term 'nurse' should actually be included in the HV title. This included the midwifes who also align themselves strongly with the 'nurse'. Most of the midwifes are actually also nurses, so perhaps this is why? perhaps though it is to do with the 'nurse' status?	

Similarly, it was obvious the participants continued to find the negativity attached to the HV image difficult and as they grappled with their own perception of the role, they sometimes made comparisons to the image belonging to their former role, looking back to when they considered they were perceived more positively. They also discussed the difficulty they experienced in justifying their visits to families when they felt, in some cases, unwanted or unneeded. The conversation in FG3 is representative of the wider feelings of the participants (A16,T2,CC20):

When I went in as my old self it was a referral to me- so the parents had asked the GP for support and by the time you went they were desperate to see you- they wanted you there, whereas now you kind of have to sell the service- you know and I found that difficult in the beginning- I'm actually selling why I am there instead, rather than being wanted. (FG3)

P10, a MW, also discussed feeling unwelcome and the general confusion surrounding the HV role, reiterating the consensus:

> *As a midwife people always wanted you to come and see them.. whereas as a health visitor you kind of feel like [they don't], I think there is some confusion about the role and I think a lot of the public um- the stereotypes- do you know what I mean? (P10,Int2)*

Also, in this second phase, was further discussion surrounding the need to change the image of the HV, supporting the strength of feeling surrounding this issue (A16,T2,CC40). This is typified by P1:

> *I am building those bonds and actually I am taking down those barriers and perceptions of health visitors- I do get a lot of them saying oh I'm glad you're not like the last one that is 'they told me this and they told me that' and I'm still saying the same thing as them but in a different way. (P1,Int2)*

In phase three of the data collection the participants had been working in the role, as a student and then a qualified HV, for around 18 months in total and their experience and perceptions of the role were more established (A16,T2,CC40). Despite this there remained issues with role ambiguities and limitations for many of the participants (A16,T2,CC39+58). For example, this excerpt from P1 is representative of 5 of 8 participants in the final data collection phase and particularly illustrates the lack of role clarity, HV role limitations and how these can be managed:

> *In health visiting you are a jack of all trades master of none, but you can refer, we're a referral service really, but one with a bit of knowledge behind it. When I think about my perceptions of what a health visitor was before- I thought we would know everything but no we don't and I kind of think 'what isn't health visiting?' because it's kind of everything……. you know and actually I think I need to take a step back from that and let the social worker do it. I'm here for health and that's one of the things I have realised recently that I'm not a social worker- no leave it to them and I'll focus on health. (P1,Int3)*

P3 shows the frustration that can be created by these limitations, including a lack of resources and knowledge to do the role as they would like to:

> *I think we have to cover a huge range of things and we're not necessarily well equipped to do it. I think the given time, when you manage to get the parents to open up, you should have what you need for them. (P3,Int3)*

A re-occurring theme was also the recognition of the longer-term impact and complexities of the HV role (A16,T2,CC59). P7 and P5 typify the thoughts:

Health visiting is the only role in nursing or midwifery that people can think of that doesn't give an immediate difference. In health visiting you're building a long-term relationship and the intervention is more long term. (P7,Int3)

It was the hardest thing to get my head round at first because I think you go and you think you're going to make a real difference to this family but with most of them you do your new birth check, a follow up if they want one, your six to eight week and then that's it then! But for some mums like the one that was lonely I thought, yeah- you can't say stick a plaster on and come back in a week- it's not that straightforward. Health visiting is not that straightforward. (P5,Int3)

Participants highlighted here a distinct and important difference from other nursing roles which they didn't seem to anticipate at the outset. They found this difficult to adjust to as they realised their input may not be enough to really impact on a family and that the HV role is a complicated balance of priorities.

Memo (analysis FG/Int)	Data collection phase 2
Lack of immediacy of care and reward	
Participant 5 demonstrates the need to make things better and how hard it was for her when she couldn't do this – when she didn't meet her own expectations for herself as a health visitor and when health visiting didn't meet her expectations re it's potential influence. Many felt like this and feelings of disillusionment and disappointment were obvious in the majority of participants. This impacts on their opinion of themselves and the satisfaction they get from the role. They don't feel any immediate reward which they have been used to in their previous roles. It is there, often later down the line, the participants being new to role haven't had time to realise this always.	

The memo above is supported also by P8 who articulated more clearly how this lack of immediacy or impact conflicts with her own reward system:

I do like short term fixes- as in you get somebody better and health visiting is not like that…….. So I wonder if my reward system is... I don't do it because of this but when somebody goes "aww, thank you!" and you don't- you get chucked out of somebody's house its difficult (P8,Int3)

This was also noted by further participants as they discussed the lack of immediacy of care and how it makes them feel, referring to the uncertainty of health visiting:

Its sitting with uncertainty- I think that's a change from nursing- because with nursing you pitch them off, they go and their alright but sometimes (in health visiting) you might make a difference, or you might not make a difference and sometimes the difference is not immediate – it might be later. (FG3)

There are also key changes in participants, over the course of the study, regarding the perception of the HV role focus and whether this is on the child (A16,T2,CC42) or more broadly focused on the whole family. In fact, over the time of the study the participants view changed as they initially felt their focus should be the child (A16,T2). However, with increased experience in the role they recognised the influences of the family upon the well-being of the child and began to appreciate the whole family needs to be at the centre of their interventions (A16,T2,CC56). For example, the participants in FG1 (data collection phase 1) discussed the emphasis of the role being focused on the child:

> *You know …it is all child focus and…. how it's a nought to five [years]. (FG1)*
>
> *It's the reason were going in [the child]….. they're in the middle (FG1)*

Yet by the second phase of data collection there was a recognition amongst the participants that their focus had changed (A16,T2,CC56). They were now less concerned with just the child, realising the family is at the centre of their focus. A participant from FG3 comments:

> *I thought initially it would be just about the child but it's not just about the child, it's about the whole family. If mum's not fine, then it's not fine, if dad's not fine, then it's really not fine, is it? (FG3).*

It is clear from these findings that there are a range of key skills and attributes which the participants considered vital to enable role effectiveness as HVs. It is also apparent that has they moved through the transition to the HV role the level of understanding and awareness of these attributes were being enhanced and developed. Encompassed within this subcategory are also issues of the impact of the HV, its influences, alongside its multi-faceted, broad nature. Concerns are also highlighted involving various aspects of the role, including the public perception of the HV and the challenging aspects of the work.

6.5 My Old Self

The subcategory of My Old Self encapsulates the experience of the participants as they move through the HV programme and into the qualified HV role has they reflect on their previous role and its current relevance. The theme emerged as participants discussed the skills they thought would be transferable to the HV role, alongside the value of their previous experience and knowledge base. They also make connections between the two roles, considering how using their old skills and knowledge might benefit their new area of practice.

P8 provides a good example of how the participants (A16,T3,CC10) considered their existing and embedded skills might be a benefit to the role of a HV:

> *Establishing relationships with them and sort of understanding of, I suppose, psychology and behaviours and things like that- so I was thinking that they were very yeah, transferable things and I could really bring that into health visiting. (P8,Int1)*

Rather than simply transferring their skills, they also discussed the need to adapt them to suit the HV role, recognising the need for them to be different:

> *An example coming out of my old job, I thought I am quite good at communication, and going in as a health visitor, well it's about adapting to each scenario isn't it? You need different communication skills. (FG1)*

Some also recognised the challenge this presented as they realised the depth of changes and adaptations needed to transfer their current skills to the HV role. P8, a mental health nurse, provides an example which illustrates how she felt:

> *I didn't realise quite how you'd have to adapt them [my skills] to it. I was probably a bit naïve. (P8,Int1)*

Whereas others made a clear and more seamless link between their old and new roles, as typified by P10:

> *I've spoken to my mentor about this, and I've said you know, the midwifery aspect is obviously a more clinical role and I see the health visitor as a more 'communication role' 'people -family role' and that's how I've linked it. (P10,Int1)*

Their existing skills and expertise also included those they attribute to their life experiences which are considered, by some, as being similarly important to their professional experience in this context (A16,T3,CC12). These include personal qualities such as empathy and insight:

> *Empathy and life skills- I think life skills, empathy and how you are as a person. (FG1)*

> *I think also as a mum you pick up a lot of skills, they might not be evidence based but I can empathise with a lot of families. (FG1)*

However, notably, the participants have a wide range of existing clinical knowledge, skills, experience and expertise, coming from across the range of different fields of nursing and midwifery and they frequently referred to these former roles and experiences during the study. In view of this and the requirement to be a registered nurse or MW to become a HV, I

decided to specifically explore the significance of this. This resulted in a resounding consensus that it is important to be a nurse or MW as it provides essential skills, knowledge and approach to care (A16,T3,CC13):

> *You need the nurse assessment skills- you don't even realise you're doing it – it's like ABCDE- you're just doing it constantly. (FG1)*

> *It's just a different role that you can adapt to but you're still using those assessment skills- you're assessing all the time aren't you, every time you do your observations you're assessing that patient again and that's 'holistic'- you know from your nursing background. (FG2)*

Interestingly here, a key attribute of nursing and midwifery considered to be vital to the HV role is that of holistic assessment. Others also identified the knowledge base as being key:

> *Some of the questions they ask you aren't always health but I think you need to have a background in nursing. (FG1)*

The participants also defended the value of being a nurse and acknowledged the potential consequence of not being a nurse or MW in the HV role. The conversations in FG1 and FG2 exemplify the issue well:

> *There's an aspect of being in a health care setting that's social but we are promoting health in a social setting- I also think that you are also disabling or disenabling nurses and the credentials they bring to this field. If you look at care homes and places like that and the issues that are missed there because there isn't any nursing input. I think you can't disempower the nurse and what the nurse has got, we look at the whole person holistically. (FG1)*

> *Others wouldn't recognise the same things as a risk factor- they might end up missing them. (FG2)*

P8 offered some further insight into why this is so important for the role, suggesting the principles of nursing are fundamental:

> *Definitely -massively yes [we need nursing skills] when I think about a real health visitor's understanding I am still convinced you need to have that level of knowledge [as a nurse] I can't see any other route unless you want to just make it a leaflet giving service. There are so many things that on this course are born out of nursing principles. (P8,Int1)*

This remains significant to the participants has the study progresses:

> *One hundred percent yes. It's a nursing…. job yeah, I think you would have to be a nurse. I think it's a way of thinking isn't it, nursing? So yes. (P8 Int2)*

Memo (analysis FG/ Int) Data collection phase 2

What is it about nursing and midwifery?

The participants described many reasons why you should be from a nursing or midwifery background to be a HV. These include:

> *holistic assessment, nursing principles, ethos of nursing, way of thinking as a nurse, knowledge, clinical skills, communication skills, managing and prioritising.*

Some of these are related to the essence of nursing but many aren't- including prioritising, managing, communication which are skills of many HCP and I wonder if some of the assertions about the importance of this are about the role being identified with the nursing profession rather than the nursing profession providing the only route in.

P9, when pushed suggested some of the skills needed might not just be nursing skills and maybe more about the 'person', about personality or traits. In the end though she does support the consensus that the nurse background is key to the HV role.

> *Being able to work with lots of different people, being able to empathise. Saying that I don't know if that's just a person thing, or a clinical skills thing.... Listening, empathy, non- judgemental. Yeah, I think it is important [being a nurse]. Understanding things like policy and evidence is a big one, it's a bit boring but it is. Being able to work- manage your case load, things like time keeping, all those sorts of things help. Being able to work with different disciplines. (P9,Int2)*

On further exploration of this point others also defended the skills needed are those of a nurse/MW. P1 illustrated the point well when considering if other health or social care professionals could do the HV role. She explains here why they might not, emphasising the holistic nature of the nursing role, not just at an individual level but for the whole family:

> *Before I thought well, maybe you could do it if you were a physio or something like that, whereas actually, no you can't because when they come and there on – I mean I'm looking at mum's health as well, aren't I when she's had a baby and I know which drugs she's on, I know what she's had, I know -um the pain relief medicine, what she should be having at what time. Well, if you were a social worker you're not going to be able to give that and when you're kind of looking at physical things, like if they're tongue tied and that and if their ears and- I think you've got to, kind of, know that physiology, it does help and when dads got CHD and Diabetes and this and that and the other and then he's having a fag and a drink of coke in front of me, I can give him advice on that and tell him, do you see what I mean? In a joking nice way, "oh you shouldn't be having that, you do know that don't you?" (P1,Int2)*

Contrastingly some of the participants considered if the addition of the skills and knowledge of other care professionals would enhance their own within the role. P7 acknowledges some shortcomings in her knowledge base and suggests a background in social care would also be beneficial:

> *I found really where a big gap is, is -um- knowing about social care and all the big issues social care has to deal with and how that impacts on health visitors and there's the health aspect- isn't there? That you can't get away from. You know the – it's all about the child and their growth, health and development. So, in that respect midwifery was important, but you know I always think "oh! I wish I'd got a background in social care" (P7,Int2)*

Interestingly, as I explored this area, it also became clear that many of the participants reminisced about their previous roles and were having doubts about their move into health visiting, often recounting the past (A16,T3,CC28). For some this was represented as missing their previous patients as exemplified here by P9:

> *The thing I miss about ward work is the patients are long stay patients, so you can get to know them really well, you know their ins and outs- you spend so much time with them you actually end up missing them. I did a couple of bank shifts and they were like 'we miss you' and that's the thing I miss sometimes. I know I made the right choice really, but I do miss them, but I think my previous nursing position will probably influence the route I go down in health visiting. (P9,Int1)*
>
> *I keep going back to the ward to check it out to be honest (P9,Int2)*

Memo (analysis FG 3/Int2)	Data collection phase 2
Moving away from my old role	
They seem to be struggling with leaving behind their old role in many aspects, their friends and colleagues, their patients, their usefulness and value but they also seem to realise that they need to make a break away from this to move in the HV role. They need to work at this. This is relevant for all the participants and does not seem confined to a particular background or field. They all experience this but to different degrees. I would say the most intense feelings are within some but NOT ALL the mental health and learning disability nurses. This suggests to me that the intensity is related to the individual traits rather than the background of the participants.	

Others missed the sense of familiarity and security offered by their previous role. In this role they felt comfortable and at ease, describing it as something they understood well.

> *I felt quite- I was talking to someone the other day about her son being autistic, and I was like "well essentially, my background is learning disability." And the*

barrier just went but actually, when I came out, it was nice that I came back to something I knew. If that makes sense? And I felt comfortable with it. (FG3)

Some participants also clearly articulated their uncertainty and doubts about their change of role, expressing a clear sense of loss (A16,T3,CC26):

I felt very secure where I was. You know, it's really hard to take that filter off and my mentor will say to me "you are going to be a health visitor that was a mental health nurse, not a mental health nurse that's a health visitor." You know? And I was like "Oh, yeah." I think it's a bit sad…… a bit of grieving really, you got to leave that side, that role and I keep thinking 'why did you leave then?' (P8,Int1)

Later into the programme this concept is further developed as the participants recognise the benefit of their old role but start to understand that they need to move forwards and distance themselves from it and yet are still able to revisit it as they need to (A16,T3,CC61). The conversation in FG3, encapsulates this:

I still say that, essentially, my background is learning disability but I think that's because as an LD nurse, you always s feel a little bit like a …you know, I think were quite proud about it. Yeah. You know there's only like five of you that qualifies together and if you work in a city, you know most of them. So, I don't know, sometimes I see events and things on Facebook and I think; aww- you know? But getting there, I don't know? I feel a bit...maybe if I contacted people that I worked with, maybe it would be different but I've moved area and my friends are now health visitors, although I do see, I definitely do miss my job and you know? Because that's something I can do without thinking about it? (FG3)

I agree with [name removed], because again I've moved areas to come to do the course. And so I've not had a lot of contact with the people since I've been down here. I feel more health visitor orientated than, perhaps, if I'd stayed back. If I kept in touch – well I do keep in touch with them, just not on a day-to-day basis like I did before. (FG3)

The FG itself was made up of participants from across the four fields of nursing, and midwifery and it was interesting to note the level of agreement surrounding the importance of moving away, in both a physical and thinking sense, from their former role. Some felt the HV role was more of an expansion of their old role and had less problems moving away, identifying common ground between the two:

It [health visiting] furthers the expansion of the previous role really. (P2,Int2)

I found being in practice and health visiting, I found it very similar to the community midwifery aspects [of my old role]. (P10 Int2)

Others thought of it as more of an adaptation of skills they had rather than an expansion or extension of them. In fact, many of the participants felt a sense of frustration as they realised they were not able to use their skills as freely as they hoped (A16,T3,CC34). FG3 demonstrate this when they were asked if they were able to use their expertise; they cited their disappointment and frustration:

> *I haven't drawn from my experience really- the nursery nurses generally do the behaviour and you know these sort of bits …really…..and I'm a bit disappointed actually. (FG3)*

> *My learning disability knowledge; I'm on a case load with quite a few with learning disabilities, I have a Learning disability background and the vast majority of health visitors obviously aren't from a learning disability background…. So, I've actually been in a room where, quite obviously -well he's got children on the risk and child protection - when actually he is doing behaviours that somebody with Autism would do, so he's not getting the support for his own behaviours that are impacting on the children. Do you know what I mean? He's in a catch twenty-two situation, without that support he's never going to understand why he can't do things- and I can see this! It's upsetting. (FG3)*

Although P3 reinforced this view, she also described her PTs eventual acknowledgment and recognition of the beneficial nature of working alongside her. This however was after the participant had left that placement area rather than being offered at the time:

> *I will say when I qualified my practice teacher put in a card to me that I'd taught her as much as she'd taught me, because we'd go head to head on various things (P3,Int3)*

Significantly one of the participants felt that, in their practice area, they were prevented from using their expertise, with restrictions being placed on how they could contribute when working with families. This resulted in them withdrawing and feeling undervalued and inadequate:

> *I was told not to talk about it, so I didn't. So anything that did go on out there that was mental health I'd go "oh" and then I'd just stop…..It's very hierarchic and I particularly feel like mental health is the poor relation. (P8,Int3)*

Although this is not reflective of all the participants, this wasn't an isolated issue either, with others feeling they were not always able to input into client care effectively (A16,T3,CC34).

In summary, it is clear the participants considered their expertise and experience, gained through previous roles, would be of benefit in their new HV roles. The significance given to

the nurse/MW background was particularly interesting as it was strongly defended amongst the participants. They believed, at least initially, it provided them with a good foundation on which to build and adapt. This was, however, more difficult than they had anticipated and they began to doubt the value of their experience and knowledge. It is also clear they missed their former roles, reminiscing and revisiting them as they struggled to move away.

6.6 Changes in Me

As the study progressed and the participants moved through the programme to become qualified HVs they reported a number of changes happening. These were important to capture, to explore how the participants developed over time. Several of these concepts are also encompassed by other categories but to ensure completeness some explanation of them will occur in this section of the findings.

As previously established participants have already demonstrated a level of embedded skills from their former nursing or midwifery experience and life skills. However, they also recognised their need to develop these further by identifying gaps in their knowledge and skill set from the outset. Sometimes these were identified as knowledge in specific areas. P9, a MH nurse and P7, a MW, are typical of most participants (A16,T4,CC11). They describe here where they felt the need for further knowledge as they entered the HV programme:

> *I would say my knowledge is quite minimal, not with public health but with child development. (P9,Int1)*

> *Having done direct entry midwifery and come quickly into health visiting- having done that I quickly identified a gap in my knowledge with regard to paediatric nursing. (P7,Int1)*

At other times, these gaps were identified as qualities and attributes which participants felt they needed to improve, to enable them to fulfil the role effectively. Interestingly, many related this to confidence to do the role:

> *The ability to triage things, like actual physical health needs, like knowing a poorly baby or a poorly child and having the confidence of knowing what to do with that- for me I will always be a bit paranoid thinking that I will miss that bit of it. (P8,Int1)*

> *Standing up to colleagues I would say is a big one. I don't have a problem with the relationships with the clients. I'd say it's harder working with the*

professionals- sometimes it's hard to be assertive because you don't want to rock the boat. (P9,Int1)

As they moved through the programme and the study progressed, their skills were enhanced and adapted (A16,T4,CC36). This was sometimes in respect to specific generic qualities or traits such as courage and determination, which had been developed through their experience and growing confidence alongside an emerging ability to criticality analyse and reflect on their practise. This can be seen in the excerpt below:

Now well I've still got them all (my old skills) and you know what? I've been going through, and it is that six Cs thing, they are the skills, because if you think about it compassion, courage, determination and things like that -you need them to actually do this role. Yeah definitely, because you have to follow something through, because you have to speak up for things and I don't think I had that before. You've got questioning skills so you're thinking "I can't just believe what they've told me" I've got to look at evidence and facts now. Before I think I might have been scared to question-that's courage, isn't it? And I think the implications of not questioning, that's what makes you question now. (P1,Int2)

For some these enhanced skills are related to their ability to manage and plan their work and their rising levels of autonomy in a new field as they move into the HV role:

Managing my own case load definitely, obviously, I manage my own case load on a ward but not independently. In health visiting you manage it completely by yourself so you definitely get more autonomy skills, you know more confidence, the ability to build relationships. (P9,Int2)

I think I've matured to have a better understanding of nursing as a whole, the whole element to it, autonomy, leadership, management; the things I'd been doing but didn't know why. I've had to learn that not everything's reactive, not everything's immediate. You've got to triage. You've got to learn your diary, you've got to be able to be reflective. You know, crazy, really. I've learnt that side of it. I've learnt to adapt my communication. (P8,Int2)

However, in the process of developing new skills and fine-tuning others, all the participants also experienced feeling de-skilled and a loss of confidence (A16,T4,CC20+22). P10 recounts:

I have felt deskilled at the start- feeling like I was in year one of midwifery and I kept forgetting that I actually have some knowledge and I can use that in my visits- but when I was going out on my visits I was just not using any of it- even the antenatal which I did as a midwife, it was really strange, I think I find it hard to find the boundary to know when to step in and when not to. As a student midwife you're a student and you don't know anything, but as a student health visitor you forget that actually you have got a background and you're qualified. I didn't know if speaking up would make them think 'ooh she's

a know it all' or if it would help or if it was stepping on the health visitors toes. I spoke to my mentor about it- she said 'well you are qualified so therefore if you think you can add anything to the visit then just add it' but yeah it felt like it had all been scraped back. (P10,Int1)

Significantly the sense of not really knowing your place within the practice arena and of feeling unsure of your value is reported across all the participant in the first two data collection phases (A16,T4,CC21). It is summed up by P8, who describes the experience below and in doing so identifies the sense of loss. This is mentioned previously, as this loss overlaps into other sub-categories (p74) but is emphasised here as it is profound across the participants (A16,T4,CC22):

I lost a lot of confidence at the start of it- the start of going into practice. You do lose a lot of.. it's a loss of role. You're a student and you think well actually why I have become this? Almost childlike, following a mentor round going what shall I do now? You go into student role and loosing initiative as well- it takes over. (P8,Int2)

Another challenging aspect of change was a move to the student role. This was particularly difficult and encompassed a loss of autonomy, control and status and for some a financial loss, that had previously enjoyed (A16,T4,CC25). A participant from FG1 epitomises this:

I found it hard because I dropped from a band 7 to a band 5, so I feel like it's a financial loss but also, I would be that person who was in control. I had a level of autonomy to my job and I think I find it really hard to step back and then be the student. (FG1)

Interestingly as the participants began to move into the HV role, the way in which they viewed things, or perhaps a better description; their perspective and way of thinking, began to alter, to shift from the previous view to a new way of thinking. P1 typifies this when asked about what the HV role entails (A16,T4,CC35):

It's looking at things in a different way, whereas I might have just picked up on the behavioural issue before, now I am thinking and questioning why and linking it all together. (P1,Int2)

P7 develops this further, suggesting the ability to swap between the old way of thinking and the new by referring to the way in which she can chose when to think like a HV, reinforcing the notion of this changing way of thinking:

So when I'm doing work like that, you know really, you have to think midwifery seems very distant, but that's when I think as a health visitor. (P7,Int2)

Memo (analysis FG and Int) Data collection phase 2

re thinking shift

The participants seem to have begun to think as a health visitor (their words) sometimes. They describe how sometimes they can be in the HV role- when they are confident, when they see the need to and yet the rest of the time they stay in their old role. Moving backwards and forwards between the two.

This is not the same for all the participants, in that it is happening at different times for different people but the pattern of way of thinking can be seen clearly as they become more confident and they move into the role

There was also a shift in the way the participants viewed the focus of their interventions and care, this is previously presented in 6.4, Shifting Perceptions (p79), but this continues to develop to a whole family focus, but remaining child centred:

We go in to check the wellbeing of nought to five year olds. To see how the family are functioning, to see if we can offer any support to aid the function of that family. (P3,Int3)

The child is at the centre but depending who's there I try and involve them all ……..I just try and involve the whole family. (P5,Int3)

What stands out again is the increased understanding of the impact and importance of the family as a unit and how this can affect the child within. The developing recognition of the HV role, in this context, is really interesting as they understand more about the way in which the HV needs to work, with more appreciation of the meaning of the role.

At the final data collection phase almost all the participants emphasised advanced communication as a fundamental skill for the effectiveness of the HV role (A16,T4,CC53), recognising that a higher level of communication, above their previous skill level is required and highlighting the importance they placed on these communication skills. When asked what skills had been enhanced and developed P5 and P7 typify the response:

Communication skills, because obviously, I ran clinics for rheumatology patients twice a week, so you build a relationship with those clients, but here I think that you need to communicate particularly well, because you need a

good relationship with those clients. Because if you get a good relationship they're more likely to open up to you and then I think you get a more welcoming feeling. So, I suppose it's been communication that's been the one thing that I've really developed. (P5,Int3)

I suppose the practical things and the communication, but communication - that's on a different level with health visiting. (P7,Int3)

The participants were changing profoundly during this time with a changing skills and knowledge base, losing confidence and feeling deskilled, alongside losing the status previously experienced in their former role, before a shift in the way they think and work happens. As they began to understand how they need to practise as a HV and start to move into the role, their confidence grew, and they felt able to think like a HV.

6.7 Role Identity

The next core category of role identity was developed as the participants began to consider who they are. The importance of being a nurse/MW, in terms of the fundamental principles and core skills as a background for HVs, has already been discussed within two of the categories so far. In the previous core category of 'My Old Self' (p88), the notion of identity, as a nurse/MW and its significance was clearly identified, it was therefore important to explore this further. Thus, just prior to qualifying (at data collection phase 2) participants were asked how they viewed themselves and it was very interesting to discover that almost all of them continued to describe themselves as their singular primary identity; that of their former role (A16,T5,CC37):

I very much still see myself as a midwife. (P2,Int2)

Amongst the responses it was also clear that despite this noticeable upholding of their primary identity some had also started to think of themselves as HVs; adding the HV title to their self-description (A16,T5,CC43+45):

I think we are nurses as well as health visitors. (P1,Int2)

There are other responses which, in contrast, suggest a reluctance and unwillingness to consider themselves as a HV just yet, P8 illustrates this well and was particularly defensive and protective of her position:

I haven't took on that role yet, I don't think of myself as a health visitor, that's a bit odd I haven't thought about it but if someone looked over at me and said 'she's a health visitor', I'd think I'm NOT a health visitor. (P8,Int2)

Others were less restrictive, seeming more fluid as they began to make the move towards calling themselves a HV- in a sort of in-between or liminal state. They still asserted and emphasised the nurse title however and curiously this is even apparent in a MW participant:

> *No, I don't think of myself as a midwife- that's gone, I'd say nearly a health visitor. If I could give myself a label I'd say 'pre-school nurse' (P10,Int2)*

Only one participant outwardly demonstrated seeing herself as a HV at this stage (a participant in FG3). She was very clear that she now felt detached from her previous role, reinforcing this through describing how she been '*doing health visiting* (FG3) and is now using the language of a HV:

> *I do definitely see myself as a health visitor, my lingo is more health visitor now. (FG3)*

Despite this individual participant's early recognition of the HV identity in herself, it is noticeable that over the course of the whole study, being a nurse/MW remains important for the majority. This is also consistent across the background of the participants as they maintain and preserve their primary identity during the programme and well beyond qualification as a HV, still referring to themselves as nurses (A16,T5,CC37). This is illustrated by the following excerpts from phase 3 data collection, here the participants have been working in qualified HV role for at least 5-6 months:

> *I'm a health visitor – well I actually still feel as though I'm a nurse but I'll always say I'm a health visitor and a nurse. (P1,Int3)*

> *I have the title of a health visitor. I will be honest if I tell somebody what I do I'm a nurse. I don't say learning disability nurse until they ask me what kind. (P3,Int3)*

However, we can also see they do ultimately consider themselves to be HVs alongside their primary identity (A16,T5,CC45). This is exemplified by P7 who explained this is due to feeling newly autonomous when she practises as a HV, suggesting an important link again to *doing* health visiting:

> *Yeah [I feel like a health visitor] and it comes down to being an autonomous practitioner. That is how I feel now, much more so than ever- so that is a good feeling. (P7,Int3)*

As previously discussed, the level of confidence and autonomy experienced by the participants as they moved into their role as a HV has fluctuated over the course of the study.

From losing confidence early on, feeling undervalued and struggling with the lack of autonomy and independence in their student role (p93), here typified by FG2:

> *It's a different area and even though you do feel de-skilled as a student I think you do have some valuable points to agree on but you don't want to say because they're the experts and you'll get shot down, you don't feel valued, it's a confidence thing.(FG2)*

> *I didn't have the confidence to say anything I just sat there listening to my mentor thinking how the tables have turned. (FG2)*

To an increasing confidence and self-belief for the majority of participants (A16,T5,CC48), interestingly associated here with the credibility to do the role:

> *I see myself in a different light now because I was actually very nervous and I questioned my ability whereas now I think, I'm still learning, but I know a lot more now and I think I deserve to be a health visitor, whereas before I was questioning it. Whether I'm going to be good enough, can I get this, can I grasp all this? (P1,Int2)*

Confidence and self-belief grew significantly for the participants in the period after qualifying and by the end of the study most now speak with an air of authority and assertiveness suggesting increasing confidence (A16,T5,CC57). P11 discussed an aspect of her working day as a HV and how she could influence the outcome, illustrating this growing confidence and self-belief:

> *I had a woman who was in domestic violence, and she needed to be re homed. Women's aid couldn't rehome her, but the council have their own policy against DV. So I phoned them up, and they were like "oh, no you need to go to such and such..."I was like "I <u>don't</u> think so! Can I speak to your manager." she put me through to the manager. I was like "You've actually got a policy. This is where this lady lives...blah blah blah." they were like "Yeah, do you want to tell her to come and meet with me in the next half an hour?" (P11,Int3)*

The following participants, in discussing increasing confidence, offer a good reflection of how the majority felt as they are now working as qualified HVs, confident but at the same time recognising their limitations and the need to build their experience further:

> *I wasn't very assertive……. and this course has helped me to be more assertive, I'm more comfortable with saying "No!" whereas I would never have done that in my old job. I think "you've done it now." there is lots that I do not know. But I don't need to know it all either, it just comes with experience. (P1,Int3)*

I think I've become more confident and been able to deal with what's been thrown at me. I've also got no problems asking for help, if I'm not sure about something I'll bring it back to the office. (P5,Int3)

Participants frequently referred to overcoming difficulties in practice and how this helped them regain their confidence, autonomy and identify with their new role. P7 explains how she thought being immersed in the challenges of the role helped to develop the HV identity:

I think the fact that I have a caseload that I feel responsible for [makes me feel like a HV]. It was about a month into qualifying I think because I got a case load that wasn't really needy there was nothing you know [challenging] …. I know some newly qualified who have got social care referrals straightway, I didn't- so I think for that reason it didn't dawn on me that I am a health visitor. (P7,Int3)

Others also supported the idea that dealing with the challenges allowed them to now consider themselves as a HV (A16,T5,CC54+57) and P11 provides a further example:

I knew I was a health visitor but I think it was when I did one of the most difficult bits, when it was safeguarding. None of them [the team] felt comfortable doing it and I said 'I'll do it then'. They'd failed to get in and I managed to force myself, politely, onto this family. That's when I thought 'yeah!!' Actually! I think it began the process of it. It's when you get your own case load and you think, yeah I am a health visitor! (P11,Int3)

As confidence returned, the level of autonomy in the participants (which is associated above to enabling a HV identity) also increased (A16,T5,CC55) as they felt more independent within the role, especially in their ability to manage and prioritise their work (A16,T5,CC54). Importantly there also appears to be a connection between the regaining of autonomy, being trusted and being given recognition from others to do the role (A16,T5,CC60):

I feel a bit more part of the team now……I feel able now and the staff in the team will ask me to do things. (P10,Int3)

I know my team leader is there to support me but she's also just letting me get on with it, but she's there and she's quite happy. (P7,Int3)

For many participants, it was also important to be trusted and recognised by the families:

When I was on a visit I did feel like I'm trusted now. I felt so much better (P1,Int3)

I went to this unit with this mum and I really liked it because I wasn't there as a psychiatric nurse, I was there as the health visitor and I thought that's quite good and when I was on there, I got asked to go and look at another baby and

that's quite interesting, that progression has gone on, that you're not seen as a mental health nurse -you're the health visitor. (P8,Int2)

This suggests the role of others in providing trust and recognition, both colleagues and clients, is an important factor for the participants in realising their new role identity.

Despite all the participants in the study completing the HV programme and successfully qualifying as HVs, a small minority remained reluctant to identify specifically with the HV role, even by the end of the study. When they were asked if they would describe themselves as HVs their responses evaded the actual HV title:

I just say I'm a mental health nurse (P9,Int3)

No, I say public health nurse, I'll say specialist public health (P8,Int3)

P8 also goes on to say she found it very difficult to belong or integrate herself, seeming to blame the collective HV culture:

Culturally health visiting is like a different world and I don't fit in. I think culturally I just find health visiting very different. (P8,Int3)

Both of these participants were from a MH nurse background and had previously worked in very therapeutic, client focused environments. As discussed in 6.3, Motivation for the HV role (p72), these participants eventually either returned or planned to return to their old role. The significance of this can be seen when considering the reasons they are returning to their old roles and the fact both of these participants continued to visit and mix with their previous work place and colleagues through the whole study (A16,T5,CC44). This was unlike the other participants who although spoke of their old roles didn't have any significant contact with these areas. The following memo provides further insight into this;

Memo (analysis interviews)	Data Collection Phase 3
New way of thinking/ putting old role aside	
As I re-read and organise the interview transcripts today- it strikes me that a key theme- coming through a number of the interviews in this stage is a shift towards using a new theoretical framework for these participants- I think as a health visitor- they can still shift though from one role to the other and back and forth and this is important. These two participants have never been able to move away from their old role identity and continually revisited and maintained links with their previous roles. Both chose to work bank shifts to maintain this contact. Both also felt their expertise was undermined, underused and undervalued and found that very hard. They haven't been able to make the shift from one role to the other back and forth- the other participants who have successfully moved into their role as a health visitor have been able to put their old role aside.	

The need to fit in, to be trusted and recognised in the role and to reach the level of autonomy to enable the role to be undertaken effectively have all been found to be important to participants. Throughout this the preservation of the primary identity is important as they work towards the subsequent addition of the HV identity.

6.8 The Journey

The final subcategory to be identified within the findings; the journey, encompasses how the participants experienced the period from qualified nurse/MW to HV. This theme captures the barriers, facilitators, the highs and the lows during this journey and in doing so identifies and explores the different influencing factors and the way in which they impact on the experience and perceptions of the participants.

Significantly all of the participants, even at the start of this journey found the experience difficult and immensely stressful (A16,T6,CC49). FG1 sum up the consensus amongst the participants at the start of the study:

> *I know we're looking for the light at the end of the tunnel, but the journey to get there- It's hard, it's scary and it's a rollercoaster and I don't know about any of you, but I hit rock bottom the other day and I just cried to my mum- I did- because everything just got on top of me, all the work and... I'm starting to get up again now but... haha. (FG1)*

We can also see here some acknowledgement of the support needs and mechanisms of participants (these will be further discussed later in this section). A key finding was a real sense of anxiety and heightened emotion that was common across the participants. This was often apportioned to leaving behind their previous role where they felt at ease:

> *We're coming out of our comfort zone to start feeling woooaa. (FG1)*

The participants also reported many challenges and difficulties along the way (A16,T6,CC24). They struggled with feeling vulnerable and at the same time were conscious of the need to adapt and adjust to their new circumstances. P8, representative of the majority, discussed the realisation of the change she is undergoing and relates this to the different level of autonomy and responsibility she now finds herself managing*:*

> *It's a bit of a rollercoaster I suppose; I'm changing, moving into a different professional forum, if you like, just sort of realising – can't explain it what the thing is; it's like autonomy, and on the wards although you practise on your own your massively part of a team and I think that's what was nice was there*

was always someone there to hand over to, so I think its realising that level of responsibility. (P8,Int1)

Self-doubt and lacking confidence were also frequently referred to, including the feeling of being swamped and a real uncertainty of their successful completion of the course:

At the start it was very overwhelming, I couldn't get to grips with anything. I was finding it very hard, it felt like a very wide job, it felt linked to too many things and I just could work out what, it felt overwhelming and I thought 'oh god can I get through this year'. (P10,Int1)

Interestingly only a minority of participants cited the academic requirements of the course as a difficulty and when it was, it was also associated with managing the academic challenges alongside others:

It's been really hard juggling and the academic side of it, it's very intense, I was thinking I just want it all to end. (P7,Int2)

It is also clear from the previous findings (p97+101, A16,T4) that many of the participants found the student role a significant challenge. This is partly because of the way in which they were regarded rather than just simply a change in role and has impacted negatively on the way in which participants have experienced the journey:

You were made to feel like you were a student! Really difficult! I mean you do need to be a student but it's the way that you are treated as a student. I think it's a culture where you're really scrutinised and it makes you feel like that big [made small gesture with thumb and index finger- signifying like nothing]. (P1,Int3)

As qualification as a HV became close the participants all described a sense of relief and excited anticipation. This appeared to provide them with a lift and helped to overcome the difficult feelings they have experienced. P1, an adult nurse whose feelings capture the essence of the majority, expressed how she found the journey and describes a difficult road, with many highs and lows, including the elation and excitement of getting on the HV course, the realisation of the challenges she faced and ultimately the return to normality as she settled in the HV role, overcoming the difficulties along the way. What she describes below was common across the participants from all backgrounds (A16,T6,CC49):

It's been – um – I called my portfolio "the long road." and it had a hill going up and I only found it by accident, it wasn't that I was looking for a picture for it, it was just there and I thought 'that is how it is, isn't it?'..... So, you start on a high, don't you? "Oh, I've got this job and I'm so happy!" I was telling everybody "well I'm going to be a health visitor" like "look at me! I'm so good!"

and then you get in to it and then you think "shit! It was so much easier at my last job". Yeah. I thought "oh my god, I'm not valued as a team member!" I can't do anything, I'm a nurse with all these skills, I'm losing them-you know? And then consolidation hits you and you're like "oh! this is how you be a health visitor, actually I can do this!" because then your work's handed in isn't it and you're not doing it every night, come home and you're on the computer. So, you've not got that and you kind of…. you settle into normal life, so your routine and you're back and it's not that bad. (P1,Int3)

In fact for most, by the end of the study there was a noticeable more positive edge to their stories as they describe their perceptions of the journey (A16,T6,CC33). P11 shares this describing how, in spite of being very low, scared and intensely emotional, she now feels rewarded and even revels in the difficulties to a degree. The excerpt below also reinforces difficulties of being in a student role mentioned previously:

It has been like a roller-coaster. The transition of doing something that I knew, and that I was good at. To then go and re-learn everything. But it was like starting from scratch, that's how it felt. Mentally for me, it's been fantastic…. I loved every minute, even the really hard bits. The bits where I've been pooping my pants thinking, I'm never going to get that done. I don't understand this. Why am I on this course? I can remember my very first day at Uni and you all stood talking to me, and I broke into tears then. I thought what am I doing? I was like "what on earth is happening? What am I doing?....." it's been really emotional, it's been an emotional year, and it's been tough because you work to safeguard children like you would your own. That bit's really hard, but it's so rewarding. Ask me now if I'd go through it again. Possibly, I don't know. I'd like to think no I wouldn't but I know I would, I really would. I loved being in Uni as well, I loved being on placement. Although I found being a student really hard. (P11,Int3)

The exception to this, as previously identified, are two participants who just prior to qualifying, acknowledged their future plans are not to practise as a HV, despite qualifying to do so. Interestingly both the participants who chose not to practise as a HV came from a MH nurse background, finding the change to their way of working very challenging. They particularly felt as though their expertise was underused and undervalued. The reasons for this are further reflected in the quotation below as P8 articulates how she misses her old role in MH nursing and struggles to step outside of her comfort zone. She also clearly recognises the role of support and importantly, resilience as being part of the process*:*

I'm very, I am mental health. I love mental health. I like doing therapy, and you know sort of using those skills. I find I'm insecure about being an expert to being a novice. I don't know if I'm ready to do that. Somebody said to me, who is a friend who finished the last course. She said it's like having a baby-you

forget how hard it is after you've done it. ……., you're just on that treadmill. Its resilience isn't it [I need] and peer support, professional support. (P8 Int2)

This also further supports the previous quote (p104) where FG1 discuss the challenges and support needed and how they have managed to get themselves back on track. The recognition of the importance of a supportive or non-supportive environment and how this had impacted on their experience was in fact shared by all the participants (A16,T6,CC50). Many highlighted the role of the PT and mentor (A16,T6,CC27) and their own resilient tendencies (A16,T6,CC52).

I didn't really have a great time for the first five months really, but kept going you know, I must have seen the light-at the end of the tunnel, really and thought just keep planning a head, but – and then I've had really good support from my mentor and it's really made a difference. (P7,Int2)

Resilience was obviously important and the need to *"get up again" '*(FG1) and "*get through"* (P7) were frequently referred to by the participants as they expressed their tenacity and determination. Here P1 articulates the necessary resolve:

So, that was a relief and then I thought "actually. I can do this." and it was a bit of determination that I think you've got to have anyway because people will just drop out. And with my mentor, it was very negative and I thought 'god, if this is what health visitors are like then I don't really want to do it, and then it was like, I got into consolidation, nobody breathing down my neck, I'm actually all right, I can do this. (P1,Int3)

It is very clear the mentor and PT (whose responsibility it was to provide support, alongside assessing the student's practical competency for the role) were particularly significant to the way in which the participants felt supported and the way in which they experienced the journey (A16,T6,CC29). Focus group two typify the feelings:

It makes a difference what kind of mentor you have. My mentor's amazing, brilliant, I've learned so much from her and I can relax in her company, whereas other people have found it difficult. (FG2)

Yeah, they probably haven't bonded with their practice teacher so much and it does make a huge difference. (FG2)

Interestingly the relationship participants had with their mentor or PT was very challenging for some and at times their interactions appeared to create a barrier:

I've got a mentor and a practice teacher and they keep saying things like, it's transferable skills but in the other breath they say I need to leave them behind and I can't. (P8,Int2)

P1 reinforces this as she discusses her mentor and how she found the support lacking and yet this also made her build her own strategies for resilience, which are important as previously mentioned:

> *Well sharing of knowledge, I felt there was none. So, I've found out I have to find things out for myself and this is how I will start learning. I will ask who else I can but I will have to think outside the box and know that I haven't got that support but I'm not relying on somebody to help me, I'm doing that for myself and I think I'm learning more from being a bit more vulnerable if you know what I mean. (P1,Int2)*

In the final phase of data collection, it became obvious that the wider team, rather than just the PT/mentor, becomes the key mechanism for support as they began to consider their future needs (A16,T6,CC50). P7 reflected the feeling of many as she advocates the importance of a good team for support, here she discusses her hopes at the end of the programme:

> *Allow myself to settle and just be- and speak and listen and be with the team again, getting that to-ing and throwing, using what's there, you know? and hopefully I'll have a good team. (P7,Int2)*

In fact, being part of a team and the team's dynamics were clearly important to many participants and are identified as such below: in relation to being asked about barriers and difficulties that had been experienced on the journey:

> *Um, with the team. the team dynamics, actually, not with the job, I think the job's great, not when you come in to a new team, when your settling in, this team was quite dysfunctional (P1,Int3)*

> *There's a lot of staff politics here, staff morale is horrendous here- that's difficult (P9,Int3)*

This sense of belonging to a team also provided a positive influence on the participants experience and P8, who moved placement area during her programme, described the positive influence of the second team as they recognised her contribution and value:

> *He actually would come and seek me out to come and ask me things and that made me feel really happy, that was when I moved to the second place and then other people in the team would involve me in the conversation. So I definitely felt "oh, I am a nurse!" (P8,Int2)*

The participants referred to factors influencing the journey throughout the whole study but as they neared the end of the programme they also reported their concerns and fears for their future role (A16,T6,CC46). Whilst it could be argued apprehension and worries are to be

expected as they are entering a new role, it is important to acknowledge these are occurring as the anticipation of becoming qualified HV grew. For many, this centred around the prospect of making a mistake, especially within a safeguarding or child protection capacity:

> *Getting something wrong- not picking up on something important like child protection or not recording something that then comes back to haunt me. It's the autonomy and the accountability (P7,Int2)*

> *I need more confidence in my case. I think I'm worried about missing something and not doing something right, but that's getting better as time goes by- when you think of all these high-profile cases you always think you're going to be that one health visitor dragged through court because you've not picked up on something. So perhaps I spend a bit longer with families just to make sure that I've done that full assessment. (P5,Int3)*

At the same time, they also had begun to plan ahead and think about their futures and most were very obviously looking forward to being in the HV role (A16,T6,CC30):

> *I'm looking forward to some sense of normality- I've been thinking about being a health visitor for many years so it feels like something I've been planning for ages. (P10,Int2)*

At this final data collection phase, the participants, except for the two who had significant doubts about the role, were very positive with some already in specialist HV roles, taking on additional responsibility and others planning and thinking about their future professional development and where this might take them.

> *What we're talking about is fulfilling potential, if it was going to be easy I wouldn't have fulfilled my potential, this has broadened my horizons, look, I'm looking into FNP! I never thought I'd 'be a band six let alone a band 7 but when looking at those opportunities…… it's a band seven, similar to what I do now and I'm thinking oh my god! (P1,Int3)*

P11 epitomised the majority of participants as they reached the end of the study and have moved into the HV role:

> *Every day is different, there's never a calm, its constantly always up. You usually get a bit of a lull but the rest is always high, I enjoy it though because every day is different. (P11,Int3)*

The sense of fulfilment and satisfaction as they reflected on their role as a HV is clear despite the continuing recognition of the challenges still present.

The journey is clearly a difficult one with influences from a wide range of factors including, high levels of anxiety and emotion, personal resilience, support from others, recognition and

personal reward. Sadly, for a small minority the journey was not fully completed or sustained as they left the HV role to return to their former.

6.9 Summary

This chapter has provided a summary of the findings of this study, presented within each of the six subcategories. These were linked to the evidence provided in the tables (Appendix 16) and excerpts from the transcripts. The findings are gathered from across the data collection phases to illustrate and explore changes over time.

It is clear from the findings that there are a number of complex processes happening during the process of transition to the HV role with fluctuations and changes in motivation, attributes and perceptions as participants are immersed in HV practise. The findings also highlight the challenges faced by the loss of their old role, across many aspects, including a loss of confidence and of feeling undervalued. The significance of a being a nurse/MW is acutely evident and is especially interesting. The experience of the participants, although individual, has been perceptibly difficult for all participants. This has been influenced by the support of others, including PTs, mentors, peers and clients alongside their own ability to cope with the many challenges faced.

There is now the need for further analysis and theorisation of the concepts identified so far. The phenomena under study, the transition to the HV role, is therefore the centre of this next phase of theorising and conceptualising and will form the following chapter.

7.0 DISCUSSION OF FINDINGS

7.1 Introduction

In this chapter I will further discuss and refine the subcategories identified so far keeping 'the transition to the HV role' central to this final phase of theorising and conceptualising. The systematic approach to data analyses adopted for my study ensured the data collected and analysed has shaped the emerging concepts, rather than imposing any preconceived ideas upon it. The detailed nature and thoroughness of the process, although extremely demanding, has allowed me to develop a deep, powerful understanding of the experiences of the participants, safeguarding the participant's voice, through my interpretation of the narrative provided by the transcripts and the memos generated through this analysis.

Through reflection on the complexities of the many processes and experiences identified during this study I considered the mechanism for further theorising. Charmaz (2006) prioritises the *how* and *why*, so how participants have experienced the transition to the HV role and why participants have acted or responded in the way they did during this transition, became the focus of this further theorising, in keeping with the CGT methodology.

Within this chapter cross referencing is made to Chapter 6 and the Appendices using the previously described format (p 72-73).

7.2 Emerging core categories

When exploring the key findings within the identified six subcategories, I could see clear associations between some elements, as it became obvious they overlapped and merged into one another at times. To aid my thinking and enhance the level of scrutiny of these subcategories I began to draw and develop my growing ideas and conceptualisation though visualisation. These early conceptual drawings can be found in Appendix 18. Diagramming is recommended as a way to allow you to see the categories in more depth and enhance identification of the "*connections among them*" (Charmaz 2006 p 118). This resulted in the identification of three core categories: Role Identity, Way of Working and Living the Journey. Each of these core categories will now be critically discussed.

Considered fundamental in GT, critical discussion and evaluation of these core categories will also be related and contextualised to former relevant literature and evidence. This is weaved into the analysis and serves to locate my research within the evidence base, illustrating contributions made to present knowledge and in providing original contributions to the field. Any significant existing research not previously included within the literature review (Chapter 2) but included here, will be critically discussed within this chapter.

7.3 Role Identity

The acknowledgment of Role Identity as a core category in the transition to become a HV resulted from the significant emphasis on the complexities of identity faced in the role transition demonstrated through the participants in this research. My earlier literature review highlighted the relationship between transition and identity, hence this was not a surprise, however what was especially important to this study is what was happening to the participants' identity as they moved through the transition to being a HV. It is clear from the findings the primary role identity of the participants (nurse or MW) remains significant to all the participants throughout the study (P1,Int3,p100, P3,Int3,p100, A16,T5,CC37). However, there is also consensus in the data that the participants did eventually begin to develop an identity as a HV, albeit a new and still emerging identity (P11,Int3,p102, A16,T5,CC45). The process (how the identity changes) of this phenomenon will be explored in this next section. Further discussion of literature in the field of identity is explored as part of the process of constant comparative analysis as the significance of identity complexities became known.

7.3.1 Primary role identity

The early part of the transition to the HV role was discussed as the *"comfort zone"*, by some of the participants, suggesting a safe space and somewhere they felt at ease. It soon became apparent, through the process of analysis and subsequent memo writing, this was a consequence of the significance placed by the participants on their primary identity (the original nurse/midwifery field to which they are registrants) (A6,T5). The depth of feeling about this aspect really struck me, as it became evident this familiar primary identity seemed much more than a job role or title, but one which encompassed their sense of self (how they saw themselves). This was well articulated by P8 (Int2,p106) in her declaration, "*I am mental health"*. It also clearly provided a sense of belonging and security, referred to as being

"*something I can do without thinking about it"* (FG3,p93). Notably for all participants 'being' a nurse or MW seemed fundamental to them as a person (A6,T5,CC37). Within the literature there is considerable agreement the professional identity of a nurse is an inherent component of the personal identity of the nurse (Öhlén and Segesten 1998, Fagerberg and Kihlgren 2001, Ware 2008, Flaming 2005) and is strongly related to personal and core values (Fagermoen 1997), and so, perhaps the reason for the significance of the primary nurse or MW identity and the sense of belonging this seemed to provide. The process of memoing and existing literature was then used to explore and refine this reasoning.

Fagermoen's (1997) influential research is significant here as it explored the formation of a nurse's professional identity and its relationship to personal values. This was an important study, still commonly cited, signifying its relevance to the current environment, providing seminal evidence of the embedded nature of our personal values within a nurse identity. The findings highlight a very close relationship between being a nurse and personal values, both intrinsic, 'self-orientated values' and extrinsic 'other-orientated values'. Fagermoen (1997) also highlights the altruistic nature of the nursing role, exploring the importance of these 'other orientated values' and actions of nursing in providing a moral underpinning of care, in caring, comforting and helping the patient. There is also further consensus in the nurse identity literature that in order to identify as a nurse it is important to feel like a nurse; a nurse identity is not simply attained by doing nursing work (Fagermoen 1997, Öhlén and Segesten, 1998, Johnson et al 2012). Suggesting therefore, being a nurse is again, much more than just doing a job, a title or role. Öhlén and Segeston (1998) and Ware (2008), both claim there is a strong concept of the 'self' in the practise of nursing or to put it simply, personal identity is part of the professional identity of a nurse and the professional identity of a nurse is part of personal identity; the two therefore being inextricably linked. Thus, providing a rationale for the strong feelings demonstrated by my participants towards their primary identities. Similarly, Flaming (2005) also strongly linked the concept of self to a nurse identity, describing the practise of nursing as a *"fit"* (p96) to her participants self-identities, claiming nursing embraces being a particular kind of person.

This intertwining of self and professional identities is also evident in literature surrounding the professional identity of midwives with midwifery described as something *we are rather than something we do* (Hunter and Warren 2014) and likewise, Flaming (2005), echoes this in

nursing; we *are* a nurse, we do not just *do* nursing. Interestingly the literature relates this to a strong sense of vocation, in which one becomes a nurse or MW to make a difference to the *greater good* (Hunter and Warren 2014) (Professional Standards Authority 2016), again related to altruism.

The literature, therefore, supports my research findings and gives credence to my earlier claim that, for the participants in my study, their primary identity was essential to them as it encompassed their sense of self, creating a deep bond and connection with it. It also provides further support that the primary nurse or MW identity of the participants was much more than a job role or title but deep-rooted and linked to 'who they are'. Interestingly several of the participants describe their motivation for the HV role as wanting to 'make a difference' further reinforcing the notion of altruism as one of their key values.

7.3.2 A Sense of loss

During the study, a distinct sense of loss and vulnerability evolved as the participants began to move through the HV programme. There are clear indications the participants started to feel their primary deep-rooted identity is threatened and they began to falter and struggle with the transition to the HV role (P8,Int2,p93, T3,CC26). This struggle was apparent through their palpable heightened anxiety and levels of stress, which was not only noticeable in their transcripts but also in their behaviour *"I just cried"* (FG1,p104*)*, "*I broke into tears"* (P11,int3,p106). Interestingly they also defended and coveted their primary identity, "*if I tell somebody what I do I'm a nurse"* (P3,Int3,p100), and actually articulating this loss, *"I'm losing them-you know?"* (P1,Int3,p106) *"I think it's a bit sad…… a bit of grieving really, you got to leave that …role"* (P8,Int1,p93). It is notable these feelings of loss were experienced by all the participants (A16,T3,CC26) and hence, loss constitutes a significant element within the transition to the HV role.

This loss is multifaceted, for example, a shared palpable concern amongst participants was also their loss of identity as an experienced and valued practitioner, as they become 'students' again, which resulted in a perceived lack of status by themselves and by others (FG1,p97). Evidence from the literature again supports these findings; Watts (2009) explored the challenge of status transition. She emphasised the move from expert professional to student as very difficult, linking it to a change in identity. Likewise, Case et al (2010) claimed it

provokes a high level of emotion as the challenges of the student role are faced. The study by Case et al (2010) explored teacher to student transition, and suggested a key factor within the transition were the use of multiple lenses and the dilemma this presented (teacher or student or professional), which is pertinent when I consider the role reversal that has taken place for many of my participants who had previously acted as mentors themselves for other health care students and were also experiencing multiple 'lenses' of nurse/MW, mentor and student HV (FG2,p101), adding further understanding of the different complexities faced within the transition to the HV role.

It is important here to discuss the recent work of Hughes-Morris and Roberts (2017), who explored the issues of returning to the student status in SCPHN students (both HVs and SNs). Their study, although having a different focus to my own also related in a number to ways to my research. The key differences being, demographics of the participants, a retrospective data collection and a specific and distinct focus on the move to the student role. The similarities revolve predominantly around the findings as they echo some of my participants concerns, namely around the difficulty in moving to the student role, the impact on the loss of status this entails, combined with the resulting tensions. The study does therefore offer support for my findings in this part of the transition (qualified nurse to student). Hughes-Morris and Roberts (2017) concluded the primary identity of the qualified profession needs recognition, but they did not explore in any depth the reason this concept is important. What my research adds to this is the in-depth knowledge of the complexities of identity as a key element of the change to the student role within the transition to the HV.

The loss of status and threat to their primary identity demonstrated by my participants fits with the transition theorists Bridges (2004), Schumacher and Meleis (1994) and Van Gennep (1960), who all referred to a period of loss, separation or ending as an early part of a transition. My findings show this loss is felt deeply by all the participants, even likened to a bereavement. The data from my study suggests the inner tension and stress this creates was completely unexpected and unprepared for by the participants who referred to hitting *"rock bottom"* (FG1,104). This lack of preparedness and failure to recognise and support this loss and threat to identity, resulted in the participants feeling overwhelmed and pushed them back towards their safe place, their comfort zone, *"it was nice that I came back … I felt comfortable"* (FG3,p93).

Additionally, within their primary identity the participants understood their position, able to locate their place, contribution and value in the practice environment. However, as they moved away from this role, all participants described feeling undervalued, losing skills and confidence (A16,T4), often reminiscing about their confidence and ability in their previous role, "*I can do without thinking about it?"* (FG3,p93, A16,T3,CC26+28). Applying the widely used concept of Community of Practice (CoP) (Lave and Wenger 1991) helps to understand the reason for the challenging effects of changing role and hence, identity. In this seminal work belonging to a CoP is strongly related to the formation of identity (Wenger 1998). Unpicking this further, within any CoP, the members share knowledge, community and a common framework, within these three domains they also share other common ground including, values, ideas, tools, language and history (Wenger et al 2002). These values include their personal values, which already discussed, are embedded within their nurse/MW identity (Fagermoen 1997). Thus, as the participants had all previously established belonging to a CoP as a nurse or MW, sharing common values and knowledge, it is of no surprise moving away from and losing this CoP is also difficult as it produces another threat to their primary identity.

7.3.3 Negotiating with the HV role

What is especially interesting is the shared view of the participants regarding the need to be a nurse or MW, prior to being a HV. It is also obvious from analysis of the data they placed considerable importance on others knowing they are already a qualified nurse or MW (both other professionals and their clients), asserting, *"I'm a health visitor and a nurse"* (P1,Int3,p100). They are clearly reluctant to be disconnected from their nurse/MW title (FG3,p85, memo,p85). This again supports the notion that this identity is very significant to the participants, expressed by the way they protect their primary identity (FG3,p85).

Intriguingly, many of the participants also suggested a change of name for a HV to include '*nurse*' in the title (FG3,p85), and oddly this included a participant who was a direct entry MW, who advocated being called a *'health visitor nurse'*. I originally thought wanting to be called '*nurse*' was simply because of the need to assert a nurse status and identity and to draw on the more positive general perception of the nursing profession (Donelan et al 2008). However, this participant wanting to include *'nurse'* in the title, made me question if this was about the perception of others and of how they wished to be perceived or perhaps they simply used the common phraseology of the other participants, as this was in a focus group.

However, the conversation between the participants at the time, was related to the respect afforded to the nurse role and hence, it is more likely the comment is driven by the need to be perceived as a nurse. Thus, indicating the perception of others is clearly an important issue within this transition process and crucially the participants felt the name attributed to health visiting influences this perception. This research provides important new recognition of this fact.

It was interesting the participants own perceptions regarding the role of a HV triggered some misgivings and anxiety. Health visiting has struggled over its history to establish a clear professional identity, as previously discussed in the literature review chapter (Machin et al 2012, Baldwin 2012) and this creates a tension, as the lack of clarity surrounding the role makes it difficult to form a strong identity (Machin et al 2012). In addition, the multi-faceted and broad nature of the role (further discussed p128) is difficult to navigate for some as they seem unsure who they need to be at any given situation (P1,Int2,p82). Not only are the participants finding it difficult to disconnect from their original primary identity they are also uncertain about what they need to become (P11,Int3,p84). The literature surrounding the professional identity and responsibilities of the HV to date supports this, referring to the often fluctuating and inconsistent remit of the HV role (Twinn 1993, Baldwin 2012, Machin et al 2012 and Burrell 2011). This uncertainty makes it difficult for students to prepare themselves, the ambiguity creating tensions in understanding the distinctiveness of HV role (Machin et al 2012, Stansfield 2016). An established and clear professional identity is therefore crucial to enable easier and enhanced transition to the role. This is a key area for further research and will form part of my recommendations.

As a profession, health visiting is sometimes interpreted in a negative light, both by clients and other professionals (McHugh and Luker 2002, Donetto et al 2013) and this view was also expressed by my participants, who frequently discussed the negative image of the HV (P9,I1,p85), which in turn resulted in doubts and misgivings about the role. So much so they sought to change the image of the HV to address this, appearing to negotiate their change in identity by balancing it with offering a different type of HV as they discuss trying to alter people's perceptions and change the HV image (P1,Int2,p86), *"I am taking down those barriers and perceptions of health visitors"* (FG1,p17). This issue, together with the ambiguity surrounding the role, resulted in a dilemma for the participants triggered by not fully

understanding what they needed to be, yet simultaneously steering away from the image of the HV they had experienced. Thus, presenting a further challenge in the transition to the HV role.

7.3.4 Immersion in the role, letting go

It is clear from the analysis, as the participants were immersed into HV practise, they began to develop new areas of knowledge, experience and increasing confidence. They also began to relax their hold on their primary role identity. This was not a simple relinquishment though, as evidence from the participants (FG3,p94) and subsequent memo writing suggest they move back and forward in their old and new roles (P7,Int2,p98). Venturing into the new role identity when they feel confident and secure but stepping back into their old role if this is threatened (memo,p98). This is really interesting and highlights the significance of the participants feeling self-assured and secure to make progress in the transition to the HV role.

It is also apparent some of the participants recognise the need to push themselves to engage with their new community to successfully move to the HV role *"my friends are now health visitors"* (FG3,p93). Interestingly the participants who were able to achieve this engagement also managed to move successfully into the role. Those that were reluctant to leave their old community behind and engage with the new community really struggled to make the transition and in fact returned to their previous role. There are many factors at play here; support for this engagement is influential, a supportive PT/mentor, peer support and a wider supportive network of colleagues were all significant. This again resonates with the theory of CoP and the notion of the gatekeepers (Wenger et al 2002), as without the sharing and acceptance of the existing members of the community the participants cannot integrate with their new community and this therefore will influence any shift in identity. What is also important is the recognition from others that they are viewed in the role of HV if they are to move forward into the role, so recognition and acknowledgment of others is essential; this is from both practitioners and clients (P1,Int3,p102, P8,Int2,p102) and reinforces the earlier discussions of the significance of perception in the process of this transition to the HV role. The evidence from this study suggests the participants want to be perceived as a HV but continue to also be recognised by their primary identity.

It is also evident within the findings (A16,T4,CC35) the participants began to view their interactions from a new perspective as they became further emersed in the transition to the HV role. Adopting a broader but yet more specialised view as, it is conceptualised, they began to take on the values and norms of the HV, they referred to *"seeing the bigger picture"*. However, the findings also suggest this change in perspective was not yet fixed (P7,Int2,p98) as they seemed to interchange between one way of thinking to the another, metaphorically changing hats, depending on what perspective they need to use or what they feel most comfortable in at the time (P8,Int1,p93). There is an apparent period of testing out the role and the way it feels and if there were difficulties or threats – they moved back to safety and their old role "*I actually want to go back"* (P9,Int2,p77). Heitz et al (2004) also acknowledge this period of testing, specifically in relation to moving into the family nurse practitioner role (FNP). They refer to the participants bouncing back and forth between roles, clearly echoing my findings. My research adding, this is similarly, part of the transition to the HV role.

Ibarra (1999) also suggested that adaption to new roles is undertaken through a series of behavioural tactics, namely experimenting with their 'provisional selves', through finding solutions to discrepancies between the present self, competencies, behaviours and attitudes and the new role expectations. Pratt et al (2006) also supported this idea in their findings, suggesting various techniques are used to construct new identities through strengthening, adapting and building on the identity already possessed. In my participants, this type of experimentation was also obvious through this moving backwards and forwards, as they swapped between the old role and their new role. Testing new knowledge and thinking, building a new perspective and identity, yet reverting back to the old if needed. This new perspective began to take over from the old, in a sense, a paradigm shift alongside an identity shift. What seemed to be important here is, as the new way of thinking developed, the significance of the primary role identity of the participants and their previous way of thinking, remained and could be recalled as required. This is clearly articulated by P7 who describes "*thinking like a health visitor"* (p98) and is representative of the majority of the participants (T5,CC45) (memo, p98+p103). This suggests the process is cognitively driven and the participants began to think like a HV.

7.3.5 Balancing identities

It was clear from the data and analysis, the participants eventually began the process of reframing and realigning their identity, "*I'd say nearly a HV"* (P10,Int2,p100*).* Critically, this is after a significant period of testing and challenging themselves in their new HV role (P7,Int3,p102). This challenging enabled recognition and acceptance from themselves, as they align themselves with the competencies, norms and values of the new identity, but also peers, managers and team members as gatekeepers to the CoP. Ibarra (1999) also claimed feedback from more senior members of the profession was influential in adaptation and encouraging the required experimentation of individuals to successfully adapt to new roles, acting also as role models and agents of social validation. Similarly, Kerr and Macaskill (2020) and Dingwall (1997) linked identity formation to the acceptance of others.

As a strategy to deal with the tensions faced by the threat to their primary identity the majority of participants appear to have developed multiple identities. Often referring to themselves as being both a nurse and a HV (P3,Int3,p100, T5,CC43 +45). A multiple identity is not that unlikely, with people often having a number of careers over a lifetime, either sequentially or running concurrently (Caza and Creary, 2016) and hence there is a developing body of literature surrounding the concept of multiple professional identities (Ashforth and Johnson 2001, Leavitt et al 2012, Creary et al 2015, Caza and Creary 2016). Caza and Creary (2016), important authors in the field of professional identity, claim having multi professional identities is complex, triggered by the way in which individuals are able to identify with and relate to each of their professional roles, whilst maintaining their self (Caza and Creary, 2016). This is clearly evidenced in my participants who need to manage the complexities, as already discussed, of having the multiple identities of, a nurse/MW, a HV and their self. During the shorter period of the HV programme (12 months into the study) only one of the participants claimed having a HV identity (participant in FG3,p100).

The evidence from the rest of the participants strongly suggests, even at the end of the study period (at 18 months and six months post qualifying), they are still grappling with role identity, and upholding their primary identity alongside an emergent HV identity. Despite, by that point, being a qualified HV, they still often referred to themselves as a nurse or MW, *"I actually still feel as though I'm a nurse"* (P1,Int3,p100*)*. I would argue this is because of the strong links between self- concept and the participants primary identity and the safety net

the primary identity provided. The two exceptions, previously discussed, returned to their old role, preserving their single primary identity, either just at or shortly after qualifying as HVs. It would seem from their evidence the challenge to their primary identity and all this entailed proved just too difficult (P9,nt3,p103).

Caza and Creary (2016) proposed there were a number of ways in which individuals can manage their multiple identities. These are described as, *dominance;* where one identity dominates over the other, *compartmentalisation*; where an individual can switch between one identity and another but not both simultaneously, *holism*; where one identity encompasses the others and *augmentation*; where there are separate multiple professional identities that can and do work together. On exploration, there is some resonance here with the experiences of my participants, where individuals can claim membership of two professional groups at the same time and chose to sustain their primary identity (i.e., nurse and HV). For the participants who succeed in managing these multiple identities it appears they adopt a version of the *augmentation* structure. Significantly though and a key finding in this research, is that there are distinct differences to the augmentation structure proposed by Caza and Creary (2016), and therefore my study adds new understanding and knowledge. I have called this an ***Attachment Identity Structure***, it consists of separate identities which can work together simultaneously, but with one attached to the other. So, the two identities of nurse **or** MW **and** HV are connected and work together, not separately, one underpinning the other, depending on the situation.

This simultaneous working is not as straightforward as Caza and Creary (2016) imply, as my findings show my participants really struggled to balance the two identities and move away from the internalised salient nurse or MW identity (P8,Int2,p93). Balancing of these attached identities seems crucial to the process of transition, as those that were not able to use the two identities together, failed to continue in the HV role and returned to their old role (memo p99). It is clear the salient primary identity and the establishment of the HV identity are both important and therefore, I would suggest, a form of mutual collaboration between the two identities is required to reduce the stress and threat of the transition process and allow the two identities to work together successfully.

Although this is not the same for all participants most were able to find a way to use the two identities in a mutually supportive and effective way by the very end of the study

(P1,Int3,p100). Interestingly many participants relate their claim of a HV identity at this point to the feeling of autonomy in their new role, being trusted and allowed to take responsibility in the role (P7,Int3,p100, P11,Int3,p102).

What is especially striking is the primary identity remains strong across the numerous backgrounds of the participants. Fundamentally it is being a nurse or MW that is essential to them. This is important knowledge as it is clearly essential to acknowledge the significance of primary identity throughout the process of transition to the HV role.

7.4 Way of Working

The findings of this study demonstrate an important shift in the way in which the participants work and deliver care that is fundamental within the transition process. This incorporates changes to autonomy, dealing with new areas of care, grappling with limitations and accepting the challenges of the HV role. As in the previous 7.3 Role Identity section, 'Way of Working' adapts and changes over the time of this study as the participants negotiate their way through the transition to their new roles.

7.4.1 Preconceptions and building blocks

At the start of the transition to the HV role there were obvious preconceived ideas of the HV amongst the participants. This included the anticipated responsibilities and activities of the HV, as they acknowledged there would be an emphasis on public health and working with families (FG1,p74). Their views, however, lacked a depth of understanding of the role complexities, not surprising when the previously discussed ambiguous nature of the role is taken into account (Machin et al 2012, Baldwin 2012). Nevertheless, importantly at his time, it is clear the participants felt they would be able to adapt easily to the HV role, seamlessly applying their existing knowledge base, regarded by the participants as essential building blocks for the role of a HV (FG1,p89, P10,Int1,p89, FG2,p86).

It is also evident from the data there is a compelling agreement between the participants that being a nurse or MW will provide them with a strong foundation for becoming a HV (A16,T1,CC7, T3,CC13). This is a fair assumption considering the statutory requirement to be either a registered nurse or MW prior to entry to the profession (IHV 2014), but interestingly in the early stages of the transition the participants particularly believe it is the expertise

provided by their nurse/midwifery background that is essential to the role of the HV (P8,Int1,p89), and thus without this background they would be unable to fulfil the HV role. It is noteworthy, whilst clearly understanding there will be challenges as they move into the HV role, the findings suggest at this point they do not foresee any significant challenges and they feel safe, confident and assured.

7.4.2 Expertise and autonomy

As the participants began the transition and moved into their role as student HVs, they left a field of practice in which they were experienced and often expert practitioners. The data from this study indicates that in this previous arena, they had a high degree of autonomy and self-efficacy, "*I came back to something I knew…and I felt comfortable with it"* (FG3,p93).

Autonomy, as a concept, is an important aspect of working as a nurse/MW and there is a considerable evidence base from which to draw (Finn 2001, Kramer and Schmalenberg 2003, Skår 2009, Wade 1999, Oshodi et al 2019). Skår (2009) claimed it is the action of choice in the process of decision making which creates autonomy. Importantly though, being autonomous is also dependant on the level of knowledge to enable effective, safe decision making (Manzoukas and Watkinson 2007) and the level of responsibility of a profession, as this defines the scope of decisions available to them at any given time (Skår 2009, Oshodi et al 2019). Hence, in their previous roles, the participants held knowledge, expertise and experience which allowed them to act in an autonomous way, albeit within the context of scope of practice.

Within this environment they were also, as qualified nurses and midwives, working with a degree of autonomy, which is known to provide job satisfaction (Kramer and Schmalenberg 2003, Finn 2001, Whittaker et al 2017) and a feeling of well-being (Gagné and Deci 2005, Oshodi et al 2019). It is from this autonomous position they moved to the new and unfamiliar territory of the HV. However, it is clear in the evidence, as they tried to apply their current underpinning knowledge base to the HV role, they realise their level of expertise is now insufficient and mismatched to their new role, " *I didn't realise quite how much you would have to adapt"* (P8,Int1,p89). This brought feelings of uncertainty and insecurity in the participants, and as they relinquished control over their practise they lost confidence, which in turn impacted on their sense of autonomy, self-worth and value (P10,Int1,p96).

Also noteworthy, all the participants, although from a variety of backgrounds, were accustomed to working in a ward or a team environment that provided round the clock, continual care. Here, as the working day comes to an end, the care responsibility is passed onto the following shift. This way of working has been familiar to the participants throughout their nursing/midwifery careers (P8,Int1,p104). Consequently, for most of the participants, the autonomy held within the previous role allowed decision making as a member of a team, a team which provided collaboration for decision making, alongside continual care for patients (P9,Int2,p96). This team approach brings with it mutual support and enhanced confidence in decisions made, further supporting and enhancing feelings of autonomy and hence wellbeing (Oshodi et al 2019).

As the study progressed it became evident the participants began to both lose their previous sense of autonomy (FG1,p97) and simultaneously began to realise new levels of autonomy within health visiting (T5,CC55). As a HV, caseload management determines the way in which the service is delivered and work is organised, with individual HVs being responsible for their allocated families within the caseload or for the whole of a caseload. This was, therefore, significantly different to the previous familiar way of working of the participants, as they remained responsible for the care provided with no-one to directly and routinely, hand care over to. It is clear initially the participants found this difficult. Especially when, due to the nature of caseload management, the participants had to leave client problems unsolved and needs unmet. This sometimes meant leaving a family situation uncertain for a time and relying on their individual judgment and decision making to determine the appropriate next steps i.e., to signpost or refer to other more specialist or appropriate services. This freedom to make isolated individual decisions, is a necessity of the HV role, with recent work by Whittaker et al (2017) recognising this method of autonomous decision making as a key value and aspiration within HV practice, signifying its importance. Alongside signposting, referrals and coordinating care resources, as the significant care professional, this was a new method of autonomous decision making for many of the participants. Unfortunately, evidence from the data suggests many of participants struggled initially with this increased level of responsibility and autonomy, illustrated well by participants in FG3 (p84), at least until their confidence and self-efficacy began to return. Additionally, autonomy in health visiting is also increased in terms of control over daily schedules, self-management and in planning for and

managing their own diaries to meet the needs of the service and their case load (Whittaker et al 2017). Most participants however welcomed this aspect of increased autonomy, seeming to enjoy being self-directed and were happy to except this responsibility.

7.4.3 The new way of care delivery

This study provides clear evidence the participants experienced a new way of care delivery as they transitioned to the HV role. This was complex and involved many aspects of care delivery at many levels from the rewards attributed to the HV role, the nature and method of the care delivered and organisation of care giving.

One of these aspects stemmed from the way in which nursing care is considered by the participants as offering immediate impact and reward, "*getting somebody better"* (FG3,p88). This is also something the participants demonstrated they want from the HV role "*I wanted to make a difference*" (FG1,p73) and was therefore a key aspiration of the participants, clearly hoping to assert their values and objectives within their role as a HV. It is important to step back and consider here the consequence of nursing and midwifery interventions compared to those of a HV. For example, nursing interventions usually offer both immediate, and longer-term benefits, where patients and clients see a direct and quick response or benefit to the care provided (Fagerberg and Kihlgren 2001) from simply providing comfort i.e., 'fluffing a pillow' to more technical and complex care needs. In contrast, health visiting typically provides care that has a longer-term impact, rather than an immediate benefit, for example in terms of prevention and early interventions to promote long term positive outcomes for children (DH/DCFS 2009).

It is apparent from this study, the delayed impact of care giving and practise as a HV was not anticipated by the participants and required some adjustment to their expectations as they came to terms with this disparity. Articulated by P5,

> "*It was the hardest thing to get my head round …..you can't say stick a plaster on it and come back in a week- health visiting is not that straightforward"* (P5,I3,p87).

Although they all embraced the preventative and public health elements, they were obviously unprepared for this new way of caring in the HV role. The evidence highlighting the shift from the immediacy of care for some of the participants appeared to directly impact on their

reward system, sense of self-worth and well-being (P8,Int3,p87). As previously discussed, (p113) nursing and midwifery are both referred to within the literature as a vocation and are considered to be closely aligned to who we are (our sense of self) and to our personal values and reward systems (Fagermoen 1997, Fagerberg and Kilhgren 2001). For some participants this adjustment to their personal benefit and resulting job satisfaction was clearly an issue, at least in the earlier part of the transition to the HV role. These findings therefore provide new and important understanding of this key issue in the transition to the HV role.

Interestingly this issue was seen across the different backgrounds of the participants and did not appear to be influenced by the original field of nursing or midwifery. This offers an area for further exploration into the impact of nursing and midwifery intervention and the influence on reward systems. This was beyond the scope of this thesis however and will be a recommendation for further research.

It is also noteworthy, frequent comments from participants surrounded the referral aspects of the role (P1,Int3,p86) as they were often required to refer to other agencies for further specialist and specific interventions i.e., social care (Cowley at al 2015). This is again quite different from other fields of nursing and midwifery which predominantly provide direct care themselves and are less likely to refer routinely. P1 even described health visiting as a "*referral service"* (p86) demonstrating her strength of feeling about this aspect and many others were clearly upset that they often didn't have the required resources to intervene and help more directly. P3 arguing *"you should have what you need for them"* (p86). This may be in part related to the lack of required skills and knowledge, as this is at the beginning of the study, but it is clearly an additional new way of working that adds to the complexity of the transition.

Another change in care delivery is the way in which HVs provide unsolicited visits as part of a universalism model of care (Cowley et al 2015). This differs from most nursing and midwifery care, where clients have either been referred through assessed need or have sought out care and support themselves. This universalism model of care delivery requires working closely together with families and negotiating a trusting relationship, to deliver a baseline of care to all. However, it is a relationship that is not always welcomed by the families and for many of the participants this was unsettling and difficult, generating anxieties about the benefit of this type of care delivery (FG3,p86). Participants reported having to sell the service and feeling

unwelcome and unwanted by their clients, something they had not experienced previously (P10,Int2,p86). This adds to the literature review of health visiting practice by Cowley et al (2015) who described the need to, *"actively encourage the use of their service"* (p273). Cowley et al (2015), however, did not acknowledge in their research this may be difficult for those new to the role, which was clearly the case for many participants in my study (A16,T2,CC20), hence my research offering clear and distinct evidence of this concern amongst aspirant HVs.

7.4.4 Child protection and safeguarding

An additional difficulty for many of the participants is the realisation of the demanding nature of the role, with the prominence of child protection, safe-guarding, domestic violence and levels of deprivation witnessed (P11,Int2,p77, FG1,p83). Evidence from the study shows the emotional demands of the HV role are obvious as the participants struggle to come to terms with this aspect of HV practice. Interpretation of the data suggests this produces a significant and very real culture shock for the participants. Although there was acknowledgement there would be some safeguarding and child protection within the role, they had not predicted the proportion, nor the intensity of this aspect of the HV role.

> *I think I originally had this sort of rose-tinted picture of a health visitor -it's all sweet and sunlight because that's what I thought it was, the reality is; it's not. (FG 3,p84)*

This naivety was perhaps a benefit however, as although the emotional stress encountered is obvious by the participants response (FG3,p84), I also wonder if they would have been so willing to undertake the role of the HV if the consequence of this had been realised earlier. None of the participants considered child protection or safeguarding as a motivator when applying for the role, despite it being a known area of responsibility. This perhaps suggests an unconscious decision to discount or play down this element of the role and thus, adding to the resulting emotional stress when these difficult aspects of the HV role materialised. This again is an area which requires further investigation and an exploration of the impact of child protection and safeguarding practice on the role of the HV will be recommended as further research.

7.4.5 Role boundaries

As the study progressed it is clear the participants picture of the HV changes as they began to acquire insight into the multi- faceted nature of the HV role (A16,T2,CC18). Becoming aware of the all-encompassing aspects of the role, they considered it a combination of many elements of health and social care and even beyond, articulated clearly by P11 "*you become everything"* (P11,Int3,p79). It appears from the data, this understanding of the boundary-less nature of the role developed as they became immersed into HV practice. This is both in terms of its multi-faceted nature and the focus of the role, as the data suggests their understanding shifts from the HV focus being centred on the child, to a broader family focus and then to the wider community (FG1,p88). This shifting of focus suggesting a change in their way of thinking or perspective utilised to do the HV role. The initial perspective of the participants becoming superseded as they began to understand the complexities and considerations required to perform the role effectively.

It is also evident the participants started to feel they needed to become many health and social care professions at once, articulated as "*all of them, in just one person in"* (P8,I1,p82). They imply the need to metaphorically wear a different hat, depending on what they found, *"whatever it is you do face, that's what you become"* (P11,Int2,p83). Clearly they consider the HV role to be more complicated than they imagined, describing it as being an amalgamation of other professionals (P7,Int1,p82) with a need for a high level of leadership and management skills (P11,Int3,p81 and P8,Int2,p96) and a comprehensive, highly advanced skills and knowledge base, particularly in enhanced communication and risk assessment. The empowerment of families is also seen as fundamental to the role (P3,Int3,p81).

Referring to a deeper and broader understanding they report seeing the *"bigger picture"* (FG3,p77) and view the HV role as being both a "*support network"* and "*part of a network"* (FG3,p82). This again provides evidence of their changing perception towards the nature of the HV role, understanding it's significance, alongside it's complexities and nuances, whilst negotiating the changes to their way of working. The evidence clearly shows, as the participants began to become further immersed into the role and come to terms with these changes, they enhanced their knowledge base, through adaptation and expansion and they started to align themselves more closely with the HV (P1,Int2,p96). Levels of autonomy and confidence began to build, and self-efficacy and belief started to return (P9,Int2,p96). Linked

to this are the feeling of role satisfaction and general well being connected to this level of autonomy (A16,T5,CC55).

The ambiguous scope of the HV role undoubtedly produced additional challenges during the transition process, as it was difficult for the participants to know how to approach different situations and settings, thus, it presented many unknowns. However, through participation in HV practice and environment a clearer picture of its many facets began to develop as the participants built a deeper understanding of the attributes and important areas of expertise of the HV.

7.4.6 Limitations and frustrations

It is clear from the data the participants recognised the need to adapt and enhance their own previous expertise, confronting and reducing the limitations in their knowledge base, early into the study. Whilst this is not unexpected on an educational programme, the process is certainly not straightforward. As an experienced lecturer, I am well aware learning is complex and very individual and at this advanced level requires significant support and from lecturers, PTs and mentors (now known as practice assessors (PAs) and practice supervisors PSs- see Appendix 17). If we simply consider Maslow's still seminal hierarchy of needs (1954), we can see, to learn effectively learners need to feel comfortable, safe and secure and have a support network that provides a sense of belonging and accomplishment. The participants have so far felt vulnerable, lost confidence, become deskilled and their previous level of autonomy has diminished significantly, impacting upon self-worth. Hence, it is clear to see how this might affect their ability to learn. Within the university environment the participants describe feeling well supported (P11,Int3,p106) but refer frequently to problems in the practice environment, reporting difficulties with recognition of their value and support (FG2,p101). Vygotsky's (1978) work theorised that social interaction and community is fundamental to meaning making and the development of cognition and reinforces the notion that the support network available to the HV visitor students significantly influences the outcome of the learning process as part of this complex transition.

Despite these obvious tensions and influences upon the learning process and the need for many new, adapted and enhanced levels of knowledge and skills, the participants did, in time, reconcile these gaps and although they felt concerned about their level of knowledge and

competency to do the role well (P5,Int3,p109), there is little evidence from the participants the formal final end product of the learning is affected by the process of transition; that is, each of the participants successfully completed the programme and qualified as HVs, gaining either a BSc or a PGDip in SCPHN(HV).

They also, although mentioning the academic challenges of learning, never apportion any of the complexities of the transition process as being attributable to the academic demands of the learning process. What did impact (on transition) however was the support offered outside the academic environment (A16,T6,CC50). It is clear in the data it was those participants who felt strongly unsupported and undervalued that, despite managing to successfully qualify as HVs, do not ultimately feel it is possible for them to assume the HV role (P8,Int3,p78).

There is further clear evidence many participants experienced frustration due to limitations placed on them in the HV role, especially when they had the professional skills and resources to address a client's needs but felt unable to use them. It is apparent some participants felt upset and rejected, as they were strongly discouraged, even prevented to use their specific expertise to support and benefit families. This created a sense of constraint, reduced control and a disillusionment in the HV role, as their levels of autonomy fell and they questioned their value, yet again (FG3,p94, P8,Int3,p94). Furthermore, Whittaker et al (2017) in their study exploring HVs professional aspirations and their impact on retention in the role, found autonomy to be highly valued, declaring, "*professional autonomy was a critical aspect of [HV] practice"* (p344). They also claimed, importantly, for student HVs the ability to act autonomously during "*needs focused contacts"* (p344) provided important motive for the HV role and argued being able to use specialist knowledge to match client need added to role satisfaction. In interpreting the data from my study, it is clear the feelings of imposed restrictions on the participants' practise (discussed above) directly impacted upon the level of autonomy felt and thus influenced self-worth and feelings of satisfaction (Fagermoen 1997, Gagne and Deci 2005, Whittaker et al 2017) (P9,Int2,p102, FG3,p94 and A16,T3,CC34). Hughes-Morris and Roberts (2019) found similarly that loss of autonomy was a key element of the move to a student SCPHN role and related this partly to the use of previous skills and expertise and the *"perceived receptiveness"* (p239), of the wider team, highlighting this is influenced by the view of others.

This is significant as it clearly demonstrates the impact a lack of recognition and encouragement from the established HV community can have on the feelings of autonomy and thus, transition to the role. Exemplified by P8 a MH nurse, they felt controlled and prohibited from using their skills to support a client (P8,Int3,p94), this directly led them to question if the HV role would be right for them. Whilst this is an extreme example it demonstrates the difficulties some of the participants experienced and the critical nature of the relationships with other team members, especially mentors and PTs (further discussed, p132). Thus, my research provides obvious further weight and robust new evidence alongside that of Hughes- Morris and Roberts (2019) complimenting and adding to their findings.

My research adds to the knowledge base from a time when the widening of the HV workforce and the diversity of the student body was at its uppermost, right in the middle of the HVIP. It is clear the impact of the varied background of the students certainly added to these complexities as the participants struggle for recognition of their expertise and worthiness to be a HV, trying to break down barriers in PTs/mentors attitude regarding their suitability for the role.

7.4.7 Changing perspective

Conversely, it is also apparent in the data the positive interactions and relationships with experienced HVs, alongside the immersion in the practice environment allowed the participants to thrive and to develop a different view or perspective. This perspective was then used to underpin their practice and ultimately, they began to think as a HV (P1,Int2,p98). The evidence, as already discussed, suggested a greater understanding of the role and a shift in their underpinning theoretical framework, enabling the enhancement of existing knowledge to build new expertise (P5,Int3,p99, P7,Int3,p99). This is supported by the work of Wenger (2010) (see p114) who theorised that by engaging with a community we are able to visualise ourselves within a new world and Kerr and Macaskill (2020) who stress the importance of engagement to enable a "*socially legitimate"* identity (Kerr and Macaskill (2020) p1208) to develop. Practise, therefore, is fundamental to this process with the resulting visualisation allowing us to see ourselves from a different perspective and facilitates the membership in this community.

Especially interesting, through further interpretation of the data, was the participants were, at this point, seemingly able to move between their old and new perspective, choosing when to do this. For some (P8, Int1,p116) this was to move to a more persistent comfortable way of thinking, yet for others this was more fleeting, with the participants moving briefly back towards their old perspective as they continue to adjust their viewpoint (P7,Int2,p98). This return to their old perspective could be understood as using or relying on their dominating perspective. This is discussed in the work of Fagerberg and Kihlgren (2001) who undertook a longitudinal study exploring the change to nurse perspectives over time. They explain dominating perspectives are related to a life paradigm (Björklund 2000), or a way of thinking that remains with us, consistently through time. Life paradigms being held by everyone, across a network of views. For example, our view of life, of others and of our practise. It is, however, something which we supplement or enhance, rather than simply change, or refashion, via our experiences, including the experience of work, learning and education (Fagerberg and Kihlgren 2001). Thus, further strengthening the previously discussed idea of the enduring primary identity of the participants and its associated perspective, as part of the findings of my study.

Fagerberg and Kihlgren (2001) also emphasise the role of the teacher in enhancing these paradigms and suggests;

> *being a teacher implies taking part in the extension of a students' paradigms of life, enriching their lives and facilitating the transition into their working lives as nurses. (p143)*

Thus, both these works, Wenger (2010) and Fagerberg and Kihlgren (2001), provide further evidence of the influence of practise and the practice community (lecturers, mentors, PTs teachers, experienced and student HVs, all forming part of this community) on the process of transition and offer support to my findings. What my research adds is the distinct knowledge of the absolute critical nature of the influence and the impact of this community, especially teachers and mentors, both negative and positive on the process of transition. The community support is not merely about facilitating learning but significantly, it also involves supporting the many aspects of transition to the HV role that have become evident through this research. Alongside this, the importance of immersion in the practice environment and the role of the CoP in allowing and enabling the participants to think like a HV is established

and adds detailed knowledge to the process of transition. It also leads me to question the influence a dominating perspective may have in the transition to a HV role and its role in providing a safe haven for those undergoing the transition when needed. This does require further exploration and will form a further recommendation for future research.

7.5 Living the Journey

This final core category is called 'Living the Journey', as it was the experience of the journey that was important and not simply the act of the journey itself. Many of the participants related the transition to the HV role as a form of journey with phrases such as "*the long road"* (P1,Int3,p105*) "a rollercoaster"* (P8,Int1,p104) and *"light at the end of the tunnel*"(FG1,p104) being used to describe their experiences. Despite the initial enthusiasm for role, the journey to become a HV is seen by the participants as something they had to get through or to be endured, it certainly was not considered to have been an easy or straightforward process (FG1,p104).

7.5.1 Aspirations and motivation

A minority of the participants journey to be a HV started as early aspirations. They specifically chose nursing or midwifery as their initial career, solely because of the desire to be a HV, knowing this was the only route into the profession (P10,Int2,p109). Clearly these individuals were very highly motivated. Likewise, though, for the participants that chose health visiting much later in their nursing career, there was also a high level of motivation apparent. Key motivating factors for the role included the opportunity for professional and self-development, an interest in and recognition of the importance of public health work and working with families, making a difference to their lives (FG1+2,p73-74).

Interestingly, unlike the minority who had aspired to be a HV for many years (as above), for most of the participants, the decision to consider a HV career was much more recent, encouraged by the then current, HVIP (2011-2015) (DH 2011a) and its consequential recruitment drive (DH 2011b). This recruitment drive helped many of the participants to realise their ability to meet the entry criteria to be a HV. Persuading them to apply, despite previously never before considering it a career option (FG2,p75).

For all the participants the beginning of their journey to be a HV was a moment of celebration, they were excited to have been accepted on the programme, *"I screamed down the phone"* (FG1,p134). Coming from roles in which they were successful and proficient nurses or midwives they were confident, autonomous practitioners with a high degree of self-efficacy (see p123). They were also enthusiastic for the journey ahead, with no doubts of their ability to achieve the HV role and were, quite rightly, hopeful for a successful outcome. The findings suggest this motivation was both intrinsic, being a desire to learn and develop and being able to give something back to the community (i.e., to influence outcomes for children and families) and extrinsic, that is the reward of further perceived status and potential future financial reward. This level of motivation is important as it is considered a significant factor in achievement, both in the academic sense and in reaching the end goals (Singh 2011). Motivation was central to accomplishing their desire to become a HV and at the start of their journey the participants had this in abundance.

However, it is also apparent from the data, this level of motivation changes as participants become immersed in the role (A16,T1,CC31+47). It is clear the participants begin to understand that health visiting, although having the potential to positively influence the health of many families, children and communities, fulfilling their goals, is complex, difficult and full of challenges (FG3,p83). Their response and feelings created by changes to status, autonomy, identity, confidence and value all impact on levels of motivation (P1,Int3,p107). Interestingly the changing motivation for the role did not appear to affect the overall process of transition for the majority of participants, that is they still wanted to become a HV despite a shift in motivation levels. However, there were two sources of motivation at play here, motivation to be a HV (as above) and motivation to carry on in the transition, to keep going. For example, they may have wanted to be a HV still but not be motivated enough to continue in the transition. It was, therefore, particularly important for the participants to remain determined and resilient to the effects of their experiences to maintain their motivation for the HV role (P7,Int2,p107) (resilience will be discussed further on p140).

7.5.2 Significant loss and distress

The findings of this study clearly show the participants soon plummeted into a period of intense stress, feeling vulnerable and threatened as the realisation of the demands of the

course and the role began to be understood (FG1,p77). The move away from their previous role and identity, into a student HV role is difficult, challenging and comes with a consequential loss of status. There is also a perceived loss of value, loss of skills, loss of self-worth, loss of autonomy and a loss of recognition (P1,Int3,p105, memo p77-8). These would be significant by themselves but in this situation, they happen simultaneously and although it is clear the participants were moving at different paces through the transition, with some progressing more quickly than others, these losses were felt by all the participants with a considerable intensity causing heightened anxiety and for some, a feeling of being overwhelmed (P10,Int1,p105).

These findings support previous work in the area of transition. This includes the work of Bridges (2005) who refers to "*endings, losing and letting go"* (p5) as the first stage his model of Transition (Bridges 2005) and Van Gennep (1960) (both discussed in the literature review) who refers to a rite of separation in his seminal *rite of passage*, in which the individual experiences a departure from their status quo. Van Gennep's work implied however, that these initial phases of loss and separation are complete prior to the *liminal* or in between phases, whereas Bridges (2005), considered the phases in his model of transition were without boundaries, as they blur from one phase to the next. This is more comparable to my findings; however, my findings differ, in that they demonstrate the participants experienced periods of loss and resulting heightened stress, vulnerability and insecurity, throughout the transition. These are not as distinct as to be contained within one period of time but are threaded throughout the whole transition process. This is a key difference in my findings which indicate the feelings of loss experienced by the participants, although concentrated in the early part of the transition, were repeated and interweaved throughout the whole transition. In addition, the findings also show the process is not unidirectional or simply linear for all the participants, as it is apparent from the data analysis, the resulting periods of threat experienced was enough to hinder, stop completely or cause a regression in the transition (memo,p74, P9,Int2,p77).

For the participants, their losses as referred to above (p135), although highly significant, were only part of the threat to the transition to the HV role and there were several other areas of threat which will be further discussed in the following section. However, it is important to

note the losses felt by the participants were considerable and even likened to a bereavement and so, should not be underestimated. My research therefore provides detailed in-depth knowledge of the critical impact of the multitude of losses felt by the participants, as they relinquished their previous role and status.

7.5.3 Changing my community of practice.

One of the key elements to this journey, involving further loss, is the movement from their previous CoP balanced with negotiating acceptance in a new one. A CoP provides a strong sense of identity and belonging and helps ground an individual firmly with a social network of likeminded practitioners (Wenger 2010, Andrew et al 2008). As previously discussed (p116), the participants belonged in a CoP within their previous role, whether that be, for example, in a CoP as a MW, MH nurse, LD nurse or children's nurse. Each of these CoP share common language, values, knowledge and competencies, tools, resources and practise. It is argued that leaving behind this CoP not only created a sense of loss, but importantly, that this was a significantly disruptive process for the participants, who found disconnecting from their important links and relationships with the existing CoP, difficult to achieve (P9,Int2,p92 and memo p103). The participants illustrate this well in their reluctance to leave behind their previous roles and workplaces. Sometimes revisiting their previous place of work, testing out how they felt in the old familiar environment, in comparison to the new. For all the participants, there was evidence of some negotiation with themselves, the PTs, mentors and HV community, surrounding what they can and cannot leave behind from their bank of knowledge, skills and expertise that they found difficult (FG3,p94). Hence, adding to the threats and anxieties experienced by the participants and highlighting the complex bartering, balancing and compromise of an individual's qualities, skills, attributes and being, as they grapple with a multitude of feelings and emotions.

It is important to note some participants also had some difficulties with acceptance into this new CoP, and were sometimes reluctant to push themselves forwards, lacking confidence, another cause of stress and anxiety (P1,Int2,p101). This acceptance relies on established members of the community, facilitating movement across the CoP boundary and enabling their engagement (Wenger 2010). These boundaries, created by shared history of learning, can lead to the exclusion or marginalisation of new members (Wenger 2010). New members

can be a benefit to a CoP, through the addition of new ideas and perspectives, therefore helping the CoP to reshape and renew its shared learning resource. However, new members also bring a challenge to the CoP which can create resistance (Wenger 2010), perhaps explaining some of tensions experienced by my participants as they grapple with aligning themselves in the established HV CoP. The participants illustrate this well as they question where and how they fit it (P10,Int1,p96) and even if they will fit in at all (P8,Int3,p103).

The participants also experience a secondary CoP in their role as a student, based on the premise a CoP can exist at multiple levels and in multiple situations bound by the collective learning process of its members (Wenger 1998). Academic challenges, studying, the nuances of student life, meeting frequent and tight deadlines are all important aspects of this community. Support therefore from the other members of the student group, alongside that of the academic and practice team are key here to successful integration into this role. The participants reflect positively of this experience within the university. Findings suggest though, that in the practice environment, the student role is particularly difficult to manage and is the cause of anxiety for many of the participants as they try to balance the academic and practise demands of the role (FG2,p101 and P7,Int2,p105).

The participants also report *feeling trusted* as being an important factor in the process of acceptance into the HV role and being able to regain their feeling of autonomy (P10,Int3,p102). Once again, this resonates with the CoP idea, where the trust of the gatekeepers or established members of the CoP is a key part of the process of being. To be trusted implies belief in competence and therefore recognition, as the participants met the expectations of membership, enabling identification with the CoP, through engagement, imagination and alignment with their new role (Wenger 2010). Being trusted also provides reassurance enabling increasing confidence and self-efficacy. This allowed participants to feel able to test out their own practise (P7,Int3,p102) and gain confidence in their abilities in the new role.

Evidence from my findings also suggests the trust of clients, families and the community are important in order to validate the ability and competence of the participants to be a HV. It is really interesting that, gaining trust, acceptance and being perceived as HVs, from the people for whom they provide care was very important to the participants, as they looked to them

to provide endorsement and further recognition. It seems that if others perceive their HV status the participants are more comfortable with claiming that identity for themselves (P8,Int2,p102). Consequently, the many gatekeepers, comprising academic staff, PTs, mentors, practice colleagues and the community are key to this period of transition as they provide support and acknowledgment for the recognition of the individuals and their acceptance into the role.

7.5.4 The role of the PT, mentor and others

At the time of this study PTs supported and assessed student HVs in the practice area. These were qualified HVs who had undertaken a programme of study in teaching and learning theory to meet specified required competencies, in accordance with the then current, Standards to Support Learning and Assessment in Practice (NMC 2008). They worked closely with the academic tutors who were based within the Approved Education Institute (AEI) and were responsible for final assessment of practice and confirming required proficiencies for recording a specialist practice qualification on the Specialist Community Public Health Nurse part of the NMC register. Until the onset of the HVIP (DH 2011a), the PT-student relationship was generally a one-to-one ratio, however the increasing student numbers resulted in a short fall of qualified PTs to enable this ratio to continue. As a direct reaction to this, the model of mentor support and long-armed PT supervision was implemented in many areas under guidance from the NMC (circular 08/2011) (NMC 2011). This resulted in students often supported day-to-day by less experienced mentors, at least in comparison to their PT colleagues. Mentors were chosen to support students based on practice need and were supervised and supported by the qualified PT, who often indirectly supported a number of students in this way. The PT was still responsible for the assessment and sign off of competencies, but this was based on feedback from the mentor and her/his own interaction with the student, which would happen periodically throughout the SCPHN(HV) programme.

Evidence from participants demonstrates the significance of their relationship with the PTs/mentors that was fundamental to the level of support felt, with good support facilitating the transition (P7,Int2,p107). This is in direct contrast to unsupportive relationships with PTs/mentors, in which case participants felt it created a barrier (P8,Int2,p108, P1,Int3,p107). Strengthening my argument that, support from the PT/mentor and ultimately, the

participants relationship with them, impacted fundamentally on the way in the participants negotiated through this difficult and challenging transition (FG1 +2, p107).

These findings resonate with the work of Ibarra (1999, 2005) and Pratt et al (2006) (previously discussed within literature review) who both argue the role of experienced senior team members is important in encouraging and enabling the development of a professional identity. This is also echoed in the work of Sayer (2007) who explored the role of the PT in the socialisation of HVs and highlights the prominence of the PT in facilitating membership of the CoP and to a lesser extent, how this assists the students in the development of a HV identity. Sayer (2011), in an article based on her work undertaken in 2007, leads us to believe PTs allow access to the CoP once the student HVs have a HV identity and for this the PTs claim responsibility, i.e., they enable the students a HV identity through a transformation approach. She reports the PTs felt it took two to three months into the programme to achieve a time when students were displaying their new identity and until this time students are not trusted to take on the role's responsibilities. I would argue this process is much longer and a HV identity is not achieved until much later and even then, the primary identity remains at the core. Sayer (2011) also recognises the difficulties faced by the students as they move from their primary identity within her research. This research however is concerned with the PT perspective of this relationship, rather than, as in my research, the under researched student voice. By adding this much needed student perception my research also identified the deeply intense complexities of the transition, not only of identity changes but also of the way of working.

My research provides evidence of the importance of 'being trusted' as a factor of the transition to the HV role but in addition, adds a much-needed perspective to the existing evidence base, complimenting existing findings but also revealing the complexity of the student HV role. Lack of the learner voice and the impact of their individual experience is also a criticism of the CoP theory (Billet 2007, Roberts 2006). Morley (2016) also suggests Wenger (1998) fails to recognise individual influences on learning, including previous experiences. My research adds depth to this existing body of evidence through explicitly exploring these influences, specifically with HV students, which can be applied to the CoP paradigm.

In addition, at the time of Sayer's (2007) research the previous model of one-to-one support with a PT was in place, since then, and especially during the period of this research, the role of the PT in supporting the students changed significantly. For the most part, PTs no longer worked solely in a one-to-one relationship with student HVs, thus reducing their time together, with this close relationship being largely left to mentors who supported the students on a daily basis (Deave et al 2017). Importantly, Sayer's (2007) findings suggested it took three years for a PT to be effective in their role, in the process of what she terms *transformation* (p19). Yet, during the HVIP (2011-2015) and the period of this research, the mentors were often very new to the role and unlike PTs, did not benefit from training in underpinning educational theory. As, although this was a prerequisite for the PT role, it was not required for the mentor role. Thus, alluding to the fact mentor support rather than PT support may have been inadequate for the level of transition encountered. This is again an area for further research. It is important to note however that since this study took place there have been changes to the practice assessment model to reflect the requirements of the new NMC Standards for Education (NMC 2018a) and a move to PAs and PSs to support supervision and assessment in practice for all NMC programmes (see Appendix 17).

7.5.5 Resilience factor

Resilience has had much attention in recent years in nursing and midwifery and is described as the ability to bounce back after a stressful or difficult experience (Earvolino-Ramirez 2007, Rutter 1985). If a person is resilient, they are said to have a good rate of recovery and high level of determination to succeed in adversity (Hart et al 2014). It has been described both as a personal trait and a dynamic protective process (Delgado et al 2017). Resilience is especially important in the transition to the HV role, as participant evidence suggests that without this ability to bounce back and to keep going the transition process is severely hindered (P7,Int2,p107 and P1,Int3,p107).

In the professional nursing environment, the ability to be resilient is influenced by various factors; including the stress of demanding workplaces and experiences, a mismatch between personal/professional goals and organisational goals, feeling valued and cared about, the balance of demands from personal and work lives, and a dissonance arising from the incongruence between the expectation and realities of practice (Hart et al 2014). This

resonates with many of the participants' experiences, who, as previously discussed in this chapter, are struggling with feeling undervalued, changing perceptions of the HV role and complex and difficult situations in practice, especially in ways of working, safeguarding and child protection.

My findings suggest however that being resilient helps the participants to react positively to the challenges faced during this transition and not to lose sight of their personal end goal of becoming a HV (P1,Int2,p129-30), whereas those who struggle with resilience find this more difficult (P8,Int2,p129). Low levels of resilience are in fact associated with a poor sense of well-being, increased reaction to stress, increased likelihood of burnout, compassion fatigues and increased physical ill health (Delgado et al 2017), which may explain the increased difficulties for those with lower levels of resilience. Some participants were able to build strategies to enhance their resilience and help them through the transition, some learned strategies from others who had undergone the experience, again demonstrating the importance of support and some by using their own strengths and experience as a personal resource (P1,Int2,p109).

7.5.6 Moving forwards and being changed.

There were as you might expect remaining anxieties and fears surrounding the new role for many of the participants. The level of responsibility, accountability and worries around "*missing something"* (P5,Int3,p109) especially in child protection cases being paramount.

As the programme of study began to reach the end and the participants anticipated being qualified as HVs, they expressed a sense of relief that this difficult year was coming to an end. Some participants discussed returning to normality and regaining themselves at the end of this process reinforcing the previously asserted idea they had lost their sense of self, but also suggesting this was eventually refound. They reflected on being changed by the process through their new and enhanced skills, an adapted and enhanced knowledge base, a new way of thinking and perspective and have engaged with a new way of working and delivering care. For the participants rebuilding themselves with all these new components begins to feel like the reconfigured but new normal (P1,Int3,p106).

As they reached their goal of becoming a HV and near the end of the journey, the participants demonstrated pride, achievement and relief. The data demonstrates a palpable sense of this in all the participants, despite some of their difficulties during the process, as they reflected on the previous 18 months (P5,Int3,p79). This is a positive outcome for all, as even those who decided health visiting was not their future, recognised the immense value of a HVs education to their personal development. However, they (2 of 18) chose not to practise as a HV, returning to their old roles.

Finally, many participants started to look forward and plan their future as a HV, some even moved into specialist HV roles and began considering further professional development. At this point (six months post qualifying) the majority of participants (A16,T5,CC45) were able to visualise and accept themselves a HVs, adding 'health visitor' to their identity. Although still not able or willing to fully relinquish their primary identity as a nurse/MW, they did achieve a balance to allow the two identities to work together in a form of togetherness, summed up as,

> *I'm a health visitor – well I actually still feel as though I'm a nurse, but I'll always say I'm a health visitor and a nurse. (P1,Int3,p100)*

7.6 Development of the conceptual model

As already mentioned, early diagramming was employed to help visualise and further analyse the findings (Appendix 18) and it is from this early and further diagramming that it has been possible for me to build a conceptual model to illustrate the findings of this study, encompassing the three core categories, Role Identity, Way of Working and Living the Journey. Conceptual models are considered useful to diagrammatically present complicated relationships in a simplified visual way and allows for further deeper analysis and consideration of any significance and application to practise (Paradies and Stevens 2005). Hence, this chapter will now present a conceptual model in the form of a structured diagram to illustrate the findings of this study and the transition to a HV role (Figure 8, p145).

7.6.1 Using the model.

Having discovered the vast complexities of this transition I felt it imperative to provide an explanatory visual framework to support aspirant HVs, who may be considering or even currently undertaking the HV programme. It is hoped the wider HV community, it's educators

and workforce planners, will also find the model a useful resource in the support of the HVs of the future. The model provides a greater understanding of the many complexities encountered during the transition to the HV role, thus allowing for further analysis and consideration of strategies required to facilitate the complex transition. The model is co-constructed through analysis of the data, with mindful consideration of the participants voice and my theoretical interpretation of its meaning, to conceptualise, in a visual form, what is 'happening' during the transition to the HV role.

The interrelationships between the core categories are complicated and interdependent, with each impacting upon the other as the participants navigate through the transition to the HV role. It is vitally important these are considered together as their interdependency and interconnectedness to each other are a significant part of the whole process, each reliant on the other. For example, in order to allow a transition into a HV role the participants each experience simultaneously; a new way of working, a change to their identity and these two phenomena are also connected directly to the way in which the individual undergoing this transition experiences the journey. The three cannot be separated and each needs to be worked through to enable a successful transition. This conceptual model is therefore multifactorial and multi-directional, rather than a simple linear one-way process. It represents the whole of the transition, encompassing its three core categories (Role Identity, Way of Working and Living the Journey). During the analysis of the data and through further conceptualising and interpretation, I could see the three core categories each encompass progressive stages, through which participants had to pass to get to the final recentering stage, and hence move into the HV role. I have labelled these stages zones because of the earlier reference to '*comfort zone*' by one of the participants.

Thus, the model incorporates a series of coloured rings, which signify zones (stages) of the transition arranged within a cone shaped funnel, denoting the intended direction. For an individual to pass through the transition each of the core categories have to successfully align within this funnel. Thus, then allowing them to pass through the final zone and reach the HV role. Each of the categories are represented by a coloured sphere.

The transition is multi-directional for each core category, hence, any of the three can individually fluctuate in their level of significance and progress during transition and therefore

their position in the model. The blue coloured area within the model signifies the start of the transition moving from the comfort zone, through the red section (threat zone) to amber and green (adjustment, realignment and reconfiguration zones), to re-centre again in a blue, when the transition to the HV role is complete.

The threat zone encompasses the major tensions in the transition journey which have been discussed within this chapter. The model also illustrates areas of adjustment, realignment and reconfiguration as stages through which participants travel on their journey to become a HV before they eventually re-centre themselves as they complete the journey and transition. It is important however, for successful transition to occur each of these core categories need to be synchronised, with each reaching the final, re-centring zone.

In using the model, it should be understood, that individuals are able to move backwards and forwards through the zones within the model, as they did in real life, the zones being two-way and hence each stage not necessarily resolved completely before they begin to move into the next one. In fact, and a key finding of this research, is that for the participants the threat zone, although more concentrated at the early part of the transition, is threaded throughout the transition process. The threats are therefore also signified by the red rings throughout the transition. Thus, revealing the way in which the 'threat zone' can be reignited or new threats experienced and as the transition progresses into subsequent zones, these can hinder, stop or cause a regression.

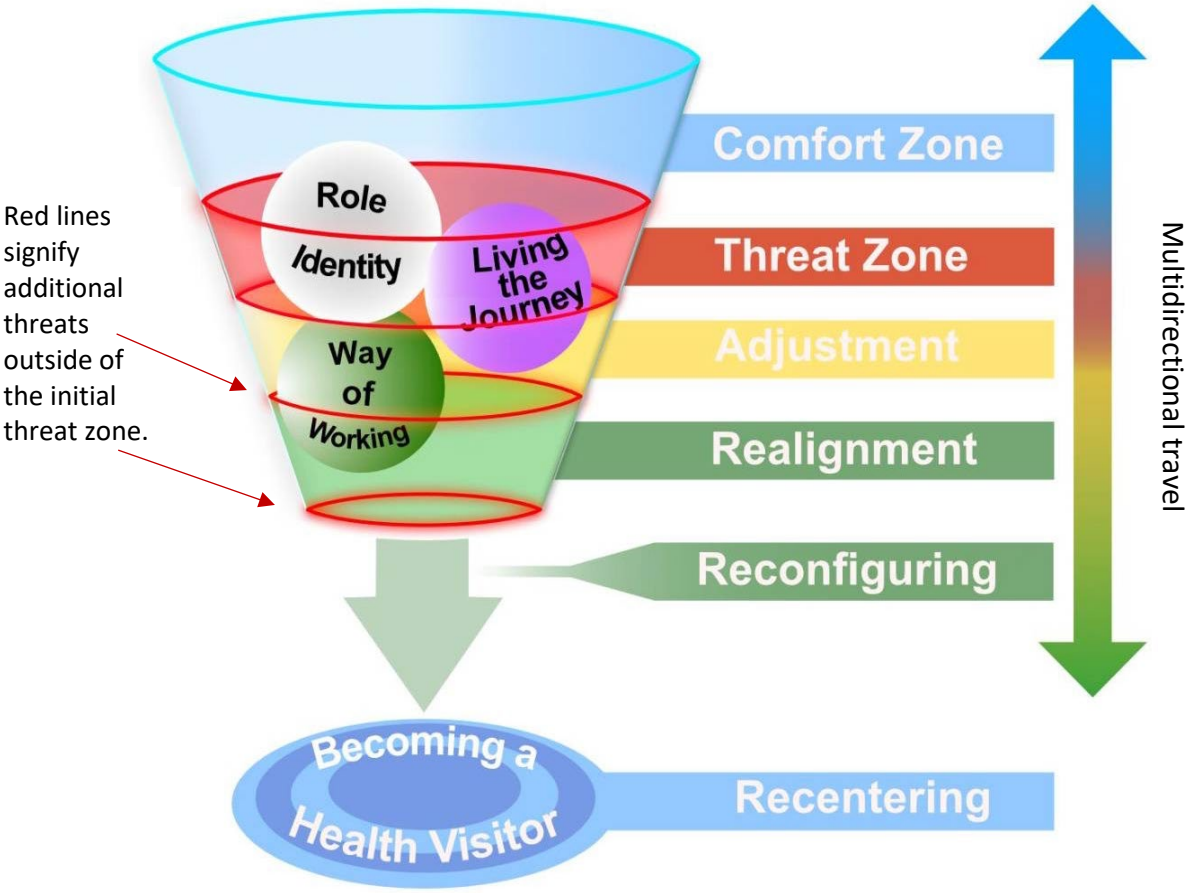
The conceptual model thus provides a meaningful and unique framework to facilitate the understanding of transition to the HV role. It is clear, from the preceding discussion, this transition is extremely complex and is fraught with many potential difficulties and threats and yet with appropriate support and individual tenacity these barriers are surmountable and ultimately, this is a largely successful transition. The following excerpt from one of the transcripts exemplifies the process exceptionally well.

> *It has been like a roller-coaster. The transition of doing something that I knew, and that I was good at. To then go and re-learn everything. But it was like starting from scratch, that's how it felt. Mentally for me, it's been fantastic…. I loved every minute, even the really hard bits. …… I was like "what on earth is happening? What am I doing?....." it's been really emotional, it's been an emotional year…... Ask me now if I'd go through it again? Possibly, I don't*

know. I'd like to think no I wouldn't, but I know I would, I really would. (P11 Int3)

7.6.2 The conceptual model of transition to a health visitor role

Figure 8



The Conceptual Model of Transition to a Health Visitor Role

7.8 Summary

Chapter seven has provided a critical discussion of the findings of this research. Exploring the process of transition to the HV role has identified the concepts of Role Identity, Way of

Working and Living the Journey as the three core categories. Each of these categories were further discussed and linked to relevant findings. Contextualisation through the discussion of the existing pertinent research and literature was also undertaken. Throughout this discussion, contributions to existing knowledge and areas of new knowledge and understanding surrounding the transition to the HV role, have been highlighted. Lastly, a conceptual model has also been developed to illustrate the findings of this research and help to support aspirant and current HVs and their educators as they move through the process of the transition.

The following chapter will bring together the key aspects of this study drawing upon the information discussed so far. It will also discuss the implications for practice and make key recommendations for both relevant practice and further research.

8.0 CONCLUSIONS AND RECOMMENDATIONS

8.1 Introduction

This study has explored the transition from a nurse/MW to a HV role, utilising a CGT methodology (Charmaz 2006). The following concluding chapter reviews the original aims and objectives of the study and draws together the key aspects of previous chapters. An evaluation of how the study contributes to the current academic knowledge base in this field, and its application to professional practice is then presented, emphasising the implications of the findings for practice. Study limitations and plans for dissemination are also discussed and finally, recommendations for the future, including for further research, culminating from the findings of this study are outlined.

8.2 Review of the original aims and objectives

- The original aim
  - To provide a substantive theory for the role transition from nurse or midwife to HV.

My original intention was to generate a substantive theory of the transition to the HV role. This has been achieved through the co-construction of knowledge, generated from the exploration of experiences of qualified nurses and midwives undergoing the role transition to become a HV. There was very limited previous evidence related to this concept, especially in the context of today's health care arena, and specifically within the enhanced recruitment period created by the HVIP plan, thus this study provides much needed understanding and knowledge in this field.

I achieved this through adopting a CGT approach to the research field (Charmaz 2006), probing, exploring and encompassing the participants' perceptions and voice, alongside my interpretations of the participants' data and relevant literature. This has provided detailed knowledge of the process of the transition. In addition, I have developed a conceptual model, which serves to illustrate this theory (Chapter 7, p145), encompassing the findings as the core categories, and the processes within these categories, throughout the transition. This

conceptual model should be used to help understand the transition to the HV role and represents the products of the data analysis and subsequent interpretations.

The original principal objective

- To investigate and explore the experiences of nurses and midwives undertaking a Specialist Community Health Nurse Programme (Health Visiting) and their transition to the HV role.

I was able to explore, in depth, the experiences of the participants during the process of transition to the HV role. Consideration was given to the whole of the transition period, with participant data generated via focus groups and interviews at key intervals, throughout the transition, allowing the exploration of changes over time. This has provided detailed knowledge of their experiences and how these have manifested over the period of the transition. Thus, allowing me to identify clear patterns and commonalities within the data. The participant voices are key to the findings of this study and have been carefully protected throughout the process to ensure integrity to their original meaning and offer a robust understanding of the process of the transition. Existing literature was also used to contextualise the experiences recounted by the participants.

The secondary objective

- To identify and explore influences on the process of this transition.

The identification and exploration of the influences on this transition process were achieved through this detailed process of inquiry and investigation. The study has allowed me to determine a complexity of influences, both positive and negative, that affect the process of transition to the HV role. This important understanding has allowed the consideration of strategies which could mitigate or enhance these influencing factors, and these will be offered as recommendations for practice.

8.3 Study conclusions

Transition to the HV role is extremely challenging, complex, multifactorial and multidimensional, being centred on the core categories of Role Identity, Way of Working and

Living the Journey. These categories have been used to present the conclusions to the study. There are key aspects of transition to the role which need acknowledging to allow future aspirant HVs, and their support network, to minimise the effects of this transition and ultimately make the process easier through adequate management and support.

8.3.1 Role Identity

The challenge to, and subsequent reformation of role identity, is a key component in the transition process; this is influenced by a complexity of factors. These include the philosophical underpinning of the participants existing nurse/MW identity and the strong connection felt to this as their primary identity. The effect of the strength of this primary identity is felt throughout the transition to a HV role and challenges to this enduring connection are experienced as a significant threat. This created an unanticipated intensity of feelings, significant stress, and anxiety. The process of developing an HV identity also involves simultaneously, negotiating acceptance into the established HV CoP alongside disconnecting from their previous CoP. The move out of this previous CoP is difficult and is felt as a noticeable loss. In fact, this loss of belonging, and the threat of loss of their primary identity, are critical factors in this transition.

There are also a number of issues which exacerbate this, for example, a lack of recognition given to the primary identity of nurse/MW, the challenge of being a student and the need for recognition of the previous qualified status from other HVs, members of the MDT and clients.

Additional factors which impact upon the move to a HV identity, are the perceived negative image of the HV (McHugh and Luker 2002, Donetto et al 2013) and the subsequent desire to change this image, to align the role to fit their aspirations. This, alongside ambiguities in the known professional identity of the HV, produce difficulties in understanding what the HV is and hence, how to become one. Better established definitions of the HVs professional identity, removing the ambiguities associated with the role are important here and are a key recommendation of this research. This has also been identified as a significant need by other researchers (Whittaker et al 2017, Cowley et al 2015, Machin et al 2012, Stansfield 2016) and yet this remains a problem, the reasons for this are unclear but I feel action in this area is essential. In addition, and adding to the role ambiguity, health visiting continues to be plagued

by the ever-fluctuating political landscape which impacts on the role's priorities and the service it provides. For example, since this research was undertaken there has been a shift in the way in which HV services are commissioned. Now local authorities, as part of the transfer of commissioning of public health services for the under-fives from NHS England to local authorities, undertake this role (DH/PHE 2014). Further developments are also currently underway as the NMC is reviewing the standards for post registration practice, including SCPHN (see Chapter 1 p5) (NMC 2021). In a sense this offers the opportunity to remodel the HV role and provide increased definition. The current standards (NMC 2004) will be withdrawn in 2023 and replaced, based on the conclusion of a detailed review (Pye Tait 2020) and a public consultation. This may yet create further complexities for the professional identity of the HV role. However, my research does provide insight into the effects of the lack of clarity in the role and the need to consider the influence of this during the transition process.

It is overwhelmingly clear the challenges, ambiguities and lack of recognition, obstruct the transition process, causing it to falter or even fail completely. Despite this, a supportive, encouraging environment, alongside personal determination, enables the move towards the HV role. This process appears both conceptual and behavioural, with immersion in the HV practice environment and a period of testing and trialling out the HV role leading to a new way of thinking, as participant 7 put it *"that's when I think as a health visitor"* (p98). However, in this move to the HV role, the primary nurse/MW identity is still strongly upheld, triggering the need to manage both the primary and HV identities.

The findings of this study suggest, this developing multiple identity is achieved by adopting an ***attachment identity structure*** (p121), where the two identities becoming balanced in a mutually beneficial way. The importance of stabilising the two identities is essential to allowing them to work together successfully. This understanding surrounding the development and structure of the HV identity is unique to my study, providing important new evidence of the process of managing multiple identities through the perspective of the participants.

8.3.2 Way of Working

The way of working changes fundamentally throughout the transition process, which begins with autonomous, qualified nurses and midwives with existing expertise in their previous roles. However, early into the transition a mismatch between this previous expertise and that required as a HV culminates in a clear sense of becoming novice again. This impacts on autonomy, confidence, sense of value and self-worth, leading to a reduced sense of well-being. These changes to levels of autonomy are particularly difficult for many participants, as they move from high levels of autonomy in their old role, to plummeting levels of autonomy and self-efficacy as they move through the transition. There is some return to autonomous practice near the end of the transition; however, this itself provides some further tension, as new levels and areas of responsibility are required.

There are important skills and attributes the participants related to their qualified nurse/ MW background, that they identified as supporting their role as a HV. Interestingly however, these are generic, transferable skills of communication, assessment, prioritising and holistic care giving, rather than any specific clinical skills they have obtained as a nurse or MW. Hence, they may also be considered the foundation of other health and social care professionals (HCPC 2016). This leads me to question, if in fact, it is essential for a HV to first be a registered nurse or MW? Despite the assertion by my participants that their experience as a nurse is fundamental to the HV role, I advocate further research should be undertaken to explore the potential for other methods of entry into the role. This should include whether a direct entry, without the pre-requisite to be on the NMC register (part 1 or 2), similar to the existing direct entry route in midwifery education, should be possible. I would argue that it ought to be as this would potentially alleviate some of the intensity of the transition, by removing the significant issue created by the primary identity. This move to a direct entry to the profession, has been suggested and discussed previously within the literature by Cowley and Bidmead (2009) and the IHV (2013) who consider the benefits of flexibility in the entry criteria to health visiting would enhance recruitment. This was also reiterated in the IHV recent response to the aforementioned NMC consultation (Nettleton 2021). In the future it would be very interesting to compare the transition to the role from fields other than nursing, perhaps social care or early years professionals. However, this would require a change in legislation at

present and therefore is a significant, but importantly, not insurmountable, challenge (IHV 2014).

Changes to the way of working also occurs in terms of managing and delivering care and is another important aspect of the transition. This includes the lack of immediacy of care, and the effect this can have on personal reward systems. In addition, there is a move to the universalism model of care delivery, which relies, in part, on unsolicited care. Participants really struggled with the notion of feeling unwelcome and *selling the service* alongside the sometimes negative response to the HV from clients and families, which are created by the links to surveillance and scrutiny of family life and child development.

The culture shock experienced by many participants surrounding the level of child protection, deprivation and safeguarding issues was also obvious and very challenging, adding to the levels of anxiety felt during the transition. This is an area in which enhanced preparation for this element of the role could alleviate some of the levels of stress felt and in addition, this warrants further investigation for the health visiting profession as a whole.

A further difficulty in the transition process is caused by the broad nature and wide-ranging responsibilities encompassed in the HV role. This, coupled with the ambiguous professional identity previously mentioned, leads to unclear role boundaries and a blurring of the responsibilities between the HV and other health and social professionals. This again leads to recommendations surrounding the professional identity and role description of the HV, which needs to be more closely defined in order for those undergoing to transition to understand what they need to become.

In making changes to the way of working there is obviously a need for a period of learning to close the skills and knowledge mismatch that has developed as the transition process moves forwards. The environment impacts significantly on this learning process and the previously mentioned CoP is fundamental in offering support through role modelling, peer support, shared learning resources and acceptance. PTs and mentors (now PAs and PSs) were critical in supporting the use of existing areas of expertise, gained in previous roles, nurturing and recognising the benefit these wider skills may bring to the HV role. The resistance to accept these benefits by some PTs and mentors led to a real sense of incongruity between the

participants and the HV role. The challenge brought by new members to the profession from different backgrounds may have been difficult but should be seen as an enhancement to the HV profession, rather than to be resisted, which this study demonstrates was often the case. The lack of recognition for previous experience was an area in which all participants had difficulties and it is important to recognise this. It is also an aspect of the transition process in which enhancements can be made with relative ease, whilst making a significant difference.

Practise is extremely important in allowing the participants the opportunity to be immersed in the HV role. This engagement allows the development of a new perspective on practise and a move to a new way of working. Although to begin with this is overshadowed by the significance of their previous role and existing way of working, this is gradually replaced through a period of experimentation, challenging themselves in increasingly complex situations and drawing on their new perspective until this became the new normal.

In times of stress and challenge during the transition, this study demonstrates that the old way of working and perspective is restored, sometimes only briefly until levels of stress subside, and sometimes remaining significant (as is the case in the participants who chose not to practise as HVs after qualifying).

8.3.3 Living the Journey

The experience of the journey itself is fundamental to the whole transition to becoming a HV and by that, I mean the way in which it is experienced, not simply what is experienced. The transition is viewed by the participants as a difficult journey, as exemplified by the terminology they employ to explain what is happening to them, such as, "*the long road"* (P1), and this is to be expected. However, the language they use also points to the intense nature of this journey. It is akin to a rollercoaster with many ups and downs, and twists and turns along the way.

The intensity of the journey, as the experience of dealing with changes and threats to role identity, changes to their established patterns and ways of delivering care and the loss of value, autonomy and self-worth, is particularly notable. The losses felt are certainly not anticipated by the participants, who really struggle to negotiate this challenging time and who

can be resistant to these changes, particularly when they feel vulnerable. The losses are experienced so intensely because of their simultaneous nature, but also because they are felt very personally, linked to their sense of self and personal values and not simply about changing role. This detailed knowledge of the nuances of transition are important new knowledge and help to understand the effects of the process.

A supportive network of the wider HV community, especially PTs and mentors, was fundamental to alleviate the series of challenges, threats and negotiations which are encountered in many aspects of becoming a HV. For example, in the challenge in determining access to a new CoP, important in the formation of a professional identity, the role of the PT/mentor and other established members of the community are vital as they act as gatekeepers to the CoP of HVs. This support network is also important as a source of recognition in this journey, initially for existing skills and expertise and also in providing trust in competencies as the students begin to work in the HV role. I would argue therefore the current and future PA and PS should be sufficiently experienced and prepared, to ensure their effectiveness in such a pivotal role within the transition. This should include a theoretical underpinning in teaching and learning theory, that at the very least, considers the impacts of the learning environment and importantly, it should also include consideration of the complexity of the transition, based on the findings of this study.

Additionally, it was also important to feel trusted by the families and clients who the HVs work alongside, as they also provide important endorsement and further recognition, allowing validation of the claim to the HV role. The clients, therefore, are also recognised as important gatekeepers in the process of transition to the HV role.

The motivation levels of the participants change through the transition, starting very positively and dipping as they realise the nuances of the HV role and face the many challenges of the transition. Motivation for the role and the end goal of being a HV, therefore, fluctuates up and down throughout the journey and can be positively influenced by a number of factors. This includes the aforementioned effective support network and the student's own levels of determination and tenacity. The participants who displayed stronger resilient traits were clearly able to manage the transition more effectively. Resilience is an important attribute within the transition, as it allows for quicker recovery from the complex challenges and many

threats experienced. The development and enhancement of resilience is therefore paramount in enabling an improved transition experience and should be encompassed within the HV educational programmes. This should include an understanding of building resilience targeting the educators, PAs and PSs that support the programme.

Nearing the end of the journey, levels of autonomy and confidence increased, and wellbeing grew but there were still anxieties present, especially surrounding the fear of not being competent and of *missing something.* This is mostly in relation to child protection and safeguarding cases and the new levels of autonomy and responsibility now held. However, the sense of pride and achievement as they entered the HV profession and settled into new roles as qualified team members is obvious. Importantly, referring to themselves as *'nurses'* persisted but this now was alongside the HV title. It will be interesting to revisit this in the future. Ideally, I would like to undertake a follow up study with the same individuals where possible, to explore how this developed over time.

The in-depth understanding this research has identified will assist in providing tailored support for aspirant and current student HVs, both within university and practice settings. This will reduce attrition, enhance retention in the workforce and improve the experience from all perspectives, including students, employers, the established HV community, commissioners and importantly clients. As this understanding may reduce the challenges and threats of this transition it could also ultimately improve role satisfaction and encourage lasting HV careers, potentially saving costs in recruitment.

8.4 Contributions to academic knowledge and professional practice.

The literature review (Chapter 2, p9) identified an existing body of research exploring role transition within health care. This is predominantly focused on transition to a NQN and emphasises important factors in a successful transition. There was, however, a distinct lack of research exploring transition to the HV role. Thus, this work enhances the current wider evidence base alongside, providing important new understanding of HV role transition.

With consideration given to the established evidence base within nursing, and my own experiential knowledge, gained through witnessing first-hand the difficulties faced during the HV role transition, it was clear, research in this field was essential to provide important

understanding of the process. Importantly, this understanding, could potentially allay some of the apparent difficulties in the transition and aid retention to the HV role, which was pertinent both at the time of the research (due to the recruitment drive) and currently as numbers in the profession fall (IHV 2021).

The existing body of literature that does relate to the HV role, primarily explores and highlights the HVs fluctuating professional identity, emphasising the difficulties caused by poor HV role definition. This creates conflict between role expectations and role satisfaction, that could ultimately jeopardise workforce retention. Thus, my research is important as it also adds further insight into the characteristics and attributes of the HV, through exploring transition to the role. This enables further definition and clarification of the HV role which could ease the transition process through providing a clearer picture for aspirant HVs of their eventual objective; being a HV.

This study provides a clear contribution to the current academic knowledge within the substantive area of health visiting. It achieves this through the theoretical explanation and interpretation of the process of transition, thus developing a substantive theory, through the systematic inquiry, offered by a CGT. Within this theory the three categories of Role Identity, Way of Working and Living the Journey encompass the inherent concepts and processes experienced in the transition, discovered during this research. Within the three categories, there are many specific contributions to knowledge, these include;

- The in-depth knowledge of the complexities of identity during the transition, including the significance of, and deep connection to, the primary identity.
- The distinct need for recognition of the primary identity.
- The perception of others surrounding the HV role, including the impact of the HV title.
- The impact of the ambiguity and uncertainty of HV role definition on transition.
- New understanding of the way in which the transition leads to multiple identities of nurse/MW and HV.
- The experience and impacts of a new way of care delivery on many levels, including the effect of the long-term influences of HV practice, the dissonance felt between wanting to intervene in the practice area and the need to refer to other agencies, the

impact of unsolicited care and the emotional demands of the HV role, especially in child protection and safeguarding.

- The difficulties experienced because of the blurred role boundaries in health visiting and perception of the need to become many health and social care professionals in one.
- The intensity of feelings experienced in the transition caused by a multitude of losses, vulnerability and insecurity, affecting self-worth, importantly these are not contained in one area of the transition but are interwoven throughout.
- The importance of acceptance, recognition and being trusted from the wider HV community and HV clients.
- The absolute critical nature of relationships with PTs and mentors (now PAs and PSs).

Ultimately, my research has explored the process of the transition to the HV role in-detail, longitudinally and in real time, synchronised with the experience itself, rather than it being retrospective. Crucially, this is from the perception of those undergoing the transition, thus providing a robust and deep understanding of the nuances and idiosyncrasies of the process.

The value of my research is that it provides a significant and rich evidence base for the transition to the role of HV, addressing the deficit in the present research base and providing a meaningful and unique contribution to knowledge in the HV field. This research has provided a deep understanding of the process and culminated in the development of a substantive GT as illustrated by my conceptual model (p145). The model offers a way of explaining and illustrating the three core categories and how they relate to one another throughout the transition to the HV role. It helps to visualise the different phases or stages of the transition and how this may be experienced. The understanding it provides can facilitate aspirant HVs and other stakeholders (PAs/PSs, work force planners, educators) to anticipate some of the difficulties in the transition and thus, consider ways to mitigate the many challenges identified within this study.

The model has been presented to various audiences since its initial development including PT/PA study days and the RCN Education Conference. The feedback received so far suggests it will be a valuable asset to those directly involved in the transition to the HV role, namely educationalists and PAs/PSs and current and aspirant student HVs. Additionally, I have

become increasingly aware it has potentially far-reaching influences. In particular, I was asked to present my research and the conceptual model to a group of advanced practitioners and specialist practitioners in a local acute trust. Here there was a resounding agreement the model has potentially significant use in the preparation of individuals entering the advanced practice role. I have since begun to share this with new recruits to the advanced practice role. I have also been asked to share my findings with the Royal College of Surgeons and possibly undertake further research with them to explore the application of the conceptual model in their recruitment and training of physicians (anaesthetics) and surgical assistants. These roles are both fulfilled by non-medical, registered HCPs from a variety of background professions and hence, it is clear to see how the conceptual model may be helpful to support their transition.

8.5 Limitations of the study

Deciding to use CGT to undertake my study was based on careful consideration of the best way to address the aim of the research (see Chapter 3). The methodological limitations of this research must be recognised despite the previously discussed use of reflexivity to ensure rigour (see Chapter 3, p48), these relate mostly to the risk of researcher bias.

I was engaged in delivering education to HV students for many years and this knowledge could have potentially provided a skewed view of the findings. However, the strength of this positionality is an understanding of the context of the participants experiences in more depth than a complete outsider researcher. It has also allowed me the privilege of credibility with the participants, who all knew me as part of the lecturing team and considered me as a legitimately interested academic researcher. This I feel, enabled a willingness of the participants to share their experiences with me and to trust me with their stories, as we developed a mutually interested rapport in the joint pursuit of knowledge. Importantly, as previously mentioned, I am not a HV and have not personally experienced the process of transition to a HV role and I believe this allowed me the benefit of a greater inquiring mind and hence pushed me to delve deeper into emerging concepts to ensure clarity in meaning. I have however included a broad range of verbatim quotes from the participant transcripts within Chapter 6 to represent the data without the risk of bias in interpretation of these

findings. In addition, I have carefully crafted the design of this research to ensure adherence to the tenets of a CGT study, keeping the need to ground the theory in the data at the forefront. I have detailed these processes within Chapters 3, 5 and 6, again adding rigour to the findings and to the subsequent development of the substantive GT.

The specificity of a substantive theory as a product of this research could be considered as a limitation. However, the usefulness of the subsequent conceptual model has already been validated via feedback from HV students and educators and in sharing the model more widely, both locally and at national conference. There is also clear resonance with other role transitions, suggesting this usefulness may extend beyond the substantive area.

A further potential limitation could be that the participants were derived from one cohort of HV students only. However, the demographics of the sample in this study closely resembles that of other research undertaken within the HV field (Brook et al 2019), suggesting the sample used within my study was typical, in nature, of the student HV body at that time. In addition, what was important was that each field of nursing and midwifery was represented by the eventual participants and thus, allowing exploration of any influence this might have had on transition to the HV role.

8.6 Recommendations

There are numerous recommendations for future practice and education to facilitate easier transition and to provide further research evidence in this field. These are as follows:

For practice:

- Dissemination of the findings of this research and the substantive theory of transition to the HV role is essential. This should be shared widely, especially with potential and new recruits to the role and those that support the role transition.
- This will be achieved through publication and strategic targeting of relevant gatekeepers including IHV, CPHVA and UKSC, alongside sharing the findings widely with AEIs and HV employing Trusts. This will also include highlighting the importance of the following:

- Recognition of the value of individual recruits to the HV role and their specialist skills and knowledge is essential and is an aspect in which enhancements can be made to the transition process with relative ease.
- Further preparation and support is needed for the emotional challenges of the role, in particular the child protection and safeguarding elements of the role. This should be aided by the enhancement of the current knowledge base within this subject (i.e., via research (p161)).

For education:

- A package of workshops and other learning events should be offered to aspirant and current HV students, academic assessors (AAs), PAs and PSs (previously PTs and mentors- see Appendix 17). This is to disseminate the findings of this research and share the conceptual model of transition. These will facilitate the exploration of role identity and the many difficulties and challenges faced during the transition process, as identified through this research. This should be at the very beginning of the HV programme or even in preparation to join a programme. It should include consideration of the threat to identity and loss of status and will involve enabling aspirant and HV students to build strategies, through discussion and peer support, to lead them through the change.

- In addition, a greater focus on building resilience, both with students and their support networks is required. This should explore the importance and enhancement of resilient tendencies, promoting effective recovery from the challenges of transition and encouraging tenacity and determination to succeed. The inclusion of methods to support resilience should be an integral part of all HV programmes of study.

- Workshops and focused study days should also be offered with the established HV CoP, including PAs and PSs to explore their impact upon transition to the role and how they can enhance the experience and benefit the profession through increased retention and diversification of the workforce.

- Preparation for the HV PA and PS role is vital. Both should be sufficiently experienced to ensure their efficacy as a key influence on the transition process. This should include a theoretical underpinning that encompasses the complexity of the transition based on the findings of this study. These findings should also be used to develop an evidenced based curriculum to support the preparation of these roles. All HV PAs and PSs should be required to undergo this or a similar curriculum.

For further research:

- Further research should be undertaken to enhance the understanding surrounding the management of the multiple identities within this transition.

- Further research should be undertaken to explore the altruistic nature of nursing/MW versus health visiting and the influence on personal reward systems, based on the different models of care delivery.

- Further research is required surrounding the professional identity and role definition of the HV *per se*, this would alleviate some of the problems created by the role's ambiguities and facilitate better understanding of the role.

- Further research should be undertaken to explore the potential for other methods of entry into the role, exploring specifically direct entry (without the pre-requisite to be on the NMC register) similar to the existing direct entry route in midwifery education or a return to integrated nurse/HV dual qualification programmes. This would potentially alleviate some of the intensity of the transition.

- Further research is needed into the effects of child protection and safeguarding responsibilities and experiences on the HV, to understand the current impacts of this crucial element of the role. This would help to provide more detailed information to potential HV recruits and assist in supporting colleagues with this difficult area of practice.

- Further research is needed from the perspective of the PA, PS and student role to explore the experiences and effectiveness in supporting the transition specifically.

- As a continuation of this research, I would like to widely test the conceptual model with future aspirant HVs to allow further scrutiny of its use.

- Additionally, I would like to follow up participants, where possible, to establish further retrospective insight into long term transition.

- This research should now be repeated in other areas of transition (e.g., transition to the advanced practitioner role) to further develop the theory.

8.7 Dissemination

In dissemination of this work to date, I have already had the opportunity to present early findings and recommendations to the United Kingdom Standing Conference (UKSC) for Specialist Community Public Health Nurse Education, generating much discussion and being asked to return with my final findings. This is important as the UKSC membership consists of UK leaders in the field of education of SCPHNs. This is real opportunity to share my work with influential leaders who can help to further disseminate this important work. In addition, the IHV and CPHVA both influential in shaping the HV service, will be approached to share the findings and my recommendations for the future.

I also presented the interim study findings at the International Conference and Exhibition hosted by the RCN Education Forum, Nursing education and professional development: the global perspective (Appendix 19). This again provided interesting discussion and highlighted the resonance of my work to other transitions of this nature, where the starting point is from an experienced professional role. For example, in the transition to a role as an Advanced Clinical Practitioner (ACP). ACPs come from a variety of backgrounds across numerous health care professions e.g., nurses, pharmacists, paramedics, physiotherapists etc. and since this presentation I have been asked to share my research with cohorts of other professional groups, managers and mentors, recently sharing the work at an ACP Masterclass event.

I now plan to disseminate through publication in academic journals targeting the Journal of Advanced Nursing and Nurse Education Today to reach out to academic colleagues, PAs and PS and other stakeholders. In addition, the Journal of Health Visitors will also be approached, this professional journal is accessed by many HVs and therefore has a wide relevant readership. I would also like to pursue the development of a student focused text book to support this important transition.

I also hope to develop an animated version of the conceptual model which could be used by students, educators, lecturers, PAs and PS to explore and demonstrate the findings of this study. Enabling them to consider and support the many issues faced during the transition to the HV role. This could be offered as a shared reusable learning object and hence a widely available resource.

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APPENDICES

Appendix 1

Recruitment Drive Flyer

Back of postal shot flyer from recruitment drive

Front of postal shot flyer from recruitment drive

Inside of postal shot flyer from recruitment drive

Appendix 2

A brief history of health visiting (presentation for aspirant HV students)

Slide 2

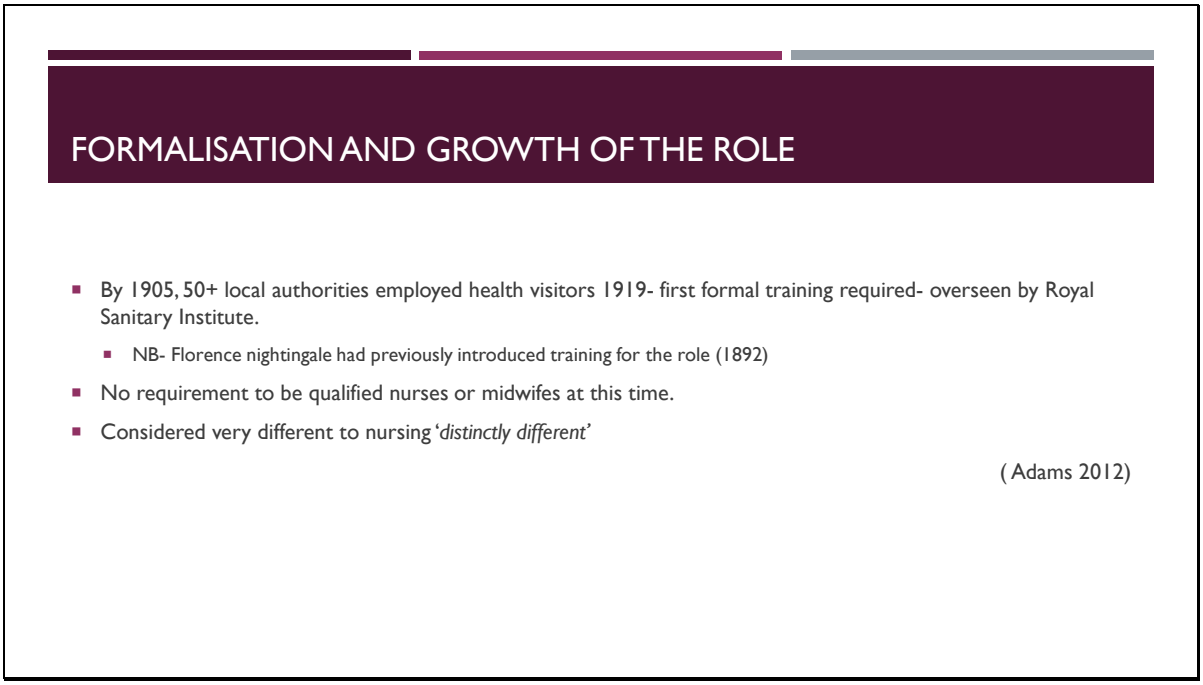
WHEN DID IT ALL BEGIN

- Victorian era
- Middle class volunteer group of women
  - Health promotion (sanitation)
  - Disease prevention (mostly related to high infant mortality rates)
- Originally 'Sanitary Visitors' from the Ladies' Section of the Manchester Association formed in 1862 (Haynes 2006).
- Became 'Health Visitors'
- First employment by local authority public health department to visit 'the poor'
- Offered education and advice, mostly to mothers about child health/care.

'The Sick Child', c.1875. Print after Joseph Clark. / Wellcome Collection, Creative Commons

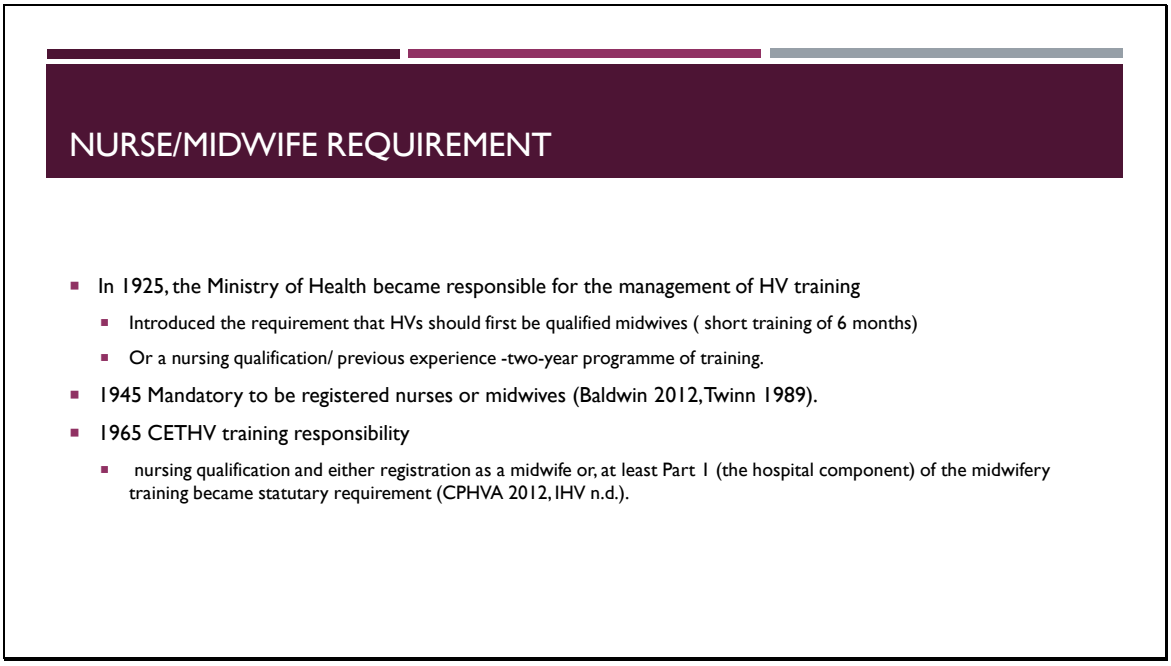
The health visiting profession began in the victorian era as a largely volunteer workforce of middle-class women who worked with poorer families, advising and supporting them in matters relating to health promotion (sanitation) and disease prevention, principally in response to high infant mortality (Baldwin 2012). The term 'Health Visitor' is derived from the name 'Sanitary Visitor', first given to the group of women from the Ladies' Section of the Manchester and Salford Reform Association formed in 1862 (Haynes 2006) who are considered the predecessors to the present-day HV role (Peckover 2013, Adams 2012, Baldwin 2012). These sanitary visitors were employed by the local authority public health department, to visit the homes of poorer families and to educate in all aspects of health, advising families and in particular, mothers the best way to care for their children. This covered hygiene, diet, family support and mental health, its purpose to prevent disease and promote good health (Baldwin 2012, Adams, 2012).

Slide 3



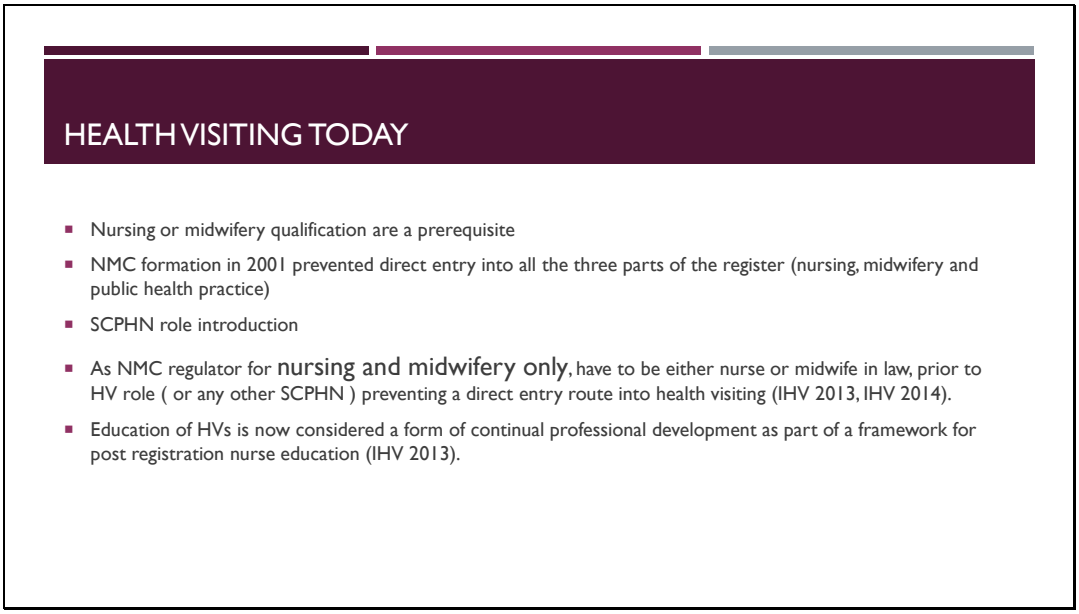
Further formalisation of the role followed and by 1905 over 50 local authorities employed HVs (Adams 2012). It was however, not until 1919 that HVs were expected to have formal training specifically for the role, this was despite the introduction of a training course by Florence Nightingale over twenty years earlier (1892) (Adams 2012). This first official education of HVs was originally overseen by the then, Royal Sanitary Institute and in this early period there was no requirement for HVs to be qualified midwives or nurses, as there is today. Interestingly, in the early development of the role, nursing was seen as being very different to health visiting. Florence Nightingale claimed that comparisons to nursing were unnecessary as the role required different qualifications and skills because the work was distinctly different. She also advocated a new profession separate to nursing should be created (Adams 2012).

Slide 4



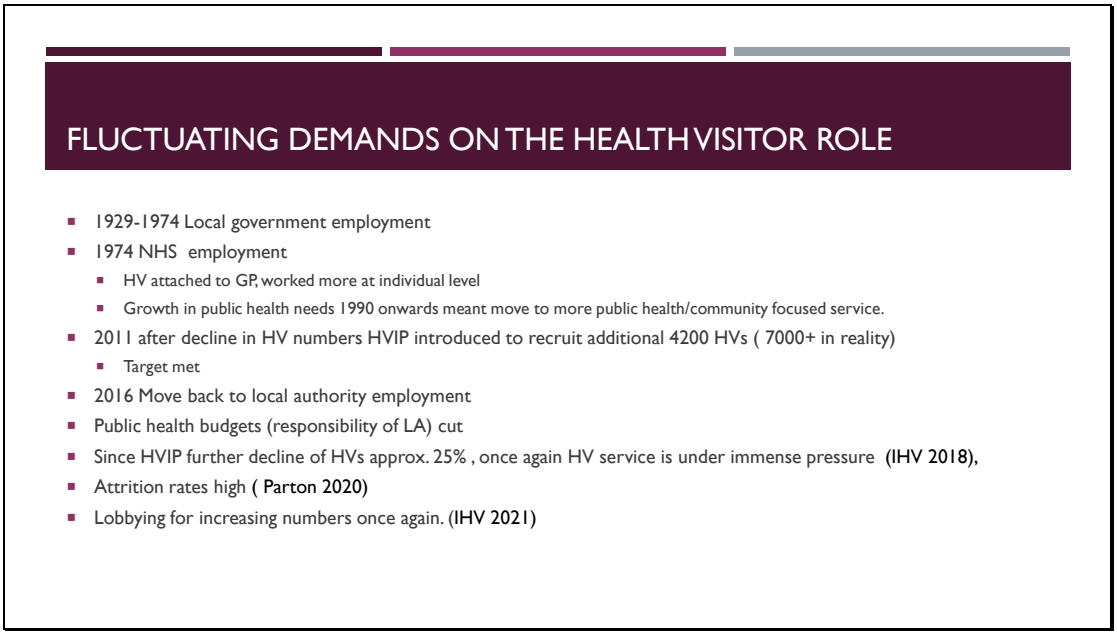
In 1925, the Ministry of Health was responsible for the management of HV training and introduced the requirement that HVs should first be qualified midwives if they were to be allowed to enter a shortened training of six months. For others, a nursing qualification or previous experience in the role allowed entry to a two-year programme of training, adding to the number of entry routes into health visiting and helping to create a dichotomy within the profession. It was not however until 1945 that it became mandatory that HVs should be registered nurses or midwives (this is considered as a result of the influence from the Medical Officers of Health (Baldwin 2012, Twinn 1989). In 1965, this was strengthened by the CETHV, now responsible for the training of HVs, to include both a nursing qualification and either registration as a midwife or, at least Part 1 (the hospital component) of the midwifery training. This was a statutory pre-requisite for entry into HV training (CPHVA 2012, IHV n.d.).

Slide 5



Today a nursing or midwifery qualification are a prerequisite, which is due to the way in which the profession is regulated (as a sub-part of the register, the SCPHN registration can only be given to those already on the main register as nurses or midwives). Additionally, the education of HVs is now considered a form of continual professional development as part of a framework for post registration nurse education (IHV 2013). Interestingly during the consultation regarding the formation of the NMC, it was proposed that the three parts of the register (nursing, midwifery and public health practice) each have a direct entry route, this, however, was not supported for health visiting as the NMC is only able to regulate for nursing and midwifery, thus preventing a direct entry route into health visiting (IHV 2013, IHV 2014).

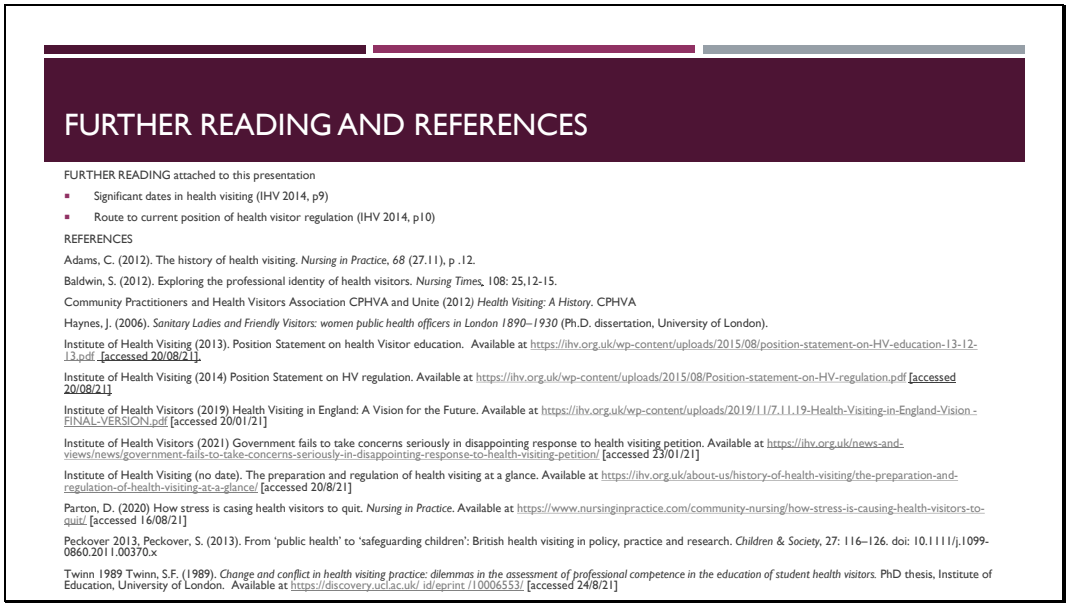
Slide 6



The move from local government employment established by the 1929 Local Government Act to NHS employment in 1974, produced a further shift in practice probably due to the dominance of hospital care at the time (Baldwin 2012). Alongside this as HVs became attached to general practice, they were less involved in the health of communities working at a more individual level. Yet as public health became a national focus in the 1990s, the public health remit became a focus once again and continues to the present day (see the following for further historical detail).

Today competing demands and fluctuations in policy continue to plague the profession. Since the HVIP there has been a year on year reduction in public health spending (England) and a decline in HV numbers of around 25%, (IHV 2018), this coupled with the impact of the current pandemic and the redeployment of some HVs to support acute services has led to the present HV service being under immense pressure to support those most vulnerable in our society and the stress and demands of the role leading to increasing attrition from the role (Parton 2020). The IHV (2021) are currently lobbying for increased numbers into the profession back to the HVIP numbers.

Slide 7



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Significant dates in health visiting (IHV 2014 p9)

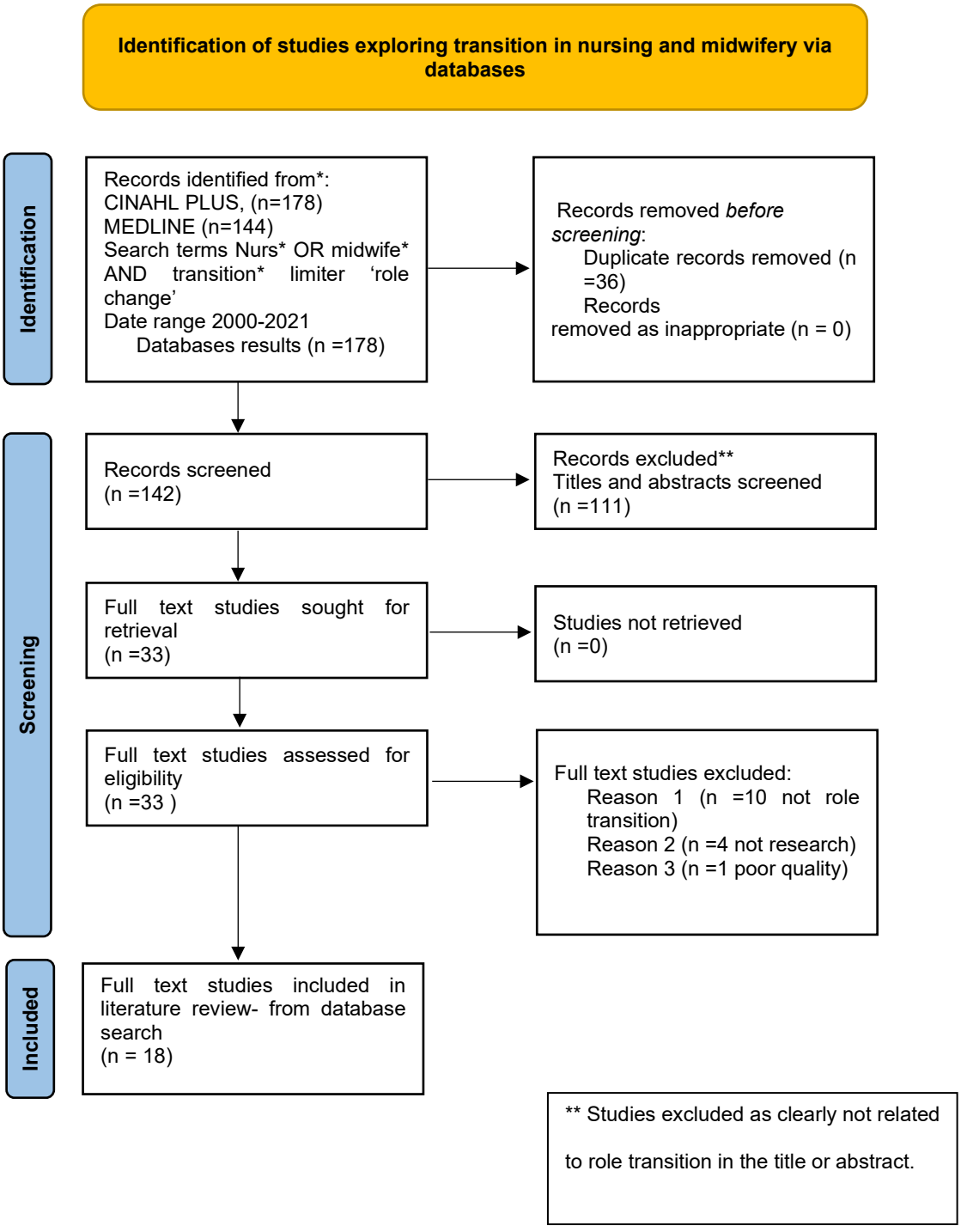
- **1862:** Manchester and Salford Ladies Sanitary Reform Association decide to employ working women to visit homes to offer practical help, advice and education about health; this is usually cited as the start of heath visiting
- **late 19th/early 20th century**: Courses of lectures run by Medical Officers of Health and various institutions throughout the country. Qualified women sanitary inspectors (fore-runners of environmental health officers) were employed to undertake health visiting duties in addition to their other work.
- **1890s onwards**: increasing number of certificated courses for health visitors; these were usually for 2 years, or 6 month for graduates, qualified teachers or nurses.
- **1907/1915:** Birth Notification Acts: began a national service based on home visiting to newborn infants. Once local authorities were permitted to raise revenue via the rates to pay for health visiting, qualifications began to be stipulated.
- **1909:** Health visitors' (London) Order for London CC Area. **First statutory qualification,** in London area only.
- **1916:** Royal Sanitary Institute (now Royal Society of Public Health (RSPH)) began co-ordinating qualifying courses for health visitors; still 2 years or 6 months for graduates/nurses: **first 'voluntary register.'**
- **1925:** Ministry of Health took over responsibility for the training of health visitors. At this stage, qualifications were definitely required for the work; a midwifery qualification was a pre-requisite. Royal Sanitary Institute was the designated examining body.
- **1929:** Local Government Act Statutory Rules and Orders (1930 No 69) laid down qualifications for health visitors and tuberculosis workers; later adjustments in Public Health Act 1936 and Education Act and School Health Service Regulation 1959. Royal Sanitary Institute as regulating authority: **'statutory register'** through secondary legislation
- **1945:** Establishment of 1 year Health Visitor Tutors course at Royal College of Nursing.
- **1945:** National Standing Conference of Health Visitor Training Centres (now UK Standing Conference of Specialist Community Public Health Nursing Education and Training Centres) established.
- **1948:** National Health Service (**Qualifications of Health Visitors** and Tuberculosis Visitors Order) Statutory Instrument Number. 1415. Health visitor certificate confirmed as statutory requirement for practice as a health visitor.
- **1950:** Royal Society of Health (now RSPH) revised syllabus and extended training from 6 to 9 months minimum for qualified nurses and midwives
- **1956:** Jameson Committee reports on health visiting: recommends establishment of the Council for the Education and Training of Health Visitors (CETHV) (initially jointly with social work; later amended and separated).
- **1962:** CETHV legally established as new regulating authority. They developed a curriculum for a *'new breed of health visitor'*, based on a 51 week course (implemented 1965). Nursing qualifications became a statutory pre-requisite for entry into health visitor training for first time. CMB Part 1 or Registered Midwife also still required prior to entry to the training at this stage. CETHV responsible for research and workforce, as well as education.
- **1964:** National Health Service (**Qualifications of Health Visitors**) Regulations (para. 2a) Wording updated and statutory status of qualification confirmed in 1973 Act.
- **1972:** Health visiting was included in the remit of the Commission on Nursing (Briggs Committee), which led to the formation of the UKCC. This committee recommended that health visitor training revert to a 6 month, non-statutory certificate in preventive nursing, and that health visitors become known as *'family health sisters'*.
- **1979:** Nurses, Midwives and Health Visitors Act 1979 established the United Kingdom Central Council for Nursing, Midwifery and Health Visiting. This became fully operational in 1983, at which time the CETHV ceased to function.
- **1983:** Health visiting register transferred from CETHV to the UKCC + regulation of health visitor education and training transferred to the four National Boards. Under Clause 7 (2) of the 1979 Act, health visiting matters had to be approved by Health Visiting Joint Committee ('joint' between Council and Boards) before they could be implemented
- **1986:** Project 2000 proposals commit future nurse education to a 'health' philosophy and increase community experience at a pre-registration level
- **1992:** Restructuring of the functions of the Council and Boards following Peat-Marwick-McClintock review removed the Health Visiting Joint Committee, thus **removing statutory control of their regulation from health visiting**.
- **1994:** New framework for preparation of specialist practitioners sets out syllabus for 'Community Health Care Nurses' to include health visiting as one area of practice, with greatly reduced scope and length of training. Further guidance (1998) confirms the statutory requirements for health visitor training must still be met.
- **1998:** JM Consulting report recommends closing health visiting register and regarding health visiting as a branch of nursing. Initially rejected by government (HSC 1999/030), but later enacted in Nursing and Midwifery Order 2001.
- **2001:** Following a raft of reports about poor education and practice in health visiting, UKCC agree new 'Requirements for pre-registration Health Visiting Programmes' – these were ratified by NMC in 2002
- **2004: Health visiting register closed.** Health visitors transferred to Specialist Community Public Health Nursing' (SCPHN) part of the register. Health visiting 'requirements' extant, but replaced with proficiencies for SCPHNs

Route to current position of health visitor regulation (IHV 2014, p10)

- **1998:** JM Consulting report recommends establishing a new 'simplified' regulatory body to replace the UKCC, closing the health visiting register and regarding health visiting as a branch of nursing.
- **1999:** In HSC 1999/030, Government accepted all of the recommendations in the JM Consulting Ltd report **except** those pertaining to health visiting, which it rejected. Despite this rejection, the recommended changes to health visitor regulation were introduced in the draft Order when it was published in 2001.
- **2001:** Nursing and Midwifery Order enables establishment of NMC. Initially, the format of the Council was designed to allow representation from three professions, but NMC empowered only to regulate two (Nursing and Midwifery)
  - Article 6 (3) g. enables the NMC register 'to include a part or parts for specialists in community and public health'
- **2002:** Nursing and Midwifery Council (NMC) takes over health visitor regulation from UKCC, ratifies 'requirements for pre-registration health visiting programmes' to be implemented by 2005.
- **2003:** Consultations on format of register. 80% agree there should be three parts (nursing, midwifery and public health practice), each with a direct entry route. Department of Health (regulatory division) intervened to prevent this from happening, because NMC is only empowered to regulate nursing and midwifery.
- **2004: Health visiting register closed.** Health visitors transferred to 'Specialist Community Public Health Nursing' (SCPHN) part of the register. Health visiting 'requirements' extant, but replaced with new proficiencies for SCPHNs
- **2005:** NMC conducted a wide consultation on revalidation process: agreed that health visitors (and others on SCPHN register) should be allowed to renew their registration on SCPHN part alone. This came into force in 2006.
- **2007:** The 'revalidation decision' was reversed without consultation, which is arguably in breach of NMC's own rules. This decision led to a vote of no confidence by the CPHVA Professional Committee, which remains in place.
- **2008-present:** the impact of the 'revalidation decision' continues to adversely affect direct-entry midwives, and led to at least one university deciding not to recruit them into the programme
- **2009:** Disinvestment, recruitment crisis and safeguarding scandals. Calls to restore health visiting to statute.
- **2011-2015:** Health Visitor Implementation Plan – A Call to Action. Massive injection of resources required to reverse earlier disinvestments and transform health visiting services. No change to the statute, regulation or education.
- **2014:** Following a three-year project, the Law Commission publishes a final report and draft Bill about Regulation of health care professionals and regulation of social care professionals in England. It proposes closure of the SCPHN part of the NMC register on the grounds that it is, in effect, a specialist list rather than a register.

Appendix 3

Example of search employed for identification of literature.



Prisma flow diagram as example of a search strategy performed within the study.

Copy of search as used above.

EBSCOhost

Monday, June 28, 2021 7:51:19 AM

#	Query	Limiters/Expanders	Last Run Via	Results
S9	((transition) AND (S1 OR S2)) AND (S3)	Limiters - Published Date: 20010101-20211231 Expanders - Apply equivalent subjects Narrow by Language: - english Narrow by SubjectMajor: - role change Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	178
S8	((transition) AND (S1 OR S2)) AND (S3)	Limiters - Published Date: 20010101-20211231 Expanders - Apply equivalent subjects Narrow by SubjectMajor: - role change Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	186
S7	((transition) AND (S1 OR S2)) AND (S3)	Expanders - Apply equivalent subjects Narrow by SubjectMajor: - role change Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	221
S6	((transition) AND (S1 OR S2)) AND (S3)	Limiters - Published Date: 20000101-; Peer Reviewed Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	4,893
S5	(transition) AND (S1 OR S2)	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search	20,703

			Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	
S4	transition	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	483,586
S3	role	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	3,782,442
S2	midwife or midwives or midwifery	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	154,561
S1	nurse or nurses or nursing	Expanders - Apply equivalent subjects Search modes - Boolean/Phrase	Interface - EBSCOhost Research Databases Search Screen - Advanced Search Database - MEDLINE;CINAHL Plus with Full Text;SPORTDiscus with Full Text	1,873,325

Appendix 4

Further defence of CGT methodology

Charmaz (2006) and Birks and Mills (2011) promote constructivist GT as a more flexible and practical use of GT. It is this approach to GT which I decided would be the most appropriate for this research, as through reflection on my own philosophical view and the needs of my enquiry, I considered it the most suitable and fitting methodology to undertake this study. It allowed me to build a theory of transition to the HV role, through co-constructing knowledge alongside my participants, incorporating their multiple views and perceptions.

The table below illustrates the alignment and close relationship between CGT, my philosophical perspective and this research, in further defence of my choices.

CGT (Charmaz 2006)	My philosophical position	This research
Phenomena being studied along with its context.	Truth cannot be completely objective as different contexts can alter the perceived truth.	Needs to be researched in context, participants will be undergoing the process of transition as the study progresses. Data is collected at time points within.
Creation of data and its analyses arise from the sharing of experiences with the research participants	There are different multiple realities which require synthesis and assimilation. The researcher cannot be completely removed from the data analysis. Knowledge is co constructed through the shared interactions of the researcher.	There will be differences in the experience of the transition to be explored- what is real to one participant may not be real to others. Deriving meanings and perceptions through the eyes of the participants
The researcher's part in the process is acknowledged- the theory depends on the researchers view and assimilation of the data.	The researcher acts as an instrument of research to interpret the researched in order to reach a consensus of knowledge.	The intended theory will arise from the researcher interpreting the experiences and interpretations of the participants. The researcher is as close to the experience as possible as a HV educator, supporting students with the process of transition.

Characteristics (simplified) of constructivist grounded theory (CGT) and my philosophical position and their application to the proposed study

Appendix 5

Example memos

Memo – in limbo
Participant 9 Interview 2
Doesn't want to continue as a HV, feels that her specialist skills are not being used and finds the role of the HV unrewarding leading to a lack of motivation. Her hearts not in it, she stopped investing herself in the role when she started having doubts and kept herself in limbo. I asked her if she felt like she was in limbo
she replied *YES and I don't feel very passionate either*
She never really settled but decided early on after qualifying to leave the HV role and return to her previous – she never really moved on from her old role- never really gave it a chance

Memo 'scraping back'
Participant 10 interview 1and 8 interview 2.
This 'scraping back' as described by P 10, is felt as a threat to their identity as a nurse, they forget they were qualified was something that is experienced by a number of the participants as they come to terms with the student role.
think about P8 *I completely forgot I was a qualified nurse completely forgot I was qualified. [P8]*
She found this very upsetting and spoke of how she felt badly treated and how it made her feel she might leave nursing all together she was extremely threatened by this. The loss of status, value and respect for them as individuals is being felt profoundly.

Memo- Being trusted
Participant 1, 8, interview 3
Many of the participants comment about how feeling trusted helps them to 'feel' like a HV, this is clearly important to them.
They don't feel like a HV until their doing their job as qualified members of the team. They need to feel autonomous again to be a HV – is this something about trust? This didn't happen straight away though but when they felt challenges and trusted.
I went to this unit with this mum and I really liked it because I wasn't there as a psychiatric nurse, I was there as the HV and I thought that's quite good and when I was on there, I got asked to go and look at another baby and that's quite interesting, that progression has gone on, that you're not seen as a mental health nurse -you're the HV. (P8 I2) *When I was on a visit I did feel like I'm trusted now. I felt so much better (P1 I3)*

Memo at end of round 2 focus group and interviews
Not quite there- skills enhanced, developing, some starting to think a HV but most still not sure, some haven't let go of their old role, not embraced HV yet- it seems to be holding them back. Team definitely important, support seems fundamental –if they embrace present skills and old role this has a positive impact, they have not then found it so hard to fit in and feel useful and valued. They need to be accepted and trusted Rollercoaster journey- very hard up and down. Confidence has grown – still growing as have other skills, skills enhanced deeper- different view ' way of knowing' Role boundary-less – all encompassing, broad, vast, misunderstood- they are finding this difficult Comfortable old role for some too hard to leave behind to take the leap forwards into this new role but until they do then health visitor role seems out of reach

Appendix 6

Expression of interest letter, participant information sheet and consent form.

Expression of interest letter

The Role Transition from Nurse/MW to Health Visitor: a Constructivist Grounded Theory.

Dear Student

I would like to invite you to consider participating in a research study. The study is designed to explore the transition you make from your role as a nurse or midwife into your role as a health visitor.

The research may involve your participation in focus groups or one to one interviews with the researcher, or both, at some time over the course of your programme of study. If you would like to express an interest in participating in this research, could you please return the slip below to the post box that will be provided in the classroom over the next week or alternatively please post via the internal mail to the address below. Any expression of interest or decision not to express an interest in the study will be confidential and in no way impact upon your studies.

If you express an interest you will then be contacted by the researcher who will give you detailed information about why the study is being conducted and what it would mean if you decided to take part. At this stage you will be asked if you wish to participate. The reply slip below may be used to indicate you would like further information about taking part in this study. Alternatively, if you would like to contact me directly with any questions please telephone 01332 501776 or email: l.henshaw@derby.ac.uk

Thank you very much for your time

[redacted]

Lorraine Henshaw

Reply Slip

Name (Please print)

Contact telephone number

Please return to:

Please tick which statement applies

☐ Yes I would like to discuss taking part in this research

☐ No I do not wish to take part in this research

Lorraine Henshaw, Senior Lecturer School of Health and Social Care, University of Derby,
Or please post in the box provided in the classroom

Participant information sheet

Information about the research

I would like to invite you to take part in a research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

Background

Previously there has been a lot of debate surrounding the professional identity of health visiting, due largely to the complex responsibilities of the role, (Baldwin 2012, Peckover 2013) which have been shaped by the political drivers of the time, most recently this is the Health Visitor Implementation Plan (DH 2011a).

As part of a lecturing team responsible for the education of student health visitors I am really interested in the process of transition that is undergone from nurse/midwife to the health visitor. I feel it is important to understand this process for a number of reasons. Previous studies (Adams et al 2006) in other areas have linked role transition to the formation of a professional identity and so understanding the role transition, in the journey to become a health visitor, should therefore provide increasing insight and clarity to this professional identity. I am also interested to find out if your background or experience in anyway impacts on this transition.

Why have I been invited to take part?
As a student health visitor you will have first hand experience of the transition process into this new role. As such I would like to talk to you about your experiences and find out what it is like to become a health visitor.

Do I have to take part?
It is up to you to decide if you would like to take part in the research. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw without giving a reason.

What will happen to me if I take part?
You may be asked to take part in a series of focus group and/or interviews. The first, early in your programme and the second, towards the end of the programme or a third, following completion. Or you may be asked to take part in one-to-one interviews with the researcher. Some of you may be asked to take part in both. A focus group is an in-depth, open-ended group discussion normally with 6- 8 participants. It is anticipated that each focus group and interview will last approximately one hour and an audio-recording will be taken of the discussion.

What will I have to do?
Before taking part in the study we will ask you to sign a consent form declaring that you agree to participate in the research. Before any of the focus groups or interviews commence this consent will be re-established, just so I know you are still happy to take part. During the focus group or one to one interviews you will then be asked to discuss several topics related to your experience.

Will my contribution be kept confidential?
Yes. We will follow ethical and legal practice and all information about you will be handled in confidence. The audio recording of the focus group and interviews will be transcribed by the researcher. Be assured that no personally identifiable information will be divulged, and your confidentiality will be maintained.

All data will be held by the researcher at the University of Derby on a password protected computer. In addition, the findings of this study will be disseminated through conferences, journal papers and a

completed thesis will be held in the university library. All data will be treated anonymously, and it will not be possible to identify any individual or their contribution to the study.

What are the possible benefits of taking part?
I cannot promise the research will help you, but you may find that participating in the interviews and focus group helps you to actively reflect, helping you to learn from your experiences. In addition, the information we get will help us to understand the role transition and what may impact on this transition. This could help the student health visitors of the future or help to give clarity to the professional identity of health visitors.

What if I do not want to take part in this research?
Your participation is voluntary, and you can withdraw from the study without giving a reason. Any decision to take part, or not, will have no impact on your position as a student health visitor at the University of Derby. Should you commence the research you can decide later not to continue and request your withdrawal from the study. However, it would not be practicable to remove a single participant from focus group recordings or remove data from the interview after it has been analysed. Therefore, you can request your withdrawal from the study before participating in any of the groups or before data analysis of your interview takes place. The information you have given in any prior focus groups or interview will be used in accordance with the consent obtained.

What if there is a problem?
Any complaint about the way this research has been conducted will be addressed. Please discuss your complaint with any of the research team or forward your complaint to the Researcher Lorraine Henshaw. Alternatively, please contact the Director of Studies or programme leader for the Dr of Health and Social Care Practice at the University of Derby:

Dr [redacted]
Director of Studies
Senior Lecturer
University of Derby
Britannia Mill
Mackworth Road
DERBY
DE22 3BL
[redacted]
Telephone 01332 59[redacted]

Programme leader Dr of Health and Social Care Practice

[redacted]
Education, Health and Sciences
University of Derby
Kedleston Road
Derby
DE22 1GB
[redacted]
Telephone 01332 5[redacted]

Further information and contact details
Please correspond with the researcher: Lorraine Henshaw (Senior Lecturer in Nursing)

Faculty of Health Care Practice
Nursing, Radiography and Health Care Practice
University of Derby, Kedleston Road , Derby
DE22 1GB
Tel:01332 591776 EMAIL l.henshaw@derby.ac.uk

References

Adams, K., Hean, S., Sturgis, P. and McLeod Clark, J. (2006). Investigating the factors influencing professional identity of first year health and social care students. Learning in Health and Social Care. 5(2): 55–68.

Baldwin, S. (2012). Exploring the professional identity of health visitors. Nursing Times; 108: 25,12-15.

Department of Health (2011) A Call to Action Health Visitor Implementation Plan Summary Progress Report London: Department of Health.

Peckover, S. (2013) From 'public health' to 'safeguarding children': British health visiting in policy, practice and research. Children and Society, 27 (2). pp. 116-126.

Consent Form

Title of Project: ***The Role Transition from Nurse to Health Visitor: a Constructivist Grounded Theory.***

Name of Researcher: Lorraine Henshaw

Please initial box

1. I confirm that I have read and understand the information sheet dated..... (version.....) for the above project. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights as a student health visitor being affected. ☐

3. I agree to having my responses audio-recorded during interviews. ☐

4. I agree for extracts of my speech to be reported in research papers but my name will not be used and I will not be personally identifiable in any research reports. ☐

5. I understand that my confidentiality will be maintained unless during the course of the interview there is information of a criminal nature or a perceived threat to myself or others, in which case I will be informed by the researcher before any necessary action is taken. ☐

7. I agree to take part in the above study. ☐

Name of participant	Date	Signature
Name of Person taking consent	Date	Signature

When completed: 1 for participant; 1 for project file.

Appendix 7

Letter of ethical approval

UNIVERSITY of DERBY

Approval with Conditions Letter

Date: Tuesday 4 March 2014
Name: Lorraine Henshaw

Dear Lorraine

Topic: The Role Transition from Nurse to Health Visitor ; A Constructivist Grounded Theory Study.

Thank you for submitting your application to the School of Health and Social care Research Ethics Committee for chairs action.

The decision of the committee is that the application be approved subject to the following condition:

- Details of storage of 'raw' recordings is unclear – are these to be copied to the encrypted device/password protected system and the originals deleted from the recording device? Are the 'raw' recordings to be held for the same time period as other data?

If any changes to the study described in the application or to the supporting documentation is necessary you are required to make a resubmission to the School of Health and Social Care Research Ethics Committee.

Also, for the committee's records, can you please notify the secretary when your study has been completed.

All the best.

Yours sincerely,

[redacted]

(Deputy Chair, School of Health and Social Care REC)

Appendix 8

Confirmation email

Lorraine Henshaw

From: [redacted]
Sent:
To: Lorraine Henshaw
Subject: Re: FW: Ethics query

Follow Up Flag: Follow Up
Flag Status: Red

Dear Lorraine,

Thanks for your email, I'm sorry about the long wait, I have been on annual leave.

Yes you are correct, I spoke to a contact at the Trent CLRN and as long as you don't recruit or interview participants via the NHS that is absolutely fine and you don't need NHS approval.

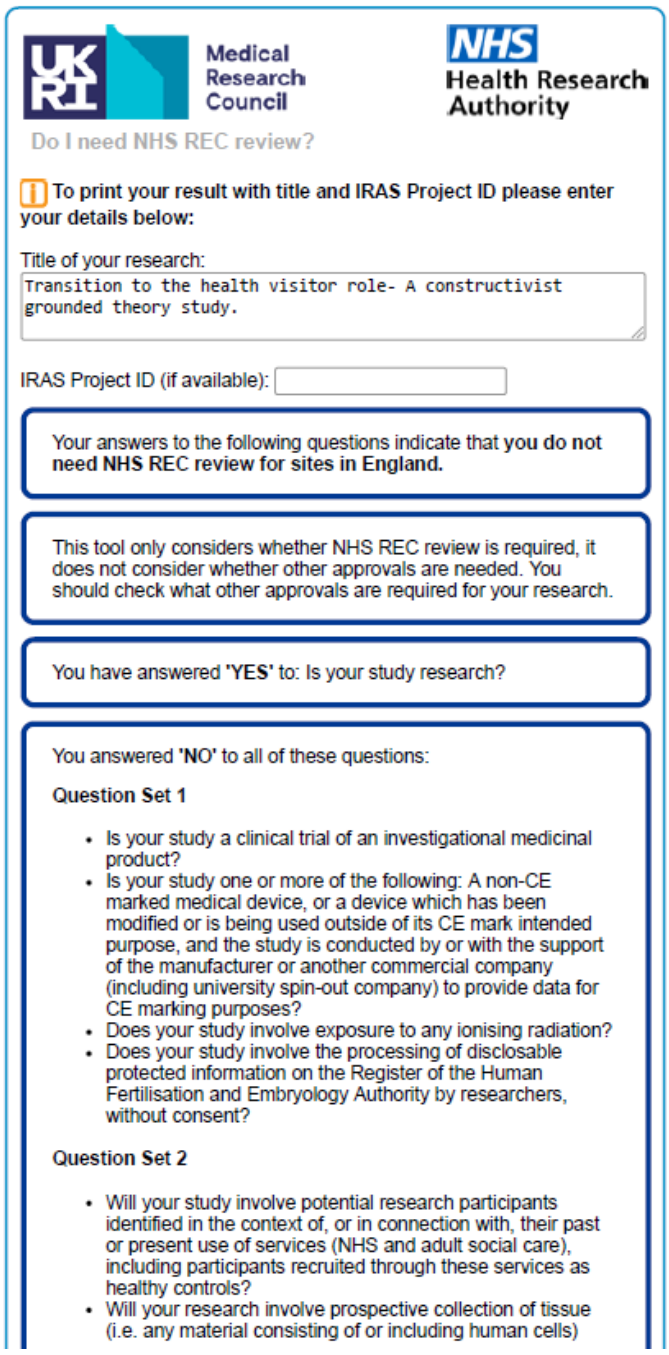
I hope that helps, and good luck with your project!

Kind regards,

[redacted]

Appendix 9

NHS HRA decision tool



Medical Research Council

NHS Health Research Authority

Do I need NHS REC review?

To print your result with title and IRAS Project ID please enter your details below:

Title of your research:

Transition to the health visitor role- A constructivist grounded theory study.

IRAS Project ID (if available):

Your answers to the following questions indicate that **you do not need NHS REC review for sites in England.**

This tool only considers whether NHS REC review is required, it does not consider whether other approvals are needed. You should check what other approvals are required for your research.

You have answered **'YES'** to: Is your study research?

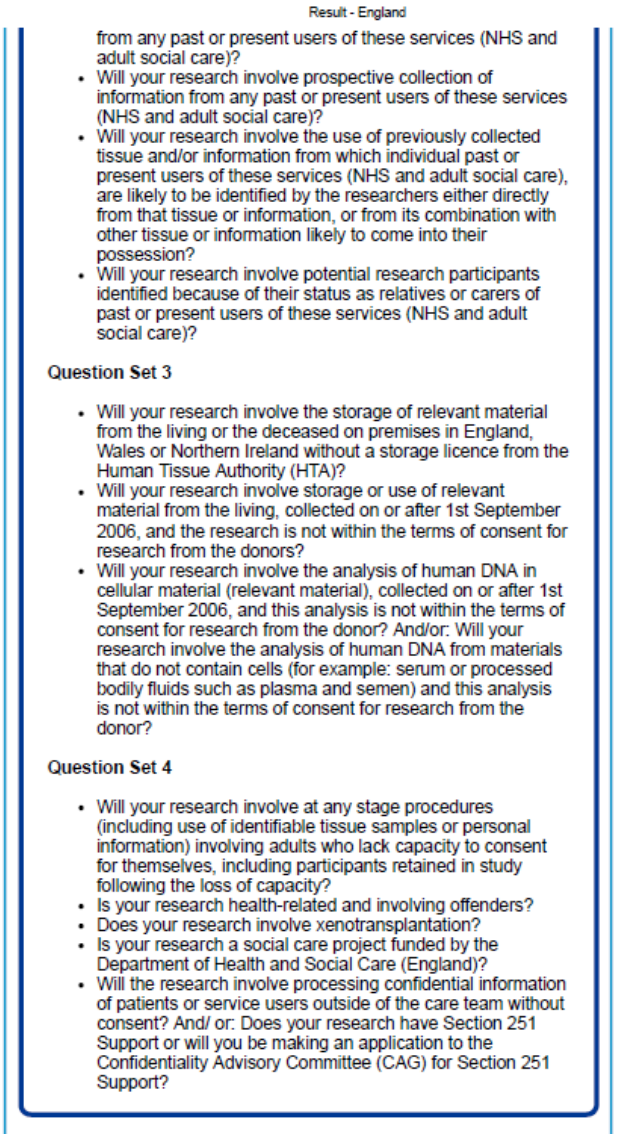
You answered **'NO'** to all of these questions:

Question Set 1

- Is your study a clinical trial of an investigational medicinal product?
- Is your study one or more of the following: A non-CE marked medical device, or a device which has been modified or is being used outside of its CE mark intended purpose, and the study is conducted by or with the support of the manufacturer or another commercial company (including university spin-out company) to provide data for CE marking purposes?
- Does your study involve exposure to any ionising radiation?
- Does your study involve the processing of disclosable protected information on the Register of the Human Fertilisation and Embryology Authority by researchers, without consent?

Question Set 2

- Will your study involve potential research participants identified in the context of, or in connection with, their past or present use of services (NHS and adult social care), including participants recruited through these services as healthy controls?
- Will your research involve prospective collection of tissue (i.e. any material consisting of or including human cells)



Result - England

from any past or present users of these services (NHS and adult social care)?

- Will your research involve prospective collection of information from any past or present users of these services (NHS and adult social care)?
- Will your research involve the use of previously collected tissue and/or information from which individual past or present users of these services (NHS and adult social care), are likely to be identified by the researchers either directly from that tissue or information, or from its combination with other tissue or information likely to come into their possession?
- Will your research involve potential research participants identified because of their status as relatives or carers of past or present users of these services (NHS and adult social care)?

Question Set 3

- Will your research involve the storage of relevant material from the living or the deceased on premises in England, Wales or Northern Ireland without a storage licence from the Human Tissue Authority (HTA)?
- Will your research involve storage or use of relevant material from the living, collected on or after 1st September 2006, and the research is not within the terms of consent for research from the donors?
- Will your research involve the analysis of human DNA in cellular material (relevant material), collected on or after 1st September 2006, and this analysis is not within the terms of consent for research from the donor? And/or: Will your research involve the analysis of human DNA from materials that do not contain cells (for example: serum or processed bodily fluids such as plasma and semen) and this analysis is not within the terms of consent for research from the donor?

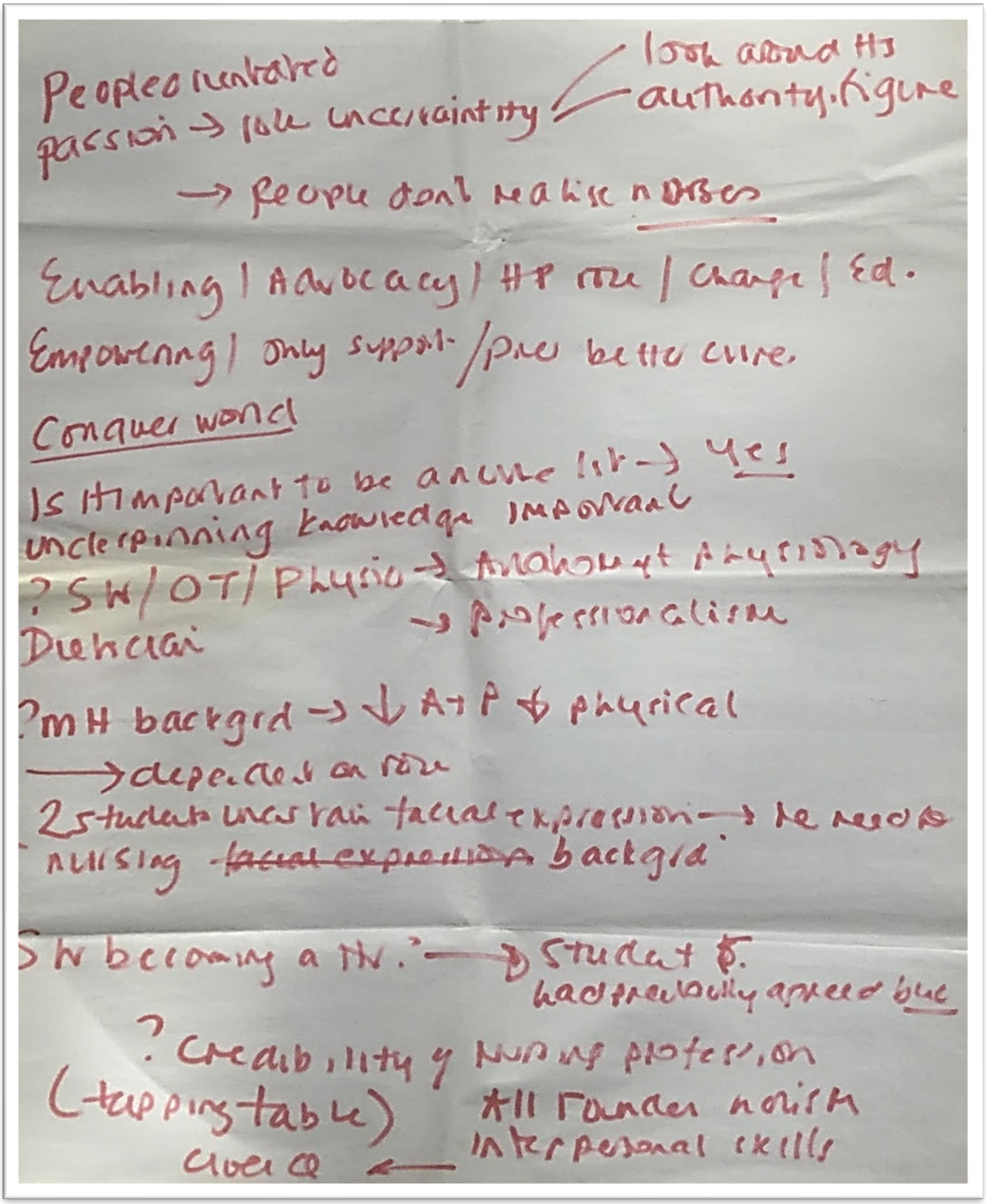
Question Set 4

- Will your research involve at any stage procedures (including use of identifiable tissue samples or personal information) involving adults who lack capacity to consent for themselves, including participants retained in study following the loss of capacity?
- Is your research health-related and involving offenders?
- Does your research involve xenotransplantation?
- Is your research a social care project funded by the Department of Health and Social Care (England)?
- Will the research involve processing confidential information of patients or service users outside of the care team without consent? And/ or: Does your research have Section 251 Support or will you be making an application to the Confidentiality Advisory Committee (CAG) for Section 251 Support?

Appendix 10

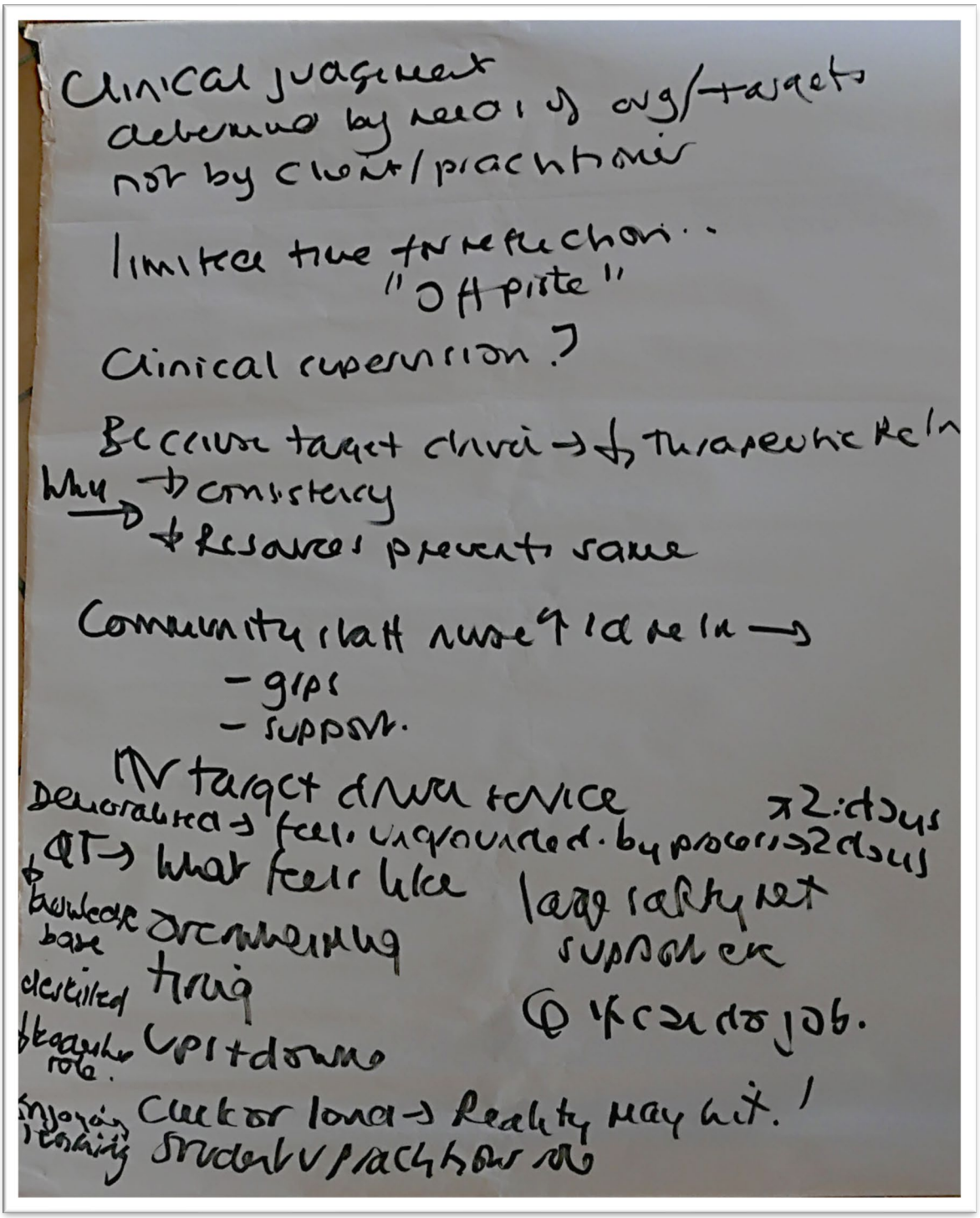
Focus group and interview notes- examples

Focus Group 1 excerpt from notes



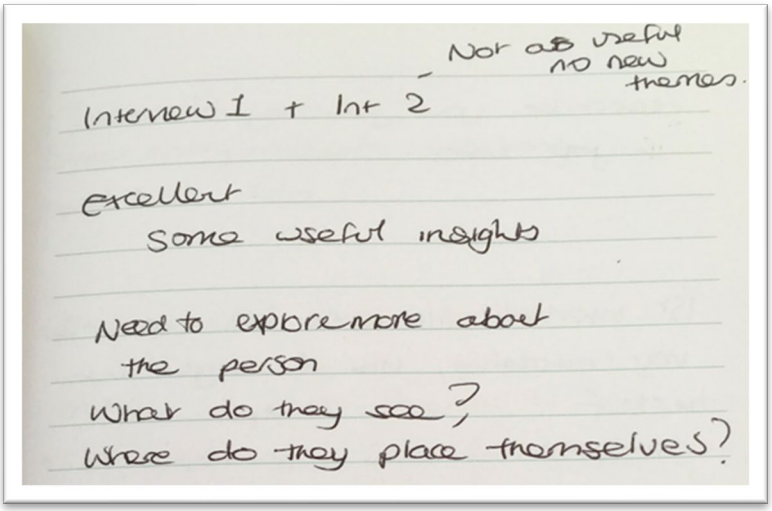
Some key words/areas- role uncertainty, don't' realise we are nurses, underpinning nurse important, others can do, SW becoming a HV? people orientated. Sister becoming student(was in navy blue)

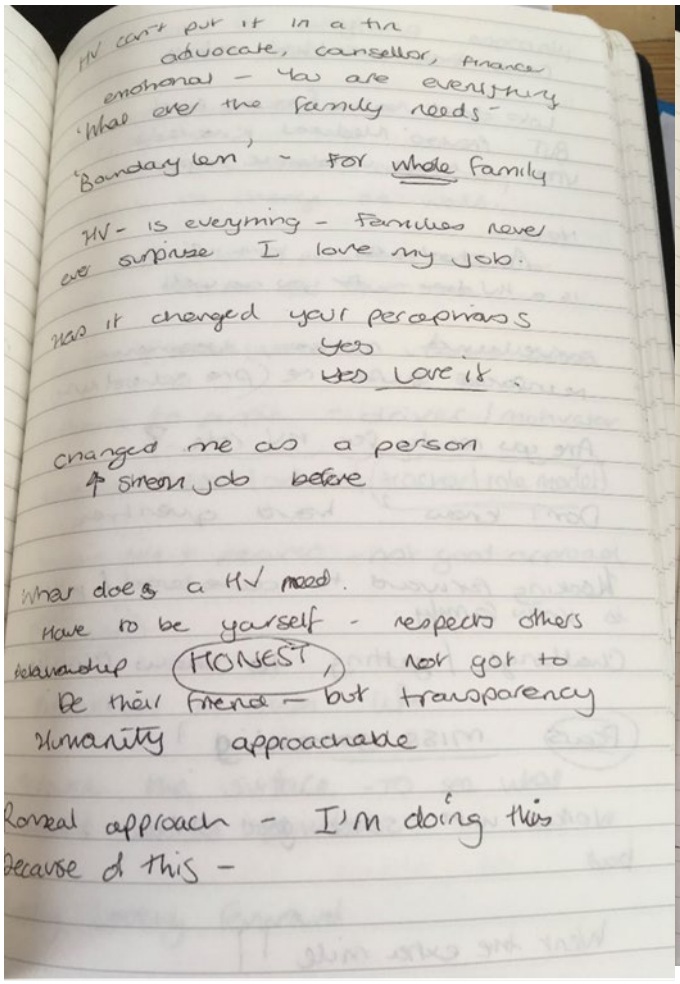
Focus Group 2 excerpt from notes

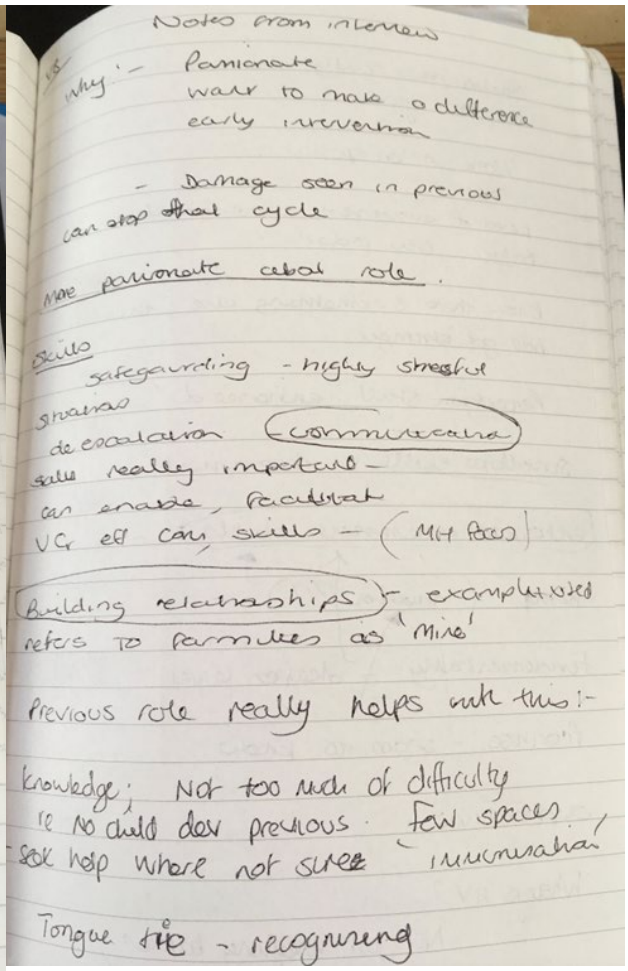


Some key words, target driven- not led by client /practitioner, demoralised, feeling ungrounded, overwhelming, safety net+ support, ups and downs, reality may hit! can I do the job? off piste, no time, deskilled, lack of consistency, lack of resources.

Example of Interview notes







Appendix 11

Initial and focused coding example

Excerpt from focus group 1		
R = Researcher P= participant in focus group		
Focus Group 1 transcript page 1 and 2	Initial codes	Focused Codes
R- What I've got is a series of questions that I want to put to you, to get your thoughts and feelings really. So first of all tell me why you want to become a health visitor. I know this is an individual question, but I'm expecting you all to chip in on your reasons for wanting to be a health visitor! Try and be as honest as you can!	**Setting the scene** **Asking why health visiting** **Asking for openness and honesty**	
P1- For me I wanted to be a health visitor because, without being too blunt I'd had enough of working with [people] after they'd offended. I wanted to make a difference I wanted to help with it beforehand.	**Reasons for a decision** **Being honest** **Previous experience with offenders** **Wants to make a difference** **Prevention**	**Prevention and public health** **Impact of the role**
R- Yeah. OK. To make a positive-		
P- I wanted to make a positive impact, really.	**Wants to make positive difference**	**Impact of the role**
R- Oh. OK. Yeah.		
P- Mine was because, um, I had a bad breastfeeding experience. I didn't feel there was enough support when I was breast feeding my own child. So I decided to become a breast feeding supporter. I volunteered. I worked	**Poor personal experience** **Feeling** **Inadequate support for herself** **Voluntary role based on poor experience** **Then worked as nurse** **Part time worker**	**Prevention and public health** **Negative or positive personal experience**

part time as a nurse and did that part time, and I enjoyed the public health role so much I wanted to go in to it deeper. Um- so I decided to apply for health visiting.	**Public health role** **Decision to be health visitor**	
R- Yeah. OK.		
P- So I could help other mums.	**Wants to help others**	**To have a positive impact- wanting to make a difference**
R- So, where were you – as a staff nurse- where were you working?	**Finding out background**	
P- Um- I was – from college and the health care of the elderly (muffled).	**Previous experience**	**Existing skills**
P- For me, I had my first son when I was only sixteen, and the health visitor I had then was fantastic. A lot of the midwives were quite judgemental, you know, because how old I was but my health visitor was really good. And I just wanted to follow suit and be like her, and help other mums and young mums. In my situations.	**Personal experience** **Positive experience with hv** **Midwife judgemental because of age** **Good health visitor** **Was a role model** **Provided motivation** **Help other mums**	**Negative or positive personal experience** **Role modelling on a health visitor they know** **To have a positive impact- wanting to make a difference**
R- So you had that insight.	**Had insight**	
P- Yeah. Definitely.		
P- I think I had a few reasons, really. I had quite a negative experience with my health visitor. Not my personal health visitor, but other health visitors in the same team. When my son was born e was quite poorly and he put his weight on very slowly. And one came and told me, I was breast	**Negative personal experience** **Not all health visitors** **Personal insight into impact of good and bad in role** **Poor experience** **Health visitor told her** **Looking on the surface only** **Negative experience**	**Negative or positive personal experience** **Role modelling on a health visitor they know** **Wanted a change in career**

feeding on demand, told me I was starving him and I need to give him far more food. There was no kind of looking at how I was feeding him, making sure I was feeding correctly lack of or anything like that. It was just straight away "you're starving your son! You're going to kill him!" There was no consideration to the fact that he'd been so poorly. Plus on the other side I was from a mental health background as well. And I wanted a change, a challenge. I'd been on the same ward for seven years. ……And I just wanted that challenge. and like xxxxxx said, get to them before it turns into an offence.	**Needed to delve deeper** **Feeling shocked by experience** **There was a reason** **Additional reason for HV role** **Mental health nurse** **New challenge** **Long time in old job** **Wanted a challenge** **Agreement with xxxxx**	Needed a challenge Felt wasted and/or bored in old role Needed a change in career
R- Yeah.		
P- Um- very similar. I felt stagnant. I was very bored where I worked. I worked in [xxxx], And I've always thought about public health, always wanted to get in there. Always thinking preventions better than a cure. Yeah and I just wanted to help children and families and I thought that's where I can make a difference and really makea difference instead of being at the other end of it, waking someone up after an operation. I wasn't being me. I just felt like I wanted	**Stagnant** **Bored** **Interested in public health** **Prevention** **Wanted to work with families** **To make a difference** **To have a bigger impact than before** **Just wanting to do more**	Felt wasted and/or bored in old role Prevention and public health To have a positive impact- wanting to make a difference Needed a challenge

to do more. Yeah. It's specialist. And although this is a specialist-		
P- Yeah. Just needed to get out.	**Needed something else**	
R- Yeah.		
P- I worked somewhere else before. I worked on a [xxx] unit. And then I moved on and I've been there for five years. And I went to [other country] and it broadened me a little bit and I thought what am I doing here? I'm wasted. Do you know what I mean? (Laughs) I'm absolutely wasted.	**Worked in old role 5 years** **Worked overseas** **Recognised she could do more**	**Felt wasted and/or bored in old role** **Needed a challenge** **Wanted a change in career**
R- OK. How about you?		
P- I worked in learning disability team.	**Learning disability nurse**	**Existing skills**
R- Oh okay.		
P- Which is like outpatients. I was there on band five and at first it was a challenge, and then very quickly felt like needed more. And I had to keep asking can I do this, can I do this? And I also spent a lot of time alongside specialist health visitors. And the more I just kept looking at them, I just kept thinking I want to do what you're doing.	**Outpatient unit** **Initial challenge** **But now needed more** **frustrated in that role** **time with health visitors** **watching them** **wanted to be like them**	**Wanted a change in career** **Needed a challenge** **Role modelling on a health visitor they know** **To have a positive impact- wanting to make a difference**
R- Oh. Yeah. Yeah. Anything else?		
P- And I never, ever thought- I didn't realise that mental health	**Lack of awareness they can be health visitor**	**Surprise I can be a health visitor**

nurses could be health visitor, to be fair.		**Amazing opportunity**
R- I think that's quite common. A lot of people didn't realise that.	**Confirming**	
P- And I'd seen the adverts and flicked by them. I would have stayed in my job for ever. I didn't want to go, but I thought what an amazing opportunity to train to do this. I'll have a go.	**Saw advert** **Provided motivation** **Amazing opportunity** **Wanted to try it**	**Surprise I can be a health visitor** **Amazing opportunity**

Appendix 12

Focused coding to conceptual code example

Phase One Focus group 1

Page no of transcript	Focused code	Conceptual code
1	Negative or positive personal experience	2
1	Prevention and public health	4
1	To have a positive impact- wanting to make a difference	5
1	Wanting to enable and empower others	5
1	Role modelling on a HV they know	2
1	Needed a challenge	3
1	Wanted a change in career	3
2	Felt wasted and/or bored in old role	3
2	Improved status of being a HV	8
2	Redundancy	3
2	Surprise I can be a HV	6
2	Amazing opportunity	3
2	Encouragement from others to apply	3
2	Communication skills important	10
4	Comfortable in old role but novice in new	23
3	Transferring and adapting my skills	9
4	Was confident in my knowledge base in old role	7
4	Confident skills easier to adapt	9
4	Relationship building is a key skill	14
4	Outside of comfort zone	23
4	Struggling	24

5	Lacking confidence	23
5	Unsure of new role purpose	18
5	Risk assessment important skill for role	11
5	Empathy important skill for role	10
5	Life skills and personal experiences important skills	12
6	Individual personality – some people are better suited	10
6	Being open and honest important to role	1
6	Rewarded for making an impact	8
6	Using skills from previous role	9
7	Negative response from others	20
7	Being a role model for mothers and families	5
7	Making things better for people	5
7	Being the right sort of person	12
8	Lack of understanding of the HV role by others	20
8	The importance of being a nurse	37
8	Surveillance element of role makes people suspicious	20
8	Role about empowering and motivating others in partnership	16
9	HV offers support	17
9	Recognising limitations of the role	39
10	Professionalism key attribute	41
10	Old role reputation and misconceptions impact	34
11	Is it a social work role	18
11	Nursing provides fundamental skills	13
11	The importance of holistic care	13
11	The importance of interpersonal skills	13
11	Those key nursing assessment skills	13

12	Being passionate about the role	5
12	Learning it all again	35
12	Gaps in knowledge	36
12	It's a different role you can adapt to	9
13	Team working and peer support important	50
13	Feeling privileged	8
13	Acknowledgment it will change me	35
14	Being a student and having a chance to take a step back and look	33
15	Looking at things differently	35
16	Frustration at limitations of role and its impact	39
15	Being a source of advice	17
15	It's the whole family not just the kids	56
16	It's the community	29
16	The child's in the middle of a web- like a jigsaw	42
16	Health could be anything	29
17	Shocked about how people live -New experiences	38
17	Showing empathy with others	10
17	Emotionally difficult sometimes	38
18	Wanting to change conceptions of the HV role	40
19	We've all aged ten years- a stressful time	49
20	Being isolated because of study pressures	49
21	It's very intense	49
22	Like being on a treadmill- or a rollercoaster it just never stops	49
20	It will be worth it in the end- light at the end of tunnel	30
21	Building strategies to cope	52
21	Coming out of our comfort zone , woah- feeling vulnerable	49

21	Starting to feel deskilled	21
22	Autonomy being stripped away	34
21	Being a student is difficult	25
21	Remember we are qualified nurses	26
22	Reminiscing about old role	26
22	Mentor relationship is really important to this experience	27
23	Not being valued	22
23	Lacking in confidence, not having the skills	23
24	Longing for return to autonomous practice	26
24	Feeling the loss of old self	26
24	Trying to find the best way to do it	52
24	Looking forward	30
24	Feeling proud and privileged to be on the course	60

Appendix 13

Initial focus group outline

1. **Tell me why you want to become a health visitor?**

   This is to explore motivation for the role along with their background.

2. **What skills do you all have think that you will find useful in the health visitor role?**

   This is to explore what skills they think are important to them, what their good at and if they feel they will be able to use them in their new role- this will be explored longitudinally to look for changes perceptions

3. **What are the important attributes for a health visitor?**

   This is to explore what they know about health visiting and what skills, qualities health visitor should have, it will explore insight and will be looked at longitudinally for changes.

4. **What do you think being a health visitor means?**

   This is to explore what they think and feel about health visiting, it will explore insight and will be looked at longitudinally for changes

5. **What has the role of a student health visitor felt like so far?**

   This will explore the experiences so far including their feeling about the transition.

Appendix 14

Initial Interview questions- round 2

These were developed based on the first data collection phase analysis, they continued to develop throughout the subsequent data collections to follow relevant lines of enquiry and reach theoretical saturation.

1. Since we last met how have you been?
2. What have been the challenges?
3. What skills have been useful so far?
4. Are you using your previous skills?
5. Are you still developing skills? What skills do you still need?
6. Do you think you understand more about the role?
7. What do you think makes a good health visitor?
8. Do you still think it's important to be a nurse?
    a. Why?
9. Have you changed since you started?
    b. How?
10. What has this process been like so far?
11. What are the barriers?
12. What has helped so far?
13. What are your worries?
14. What are you looking forward too?

Appendix 15

Conceptual Codes

1. Working with families and people
2. Role modelling and insight
3. Opportunity and challenge
4. Prevention and public health
5. Impact of the role
6. Entry requirement
7. (Application of) old role
8. Recognition and reward
9. Adapting and transferring skills
10. Existing skills
11. Skills I need
12. Using my life skills/experiential knowledge
13. The importance of previous nursing or midwifery experience- being a nurse/midwife
14. Communication and building relationships
15. Honest and trustable
16. Empowering and being an advocate
17. Giving support and advice
18. Role boundaries- bigger than I thought
19. Culture shock
20. Perception of health visitor role and image / Changing perception
21. Feeling deskilled
22. Feeling undervalued
23. Losing/loss of confidence
24. Making it difficult- the barriers to becoming a health visitor
25. Being a student
26. A sense of loss
27. The importance of the mentor/ practice teacher
28. Reminiscing and revisiting
29. Focus of care
30. Acceptance, moving forward and future plans
31. Maintaining and changing motivation
32. Recognition of challenge
33. Feeling positive
34. Felling unfulfilled/ not using my expertise
35. Shifting self
36. Enhancing skills
37. My identity as a nurse/midwife
38. It's a hard job/ difficulty in the role
39. Role limitations
40. Changing the health visitor image
41. Health visitors core skills – growing appreciation

42. Child focus
43. How do you I see myself
44. Re-affirming and returning to my old role
45. My identity as a health visitor
46. Fears and hopes
47. Losing motivation
48. Self-belief- building confidence- becoming confident
49. Intense rollercoaster
50. Supportive team and environment
51. Still not sure- do I want to do this?
52. Being resilient, tenacity and determination
53. Skilful communication
54. Managing my own time and caseload
55. Regaining autonomy
56. Family focused children centred
57. Air of authority
58. Role ambiguity
59. Progressive impact of role
60. Recognition and trust
61. Application of my old self

Appendix 16

Tables of findings

This is to provide clarity to the method by which data has been processed and categorised. The following tables illustrate the incidence of each of the conceptual codes relating to each of the subcategories as follows;

Table 1 -Motivation and Reward.

Table 2- Shifting Perceptions

Table 3- My Old Self

Table 4- Changes in Me

Table 5- Role Identity

Table 6- The Journey

Within the tables the conceptual code number can be used in conjunction with the full list of conceptual codes (Appendix 15) for further context. Where the individual conceptual code has emerged through the analysis of focus group or individual interview data this is signified by the notation FG1; focus group 1, FG2; focus group 2, P1; participant 1 and so on. The data collection phase at which this code occurred is identified at the head of the table as phase 1, 2 or 3 and relates to the point of data collection.

Table 1

Conceptual code number	**Details of conceptual code**	**Participant with code in response- Focus group (FG) or Interview (Int).**		
		Phase 1	**Phase 2**	**Phase 3**
1	Working with families and people	FG1, FG2, P7, P8, P9, P10		
2	Role modelling and insight	FG1, FG2, P7, P8, P9, P10		
3	Opportunity and challenge	FG1, FG2, P7, P8, P9, P10		
4	Prevention and public health	FG1, FG2, P8, P9, P10		

5	Impact of the role	FG1, FG2, P7, P8, P9, P10	FG3, P1, P2, P7, P8, P10, P11, P13	
6	Entry requirement and role status	FG1, FG2, P7, P8,		
7	Application of old role	FG1, FG2, P7, P8, P9, P10	FG3, P1, P2, P8, P7, P9, P10, P11, P13	P3, P8, P 9
8	Recognition and reward		FG3, P8, P9, P10, P13	P1, P5, P11
31	Maintaining and changing motivation		FG3, P2, P7, P8, P9, P10, P13	P1, P3, P5, P7, P11
47	Losing motivation		P3, P8, P9	P3, P8, P9

Subcategory and Conceptual Codes: Motivation and Reward

Table 2

Conceptual code number	**Details of conceptual code (see above)**	**Participant with code in response**		
		Phase 1	**Phase 2**	**Phase 3**
14	Communication and building relationships	FG1, FG2, P8, P9, P10	FG3, P1,P7,P 8	
15	Honest and trustable	FG1, FG2, P7, P9, P10	FG3, P1, P7, P8, P11, P13	
16	Empowering and being an advocate	FG1, FG2, P7, P8, P9,	FG3, P1, P7, P8, P10, P11	P1, P3, P7, P8, P9, P10, P11
17	Giving support and advice	FG1, FG2, P7, 8, 9, 10	FG3, P1, P2, P7, P9, P11	
18	Role boundaries/ Its bigger than I thought	FG1, FG2	FG3, P1, P2, P7, P8, P11, P13	
19	Culture shock	FG1, FG2,	FG3, P1, P2, P7, P8, P11	

20	Perception of HV role and image/ Selling the role	FG1, FG2, P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13	
32	Recognition of challenge	FG1, FG2, P7, P8, P9	FG3, P1, P7, P8, P9, P10, P11	
38	It's a hard job/difficulty in the role	FG1, FG2, P7, P8, P9	FG3, P1, P8, P9, P13	
39	Role limitations		FG3, P1, P8, P9, P13	P1, P3, P5, P7, P8, P9, P10, P11
40	Changing the HV image		FG3, P1, P8, P9, P10	P1, P3, P11
41	HVs core skills- growing appreciation		FG3, P1, P2, P7, P8, P9, P10, P11, P13	P1, P3, P5, P7, P8, P9, P10, P11
42	Child focus	FG1, FG2 P7, P8, P9, P10	FG3, P1, P2, P7, P8	
58	Role ambiguity	FG1, FG2, P7, P8, P10	FG3, P1, P2, P7, P8, P11	P1, P7, P8, P10, P11
59	Progressive impact of the role		FG3, P1, P8, P10	P1, P5, P8
56	Family focus – child centred		FG3, P2, P7, P8, P9	P1, P3, P5, P10, P11

Subcategory and conceptual codes: Shifting Perceptions

Table 3

Conceptual code number	**Details of conceptual code (see Appendix 15)**	**Participant with code in response**		
		Phase 1	**Phase 2**	**Phase 3**
10	Existing skills	FG1, FG2 P8, P9, P10	FG3, P1, P2, P8, P7, P10, P11, P13	
13	Importance of previous nurse/ midwifery experience/being a nurse/midwife	FG1, FG2 P7, P8, P9, P10	FG3, P1, P2, P7, P8, P9 P10, P11, P13	P1, P3, P5, P7, P8, P9, P10, P11

26	A sense of loss	FG1, FG2 P8, P9, P10, P11	FG3, P1, P2, P7, P8, P9, P10	P8, P9
28	Reminiscing and revisiting	FG1, FG2 P8, 9, 10	FG3, P8, P9	P3, P8, P9
12	Using my life skills/experiential knowledge	FG1, FG2 P8, P7	FG3, P1, P8, P9, P13	
34	Feeling unfulfilled/ not using my expertise		FG3, P1, P2, P8, P9, P10,	P1, P3, P5, P8, P9, P11
61	Application of my old self	FG1, FG2 P8, P9, P10	FG3 P1, P7, P8, P2, P10	

Subcategory and Conceptual Codes: My Old self

Table 4

Conceptual code number	**Details of conceptual code (see above)**	**Participant with code in response**		
		Phase 1	Phase 2	Phase 3
9	Adapting and transferring skills	FG1, FG2, P7, P8, P9, P10	FG3, P1, P2, P7, P9, P8	
11	Skills I need	FG1, FG2 P7, P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13	P1, P5, P7, P10, P11
20	Feeling de-skilled	FG1, FG2 P7, P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13	
21	Feeling undervalued	FG1, FG2 P7, P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13	
22	Losing/loss of confidence	FG1, FG2 P7, P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13	
25	Being a student	FG1, FG2 P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13	P1, P5, P7, P8, P9, P10, P11
29	Focus of care	FG1, FG2 P7, P8, P9, P10	FG3, P1, P2, P7, P8, P10, P11, P13	P1, P3, P5, P7, P10, P11
35	Shifting self		FG3, P1, P2, P7, P8, P11, P13	P1, P7, P8, P10

36	Enhancing skills		FG3, P1, P2, P7, P8, P10, P11, P13	P1, P3, P5, P7, P10, P11
53	Skilful communication		FG3, P1, P7, P8, P9, P13	P1, P5, P7, P10, P11

Subcategory and Conceptual Codes: Changes in Me

Table 5

Conceptual code number	**Details of conceptual code (see above)**	**Participant with code in response**		
		Phase 1	**Phase 2**	**Phase 3**
37	My identity as a nurse/midwife	FG1, FG2, P7, P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13.	P1, P3, P5, P7, P8, P9, P10, P11
43	Changing how I see myself/ how I think		FG3, P1, 2, 7, P10, P11, P13	P1, P5, P7, P10, P11
44	Re-affirming and revisiting my old role		FG3, P1, P2, P7, P8, P9, P11	P3, P8, P9
45	My identity as a HV		FG3, P1, P7, P8, P9, P10, P11, P13.	P1, P3, P5, P7, P9, P10 P11
48	Self-belief, building confidence-becoming confident		FG3, P1, P7, P9, P10, P11, P13.	P1, P3, P5, P7, P9, P10 P11
54	Managing my own time and caseload		FG3, P1, P7, P8, P9, P10, P11, P13.	P1, P3, P5, P7, P9, P10, P11
55	Regaining autonomy		FG3, P1, P7, P8, P9, P10, P11, P13.	P1, P3, P5, P7, P9, P10 P11
57	Meeting the challenge/ air of authority		FG3, P1, P2, P7	P1, P3, P5, P7, P9, P10 P11
60	Recognition and trust		FG3, P1, P7, P11	P1, P3, P5, P7, P10, P11

Subcategory and Conceptual Codes: Role Identity

Table 6

Conceptual code number	Details of conceptual code (see above)	Participant with code in response		
		Phase 1	**Phase 2**	**Phase 3**
24	Making it difficult- the barriers to becoming a HV	FG1, FG2, P7, P8, P9, P10	FG3, P1, P2, P7, P8, P9, P10, P11, P13	P1, P5, P8, P9, P11
27	The role of the mentor and PT	FG1, FG2, P7, P8, P9	FG3, P1, P7, P8, P9, P10, P11, P13	P1, P5, P7, P8, P10
50	Supportive team and environment	FG1, FG2, P8, P9, P10	FG3, P1, P2, P7, P8, P9	P1, P3, P5, P7, P8, P9, P10, P11
46	Fears and hopes	FG1, FG2, P8, P9, P10	FG3, P1, P7, P8, P9, P10, P11, P13	P1, P3, P5, P7, P8, P11
52	Resilience, tenacity and determination		FG3, P1, P2, P7, P8, P9, P10, P11, P13	P1, 5, 7, 11
49	The intense rollercoaster	FG1, FG2, P7, P8, P9	FG3, P1, P7, P8, P9, P10, P11, P13	P1, P3, P5, P7, P8, P9, P10, P11
33	Feeling positive	FG1 FG2 P7, P8, P9, P10	FG3, P1, P7, P8, P11	P1, P5, P7, P10, P11
30	Acceptance, moving forward and future plans			P1, P3, P5, P8, P9, P10, P11

Subcategory and conceptual codes: The Journey

Appendix 17

New practice assessment roles

In 2016 the NMC launched 'a programme of change for education' NMC (2017) to revise the NMC standards underpinning pre and post registration programmes. This was to ensure the NMC could, as the regulator of the nursing and midwifery professions, ensure appropriate preparation for the nurses of the future. A major review of all the education standards, involving a public and stakeholder consultation, was performed and new standards published. Phase 1 of this programme is now complete. In March 2018 the first part of the review led to the publication of revised,

- Standards framework for education and training for providers of pre and post-registration nursing and midwifery programmes (NMC 2018)
- Standards for student supervision and assessment (NMC 2018a)
- Standards for pre-registration nursing programmes (NMC 2018b)
- Standards of proficiency for registered nurses (NMC 2018c)
- Standards for prescribing programmes (NMC 2018d)

In 2019 the new Standards of proficiencies for midwifery were published (NMC 2019).

This work still continues, the latest review being that of the post registration standards (NMC 2019a, Pye Tait 2020) with the consultation for this review closing very recently (August 2021).

As part of this overall programme of change the 'Standards for Student Assessment and Supervision' (SSAS) (NMC 2018a) were published and the previous 'Standards for Learning and Assessment in practice' (SLAIP)(2008) replaced. These new standards are applicable to all students undertaking a NMC approved programme, including SCPHN programmes.

Providing standards for how, both pre and post registration nursing and midwifery students, will be assessed and supervised, the introduction of SSAS (2018a) led to the withdrawal of the mentor, sign-off mentor, PT and teacher roles that were previously in place (NMC 2008). Three new roles were introduced; practice assessor (PA), practice supervisor (PS) and academic assessor (AA), these new roles now jointly undertake the supervision and assessment of students.

For SCPHN students the introduction of these standards culminated in changes to their supervision and assessment in practice. This is now supported by Practice Assessors and Practice Supervisors rather than Practice Teachers and Mentors. Transition to these roles for

those with previous PT and mentor or teacher status was provided (usually by the AEI). The Practice Assessor must be registered as a SCPHN. Academic assessors who generally work within AEIs, work alongside the other two roles and also have to be registered a SCPHN.

References and further information

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Nursing and Midwifery Council (2017) NMC programme of change for education. Overview of education consultation. Available at https://www.nmc.org.uk /globalassets /sitedocuments/ edcons/ec1-overview-of-education-consultation.pdf [accessed 24/08/21]

Nursing and Midwifery Council (2018) *Realising professionalism: Standards framework for education and training. Part 1: Standards framework for nursing and midwifery education.* Nursing and Midwifery Council, London. https://www.nmc.org.uk/standards-for-education-and-training/standards-framework-for-nursing-and-midwifery-education/[accessed 24/08/21]

Nursing and Midwifery Council (2018a) *Realising professionalism: Standards framework for education and training. Part 2: Standards for student supervision and assessment*. Nursing and Midwifery Council, London. https://www.nmc.org.uk/standards-for-education-and-training/standards-for-student-supervision-and-assessment/ [accessed 24/08/21]

Nursing and Midwifery Council (2018b) *Realising professionalism: Standards framework for education and training. Part 3. Standards for pre-registration nursing programmes*. Nursing and Midwifery Council, London. Available at: https://www.nmc.org.uk/standards/standards-for-nurses/standards-for-pre-registration-nursing-programmes/ [accessed 24/08/21]

Nursing and Midwifery Council (2018c) Future nurse: Standards of proficiency for registered nurses. Nursing and Midwifery Council, London. Available at: https://www.nmc.org.uk/ standards/standards-for-nurses/standards-of-proficiency-for-registered-nurses/ [accessed 24/08/21]

Nursing and Midwifery Council (2018d) *Realising professionalism: Standards framework for education and training. Part 3: Standards for prescribing programmes.* Nursing and Midwifery Council, London. Available at https://www.nmc.org.uk/ standards /standards-for-post-registration/standards-for-prescribers/ [accessed 24/08/21]

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Nursing and Midwifery Council (2019a). *Evaluation of post-registration standards of proficiency for specialist community public health nurses and the standards for specialist education and practice standards.* Available at https://www.nmc.org.uk/

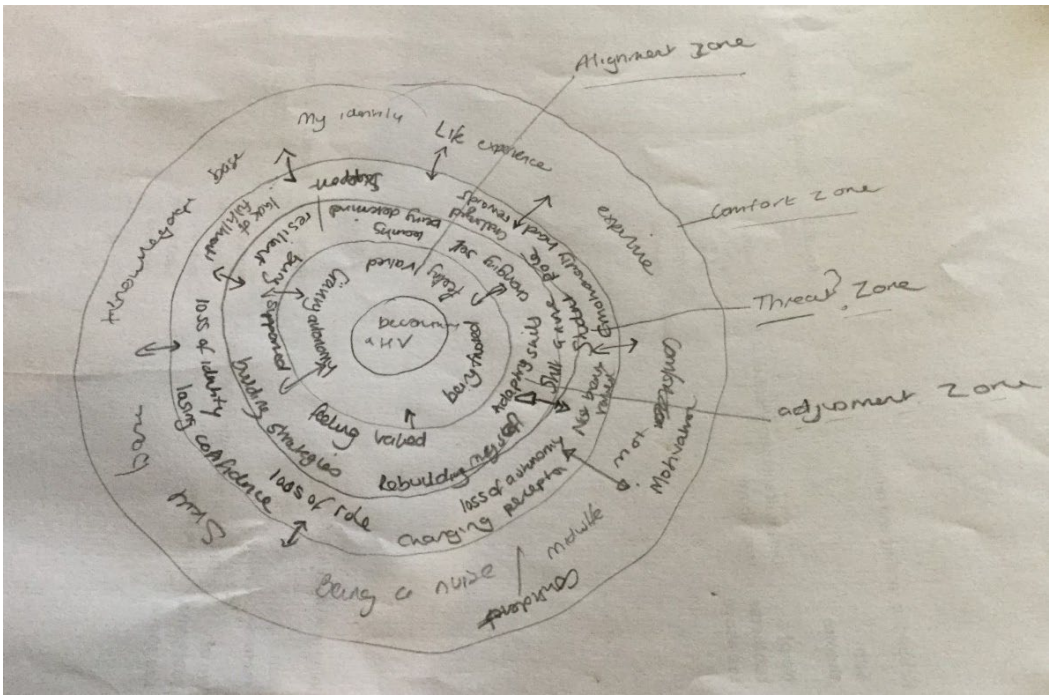
globalassets/sitedocuments/education-programme/evaluation-post-registration-scphn-and-spq-standards.pdf [accessed 24/08/21]

Pye Tait (2020) *Themes from pre-consultation stakeholder engagement for the Post Registration standards review* Available at https://www.nmc.org.uk/globalassets/sitedocuments/ education-programme/post-registration-review---pye-tait-report-pre-consultation-engagement-themes-november-2020.pdf [accessed 24/8/21]

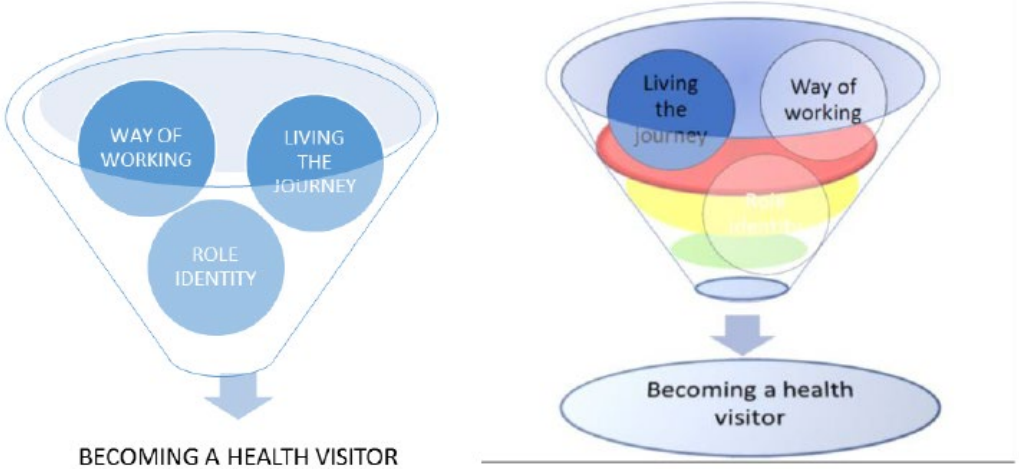
Appendix 18

Draft conceptual drawings

Initial rough hand sketch drawing at the start of conceptualisation process



Initial model begins to formulate



Computer graphics begin to be employed as model further develops

Appendix 19

RCN Education Forum International Conference

Concurrent session

5.3.3

Moving into a specialist role - An investigation of the transition from qualified nurse to health visitor exploring the influence of their previous role and experience.

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Aim

An investigation of the transition from qualified nurse to health visitor exploring the influence of their previous role and experience.

Abstract

In 2011 the Health Visitor Implementation plan resulted in the recruitment of student health visitors from an increasingly wide variety of nursing backgrounds and a potential change in the health visitor workforce as a consequence. The effect of this increased diversity in the workforce and the continuing issues with professional identity and constantly evolving role (Baldwin, 2012) (Peckover, 2013 present an interesting area for exploration. - Initially a mixed methods case study was used to evaluate the influence of the background and experience of student health visitors in their programme of study, identifying themes for a in-depth follow on study. A number of factors were identified for further exploration, in particular the length and type of the previous experience of the student, the enthusiasm for the profession, the desire to empower and the transferable skills of the students. Recommendations for practice of this initial case study included the identification of a number of potentially important features in the recruitment of new health visitor students. - The factors identified through this initial stage are now being further explored through a constructivist grounded theory study (Charmaz, 2006). Greater understanding of this transition from qualified nurse or midwife to specialist practitioner will help inform future students, work force development, employers and education providers. Early findings suggest that the move into a qualified health visitor role is comparable to that of newly qualified nurses experience, with many describing 'transition shock' (Duchscher, 2009). This is compounded by a stripping of confidence, a process of chaotic de-skilling and feeling undervalued in the work place, before this is rebuilt and redeveloped as they emerge into their new specialist roles. Key factors in the success of this process are the support available, colleagues valuing their previous knowledge and their individual tenacity. - It is hoped the findings of this study will provide us with a framework applicable in health visiting and other areas of specialist health care practice education where the potential students have advanced skills, knowledge and experience from a diversity of backgrounds before they decide to undergo a further programme of education and move into a specialist role.

Intended learning outcomes

1. To discuss the influence that different nursing backgrounds and experiences can have on the transition process when becoming a health visitor.
2. To discuss the early findings of an indepth grounded theory study of the process of transition from qualified nurse and midwives to a qualified health visitor
3. To discuss early recommendations for practice.

Recommended reading list

1. Baldwin, S. (2012). Exploring the professional identity of health visitors. Nursing Times; 108: 25, 12-15.
2. Charmaz, K. (2006). Constructing Grounded Theory: A Practical guide Through Qualitative Analysis. London:Sage
3. Duchscher, J.E.B. (2009)Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses.Journal of Advanced Nursing65(5), 1103–1113.doi: 10.1111/j.1365-2648.2008.04898.x

Biography

I am a Senior Lecturer in Post Registration Health Care at the University of Derby. My research interests include the transition of health care professionals as they move into new roles. I worked alongside a team of other colleagues in researching the transition and preceptorship of newly qualified nurses- leading to the development of a Preceptorship Toolkit (Whitehead et al 2015). This has culminated in my latest research exploring of the transition process for qualified and experienced nurses and midwives who chose to specialise and the impact their previous experience can have on this process.

Coding *is an analytical process used to identify concepts, similarities and conceptual reoccurrences in data* (Chun Tie et al 2019, p4) and is an essential element of grounded theory. It is a staged process as the researcher moves the raw data firstly into initial codes, to focused and then conceptual codes and finally into categories. From this an emerging theory develops that connects and incorporates the relationships within the data (Sbaraini et al 2011). This process eventually culminates in a theory which holds all the generated data.

Community of practice (CoP)– The original concept of CoP was proposed by Lave and Wenger (1991) as an informal learning network. Typically, a CoP grows through informal interactions rather than it being pre-planned. It comprises a group of individuals who share a common interest, field or other connection i.e., being a nurse. The members within a CoP share knowledge, community, and a common framework, this usually also incorporate values, ideas, tools, language and history (Wenger et al 2002). A CoP works collaboratively to establish a supportive community, establishing its own norms, shared understanding and builds its own resources based on the mutual engagement of its members.

Concurrent data generation is a key tenet of GT, it is what makes it different to other research designs (Birks and Mills 2011). Data generation should be simultaneous with analysis, both working hand in hand to, a) produce data for analysis and b) analyse the data generated. Thus, establishing where additional new data is required to address the resulting inquiries and follow emerging concepts (Emmel 2013, Birks and Mills 2011, Glaser and Strauss 1967).

Consolidated practice is a regulatory requirement of all HV programmes (see standard 3 of the standards of proficiency for SCPHN (NMC 2004)) and consists of a minimum ten-week period at the end of the HV programme, during which the students move full time into the practice area to consolidate their HV skills. At this point student HVs are able to take responsibility with supervision (NMC 2004).

Constant comparison analysis is intrinsic to concurrent data generation (Birks and Mills 2011). Here the researcher compares the generated data to all existing data as it arises. When patterns emerge, further generated data is then compared, and concepts and categories identified. The researcher continues to gather data until theoretical saturation is reached. The process is cyclical and relies on the researcher analysing and identifying concepts or codes (coding) and categories within the data.

Constructivism- an epistemological stance. A constructivist epistemology claims that the truths or knowledge cannot exist independently of 'us' as they are formed through our interaction with the social world (Taghipour 2014, Guba and Lincoln 1985, Merriam 1998). Constructivists build knowledge and meanings based on their interactions with the world (Gordon 2009, Morcol 2001). The meanings can be different, even in relation to the same experience as experiences will be interpreted by individuals in different ways (Crotty 1998). This leads to a multitude of meanings and views about the same experience (Neuman 2003). Constructivists look for patterns and meanings within these views to understand the processes they research (Creswell 2007).

Constructivist grounded theory (CGT) A re-positioned grounded theory methodology which takes account of the constructivist paradigm. It places emphasis on the phenomenon being studied, its context, and the creation of data and its analysis as arising from the sharing of experiences with the research participants. It clearly acknowledges the researcher part in the process of constructing a theory in partnership with the participants (Charmaz 2014).

Epistemology is the study of '*knowing*', or the consideration of *what is knowledge*? and *how you come to know*? (Broom & Willis 2007).

Fields of nursing- within the UK there are four fields of practice which nurses can study. Each field as a specific registration with the NMC. The fields are, adult nursing, children's nursing, learning disabilities nursing and mental health nursing.

Grounded theory (GT) is an inductive research methodology that incorporates systematic guidelines for gathering, analysing, and conceptualising data for the purpose of theory construction. The researcher goes back and forth between data and analysis comparing and interacting with the data to develop theories that are 'grounded' in the data. Grounded theory studies are generally focused on social processes or actions: they ask about *what happens* and *how people interact* (Sbaraini et al 2011, Charmaz 2014).

Health visitor (HV) - Health visitors are already NMC-registered nurses or midwives who have undertaken additional training in community public health nursing to become specialist community public health nurses (SCPHN) within the health visitor field.

Health Visitor Implementation Plan (HVIP) - The health visitor implementation plan set out a call to action to expand and strengthen health visiting services between the period of 2011-2015 (DH 2011a); an additional 4200 health visitors were required to boost declining health visitor number.

Identity can be described as the understanding of who or what we are, as seen through the perspective of the individual (personal or self-identity) or others (social identity) (Gecas 1982).

Interpretivism is a theoretical perspective linked to constructivism (Gray 2009, Chen et al 2011). It advocates that the social world cannot be investigated by observation, measuring and the confirmation and verification of facts, but instead it focuses on scrutinising, unpicking and understanding phenomena (Gray 2014). The endeavour of Interpretivist research is to uncover how people feel, perceive and experience the social world, aiming to establish a rich meaning and understanding (Creswell 2007, Parahoo 2006). Interpretivists also believe it is important to understand how people's interpretations of their world affect their view of their reality (Chen et al 2011). This reality is not fixed, it can be multiple and is developed together with the research subjects rather than independently – this interactive process being seen as a strength (Parahoo 2006, Cresswell 2007).

Memoing is an analytic process, and another of the key tenets of GT (Sbaraini et al 2011). It is crucial in the exploration and conceptualisation of relationships in the data (Charmaz 2014, Birks and Mills 2011) and in the co-construction of data. They provide a record of the

researcher's thoughts and feeling during the analysis and they help the researcher consider what is happening in the data, making explicit the comparisons and patterns that emerge. They should be spontaneous, stemming from the thought processes of the researcher as they help to move the findings into a GT (Birks and Mills 2011).

M**entor –** this role was undertaken by an NMC registrant who had successfully undergone a NMC approved programme in preparation for the role. They were subject to a triennial review and included in a local register, held normally by the placement provider. All nursing and midwifery pre-registration students were assigned a mentor as a mandatory requirement. Mentors were responsible for organising student learning activities, supervising, monitoring achievement and performance of students and providing evidence to support assessment. Mentors were subject to a triennial review. To support the practice teacher (PT) and the increased numbers of SCPHN (HV)students during the HVIP a model of joint PT and mentor support for SCPHN (HV) students was adopted. Mentors used to support SCHPN (HV) students were also on the SCPHN (HV) part of the register and had received mentor preparation in accordance with the NMC requirements (NMC 2008). The role was superseded in 2018 when the new NMC Standards for Supervision and Assessment of Students were introduced (NMC 2018a)

Objectivism- an epistemological stance. In an objectivist epistemology, knowledge exists outside of our conscious, it contends that reality exists independently; that there is an objective reality. Research therefore from an objectivist position aims to find this objective truth (Crotty 1998, Guba and Lincoln 1995). Objectivists also contend that the researcher can be completely independent from the researched.

Ontology is the study of 'what is' or of 'what it means to be' and it provides a position for clarifying your view of the nature of the reality being explored or studied (Crotty, 1998). Moses and Knutson (2007) consider ontology to ask, '*what is the world really made of*' (p4).

Positivism is a theoretical perspective that sits within the objectivist epistemology (Gray 2014), its basic assumption is to use objective methods to enable a near approximation of reality in the search for reliable truth, often with experimental means (Lincoln and Guba 2000).

Post- positivism also sits within the objectivist epistemology. However, post- positivists, unlike positivists, refute that truth can be absolute (Gray 2014) recognising probability of truth and believe in multiple, rather than a single reality (Creswell 2007). There are many critics of this theoretical perspective however (Giddens 1977, Crotty 2003), not least because it is felt it fails to take account of the individual, human reasoning and consequent behaviour (Burns, 2000) and objectifies human nature (Parahoo, 1997).

Practice assessor (PA) -assess and confirm the student's achievement of practice learning. The practice assessor role was introduced as part of the new Standards for Student Assessment and Supervision (SSAS) (NMC 2018a) and must be a registered nurse, midwife, nursing associate, or specialist community public health nurse (SCPHN). Except in the case of

prescribing programmes where the PA can be any qualified and experienced prescriber. In the case of SCPHN students the PA must also be on the SCPHN part of the register. There is a requirement for preparation for the PA role in order for them to meet the Standards for Student Assessment and Supervision (SSAS) (NMC 2018a). Many of the previous PTs have become PAs with the AEI and practice learning partners deciding how they could support this transition and ensure public protection, meeting the NMC standards.

Practice supervisor (PS)- the role was introduced as part of the new Standards for Student Assessment and Supervision (SSAS) (NMC 2018a). A PS is required supervise students practice and provide support in the practice learning environment. They also provide evidence to the PA. They are required to be registered with the NMC or another regulator (GMC, HCPC).

Practice teacher (PT)- responsible for the support and assessment of students on NMC approved programmes leading to the SCPHN registration (NMC 2008) up to 2018 when the new NMC standards for Supervision and Assessment of Students were introduced (NMC 2018a). PTs were responsible for ensuring the required proficiencies for entry to the register were achieved at a final assessment of the student and signed off. PTs had to be on the same part or sub-part of the register as that which the student was intending to enter and their professional qualifications had to be at least equal to the students they were supporting and assessing. They also had to have had undergone preparation for their role by undertaking an NMC approved programme meeting NMC requirements for the role. Essentially the role required an underpinning evidence base for teaching and assessment alongside appropriate professional and academic qualifications. Although the role was not registered with the NMC a local register of PTs was kept by the supporting AEI or placement provider. PTs were subject to a triennial review and normally had previously undertaken the role of a mentor. All SCPHN students were required to have a named PT and a PT was, up until the HVIP (DH 2011), allowed to support only one student at a time. The HVIP led to larger numbers of SCPHN (HV) students and hence the NMC reviewed this requirement, allowing the PT to support a number of students at one time, depending on need (NMC 2011). In addition, to support the PT and the increased numbers of SCPHN (HV)students during the HVIP a model of joint PT and mentor support for SCPHN (HV) students was adopted.

Pre-registration refers to individuals prior to registration as a nurse or midwife with the Nursing and Midwifery Council (NMC).

Professional Identity -can be used to describe the collective identity of a professional group and/or how we construct ourselves as individuals within this group. Professional identity is a professional self-concept based on attributes, beliefs, values, motives, and experiences (Ibarra 1999). Professional identity can be either or both, a social identity (group to which we belong) and/or a role identity (what we do and the meaning this provides us with) (Dutton et al 2010).

Reflexivity is the process of careful, conscious appreciation of the researcher's influence in the process of research. It does not look back on what has been done, as in reflection, but rather it is the "*process of self-awareness and scrutiny that is bi-directional"* (Engward and

Davis 2015 p 1352). It offers transparency of the why and how decisions are made during the research process, opening up the limitations of the research to review.

Role identity the individual construction of our identity within the context of our work or the role in which we see ourselves, closely reflecting the definition provided by Neary (2014),

> *the concept which describes how we perceive ourselves within our occupational context and how we communicate this to others. (p14)*

Specialist community public health nursing (SCPHN) registered title of nurses and midwives working in, and qualified for, public health roles. To undertake a SCPHN programme individuals must be already registered on any part of the NMC register. Some SCPHNs have their area of practice shown on the register. For example, health visitors (HV), school nurses (SN), occupational health nurses (OHN) and family nurses (FHN).

Substantive theory, these are theories which are specific to defined focused fields of inquiry or substantive areas and are not able to be generalised to other fields as a formal theory would (Glaser and Strauss 1967, Birks and Mills 2011). However, the reasoning of the developed substantive theory can sometimes resonate to other areas and with further application and exploration and therefore refinement may lead to a formal theory, connecting with other areas (Birks and Mills 2011, Charmaz 2014).

Theoretical sampling is seen as fundamental to the emergent nature of GT (Mills and Birks 2011). The researcher is key to this sampling technique, as they make decisions about what cues or ideas need to be followed and interrogated further as the analysis occurs. This sometimes results in additional participants being required to investigate an idea (Hallberg 2006). It can also mean the existing data collected needs to be reinterrogated or a different line of questioning is used with existing participants (Coyne 1997). This honing of questioning, sampling and analysis continues until the researcher feels full saturation of the emerging concepts and categories is reached, this is known as **theoretical saturation**.

References (please see page 164)