Role Identity in a Turbulent Environment:

The Case of Health Visiting

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She would have been so proud.

Role Identity in a Turbulent Environment: The Case of Health Visiting

Abstract

This thesis presents a grounded theory study of UK health visitors practising in an increasingly integrated, collaborative, service user focused healthcare system. Emphasis is placed in policy on a preventative, public health approach to addressing the ongoing health needs of the population. This has provoked a national debate on the healthcare contribution of health visitors. Better use of health visiting capacity and closer alignment of the role with the collaborative public health agenda have been identified as a national priority.

The theoretical framework for this study has been developed from the symbolic interactionist premise, that individuals continually reinterpret their world in the context of their social interaction with others. Data has been collected from direct observation and individual interviews. The process of constant comparative analysis has generated four interrelated data categories: professional role in action; interprofessional working; local micro systems for practice and professional role identity (core category). Three models have been developed to support the discussion of the findings. The first two make explicit the inter-relationship between the concepts identified in the data and interactive processes relating to the maintenance of identity. The third model proposes a process of interprofessional role change. It links the uniprofessional and interprofessional dimensions of practice to the core principle of valuing individuals through the maintenance of equilibrium in their professional role identity. Embedding a process for feedback on identity is identified as important.

This thesis theorises that role change facilitation should enable individuals to continually renegotiate their professional role identity in the context of their practice. It also suggests that promoting a sense of collective identity within a professional group will enhance the experience of individuals involved in a collaborative role change process. The thesis concludes with a consideration of its implications for health visiting and others in the healthcare system, in seeking to maintain their role identity in a turbulent practice environment.

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Chapter One – Introduction

Introduction

United Kingdom (UK) healthcare policy emphasises the importance of delivering integrated services which are more responsive the needs of service users. The resulting professional role change across the sector presents a challenge both to individual practitioners and to those leading the change process. This chapter provides the context and background for this thesis which considers the importance of maintaining equilibrium in professional role identity in a climate of policy driven role change. It has been written within a theoretical framework of symbolic interactionism (Mead 1934), from a grounded theory exploration (Glaser and Strauss 1967) of the practice experiences of a group of individual health visitors. The health visiting role is undertaken in a UK primary healthcare context by qualified nurses who have undergone additional specialist education (Nurses Midwives and Health Visitors Act 1997; NMC 2004a). Recently, health visiting has experienced policy generated challenges to its role and mode of practice. These challenges stem largely from policy changes relating to public health and workforce development which have occurred since the election of the New Labour government in 1997 (Appendix 1).

This chapter's discussion will begin with an account of the development of the health visiting profession, establishing its historical link to prevailing health policy. This is followed by an outline of my individual health visiting practice experience from which the initial research interest was generated. The process of research inquiry used to address the research questions will then be explained in brief. In order to understand the broader practice context of the study participants, UK policy changes of relevance will be summarised. Finally, this chapter will outline in brief, the structure of the thesis.

Health Visiting in Context

Clarifying the role

At the outset of this PhD study in 2001, health visiting practice was largely characterised by universal home visiting to people registered with a General Practitioner (GP) practice. Whilst notionally "attached" to the GP practice, health visitors have mainly been employed by primary care trusts (PCTs) (DOH 1997a). Health visiting practice can be attributed to four broad practice principles (CETHV 1977; Twinn and Cowley 1992; Cowley and Frost 2006) as follows: assessing health needs; stimulating an awareness of health needs; facilitating health enhancing activities; and influencing policy affecting health. Since their inception, these principles have provided a framework to guide both the education and practice of health visiting (CETHV 1977; NMC 2004b). Mainstream health visiting focused largely on work with families with young children (Robertson 1991) though a minority of specialist health visitors worked with the elderly (Davidson and Machin 2003), transient groups (Milligan and Williamson 2005) or in community development (Craig 2002).

In 1998 a national, multi agency initiative called "Surestart" (Home Office 1998) was launched. This was designed to ensure all children had a healthy, fulfilled start in life. Its implementation re-routed funding from universal services, to provide Surestart centres in communities where there were limited resources, thereby improving vulnerable families' access to health, social care and education services. Surestart was intended to facilitate better integrated working around the needs of families with young children. Acknowledging health visitors as key professionals working with this age group, there was a call for them to redefine their role, toward a family centred public health role (Home Office 1998). This prompted a local reaction in defence of the role, which became the trigger and focus for this study.

Questions From Practice – A Personal Perspective

In 1998 I was a practising health visitor and I experienced first hand my peers' reaction to Surestart. Whilst agreeing with Surestart in principle, the call for a "new" health

visiting role caused some consternation. Some felt devalued, expressing a view that they had always had a public health role in supporting families and communities. Others felt that whilst their practice was with individuals not communities as such, their involvement in activities such as childhood immunisation contributed to public health. They were thus confused by the call for them to change their role, expressing a lack of understanding as to what exactly they were being asked to change to. There was also a general concern about the public image this policy gave to others, colleagues and clients, and the value placed on health visiting. My experience of this confusion and disquiet generated the interest that led to this thesis.

Experiencing role change

Another trigger of interest was my own experience of role change. At that time, I was a geographically based health visitor in an area of socio-economic deprivation. It was a community characterised by the inherent health and social inequalities experienced by its residents (Townsend, Phillimore and Beattie 1987). This post was a unique mainstream role in the Trust, not being "attached" to a GP practice. Many of the families on my caseload had health issues that were clearly linked to their lived experience, issues such as crime and intimidation. Despite this, the role had historically remained framed around an individual model of practice, tackling need and solving problems through individually focused work, not community focused.

The aim of this role was to address the complex needs of individual families by enabling them to negotiate a complex network of access to services. This required a population health needs assessment to be undertaken. Using assessment as the basis of proactive, preventive work is at the core of New Labour health policy (DOH 1997a), representing a significant shift from the individually focused, reactive nature of previous Conservative policy (DOH 1991). My local assessment of population health needs identified that the complexity of overlapping practice systems presented a risk to the safety of clients. This was due in part to the complex, often delayed, flow of information that was required to ensure their health and social care needs were met effectively at times of crisis. For example in my role I needed to liaise with ten GP practice teams about the different families on my caseload. This meant that building

effective working relationships with individuals in those teams took longer, with credibility as a team member difficult to establish. Therefore when I urgently needed to speak to a GP or look at medical records, getting access in a timely way was much more difficult.

Reflection on my experience of this complexity precipitated the compilation of a report (Davidson 1998) recommending a redistribution of resources, to better meet the needs of the local community. As a result, my role became more community development orientated, with individual families being supported by their GP attached health visitors. A nursery nurse was also employed to support health visitors in the practices with which most of the redistributed families were registered.

My revised role involved closer collaborative working with community groups, charities, parent groups and other professionals across the public sector, fitting with the family centred public health role, as depicted by SureStart (Home Office 1998). Examples of this work included: a parent support group for hard to reach vulnerable new parents, encouraging group ownership and confidence; and contribution to a locally initiated anti-truancy strategy through which I established a wider network of community resources.

Whilst this reorganisation of local health visiting services was supported by management, there were a number of health visiting colleagues who opposed it. I found this somewhat surprising given the impetus for more public health work in health visiting. It became clear that some considered a community development, public health orientated post to be a poor use of resources, at a time when individual caseload work was perceived as under resourced. After an unsettling period of self reflection, I concluded that my community work clearly fell within the principles of health visiting and was worthwhile. This personal perspective was endorsed by other colleagues who were fully supportive of the change, expressing a view that a local community development health visiting role was complementary to their more individualised roles, offering support to the local community in a way that they were unable to do.

Unanswered questions

My reflections on this experience raised several questions that were not answerable through recourse to the existing health visiting and health service literature. Examples included: "was my approach to practice the correct way to do community development/public health work?; "why were there differences in opinion about what public health work was and its relative importance to caseload work?"; "if the health visiting role was to change, as policy was suggesting, was that my responsibility as an individual health visitor or was it a responsibility of management in taking a strategic approach?" Disparate views on the nature of public health work in health visiting were clearly becoming divisive within the local team. "If this was a common experience, what might be the implications for the health visiting profession more generally?"

Study Overview

Research question

In order to provide a focus for the study to capture the range of questions above that had emerged from my own practice experience, the research question chosen was as follows:

"How are health visitors' interpreting and interacting with their changing professional practice context and how has this influenced them and their practice"?

This two part question emphasises the focus on the individual, the meanings they attach to their interactions in their practice and how this may or may not have been influenced by recent changes. It was sufficiently broad to allow important issues to emerge as the study progressed, yet focused enough to enable an in depth study that focused on interaction and perception at the level of individual. The rationale for the research question will be further explained in chapter four.

Research design overview

To address the research question a methodological approach was needed that would enable an exploration of concepts such as role perception, interaction with others, context specific analysis of behaviour and participants' understanding of the public health policy context. Symbolic interactionism (Blumer 1969) provided the theoretical framework within which to systematically investigate these issues. A grounded theory methodology (Glaser and Strauss 1967) provided the process through which the theoretical propositions of this thesis were developed.

Central to any grounded theory study is the process of constant comparative analysis, incorporating theoretical sampling (Glaser and Strauss 1967). The latter is a process of sampling incidents, events, situations for their relevance to the theory emerging from the study. Collected data is then coded and analysed to determine the focus for the next sampling unit. In essence the stages of sampling, data collection and data analysis occur concurrently until the researcher is satisfied that no new data is emerging to add to the different dimensions of the developing theory. This is the process attributed the term constant comparative analysis (Glaser and Strauss 1967). Evidence of this approach as applied to this study will be presented throughout the thesis.

Development of models and their practice application

Through the constant comparative process, three models have been produced: a robust conceptual model illustrating the dynamic interactions between individual practitioners, and key influences within their changing professional practice context; a process model depicting theoretical assertions about the relationships between the components of the conceptual model; and a proposed framework for facilitating collaborative role change in the context of interprofessional working. Though derived from the research process and grounded in the reality of participants in this study, all three models require further investigation to explore their rigour and relevance in a wider healthcare context.

Service user involvement

Service users are of central importance to: the process and outcome of healthcare research; health care service development and delivery; and in the ongoing evaluation of the efficacy of the NHS in meeting their needs. However, because service user involvement in research was not a requirement at the time this study commenced, the user perspective is mainly implicit in this thesis. It is reflected to some degree in the data where participants reflect on their practice experiences. Service users were also present in the participants' practice I observed but they were not the focus. Despite this low profile, the outcome of the research has implications for the service user experience. These are therefore identified in the concluding section of the thesis, which also includes a suggestion for further research to incorporate their perspective into the models developed.

In seeking to better understand the experiences of health visitors there is a need to contextualise their role contribution in the complex UK healthcare system.

Historical Development of Health Visiting

Historically, health visiting has explicitly focused on public health work (De Witt and Carnell 1999). Prior to being subsumed into the nursing profession and the NHS in 1974 (Dingwall et al 1988), health visitors were mostly employed by local authorities and allied to the disciplines of environmental health and infection control. Early health visiting services are thought to have developed within the Victorian Age of the public health movement (Craig 2002) in an effort to help families within communities reduce their risk of contracting infectious diseases. Health visiting work also included "community development work", with middle class women employed to recruit local women as peer counsellors. The statutory Notification of Births Act (1907) was a trigger that began to focus local authority, health visiting services on post natal work and family health. At this point, it has been suggested, health visiting was legitimised as a Government means of intervention and surveillance (Dingwall et al 1988). The primary aim of these child focused services until after world war two, was a reduction in the neonatal death rate, in a country whose population had been depleted.

Following the inception of the NHS in 1947, health services became increasingly focused on individualised, curative services and health education targeted at individual lifestyles (Baggott 2000). Prior to 1974, whilst not employed by health services necessarily, health visitors' work increasingly had more in common with health service provision than local authority social service provision (Dingwall et al 1988). In this period of time, the post of Medical Officer for Health (MOH) was established, placing public health work firmly in a medical, disease orientated paradigm. Health visiting became subsumed into the NHS in 1974. It was formally linked to nursing through the passing of the Nurses, Midwives and Health Visitors Act (1979), the point at which it is suggested, these occupations formally became "professions" (Dingwall et al 1988). Chapter three considers this historical development in more detail, especially in relation to the notion of "professional" status and the relationship between health visiting and nursing.

Link to public health policy

The historical link between health visiting and public health is evident although over time this link became less explicit in the individually focused, curative, mainstream health service provision. A Government review of nursing stated that health visiting was one of the key nursing roles for public health (DOH 1999a). This reaffirmed the assertion made in a previous document that health visiting was public health "in its entirety" (SNMAC 1996). Public health is, to some degree, a core responsibility of all nursing and midwifery roles. However, subsequent policies have left little doubt that public health work in nursing was to be identified most closely with health visitors who, by the nature and context of their role and practice were best place to carry out this work (DOH 2002a). These issues will be explored further in chapter three.

This historical overview is somewhat simplistic in depicting the development of the health visiting profession as a linear progression. In reality, role development in a changing practice context is more complex. Given the explicit link between policy development and health visiting role development, further consideration of the broader NHS policy climate is also needed.

Wider UK Health Policy Context

A process of significant UK public sector reform began with new policies precipitated by the change of government in 1997 (DOH 1997) to New Labour. Two interrelated areas of national policy are of relevance to this thesis: workforce development; and public health policy.

Workforce reform

In 1997, it was acknowledged that most health care was delivered in the primary care setting and as such the NHS should be primary care driven (DOH 1997a). Primary Care Trusts (PCT) were established to be responsible for community health needs analysis, commissioning and delivering health care services to meet the needs of their local populations (DOH 1997a). This had implications for the employees of these new organisations, including health visitors. The influence of organisational contexts and systems on practice will be explored further later in the thesis. Another key premise of workforce policy was the need for better collaborative working within and across agencies, for the benefit of the public who use the services (DOH 2000a). The aim was to make the best use of available public resources by developing services that could be more responsive to the specific needs of services users, through better integration and the streamlining of organisational systems (DOH 1997a). This refashioning of service provision would require a workforce of individuals with transferable professional skills. Specifically these skills would include the ability to effectively and confidently collaborate with others, outside of traditional professional role boundaries and practice contexts (DOH 2000a).

The previously discussed Surestart policy (Home Office 1998) with its implications for redefining the health visiting role is an example of this type of policy directive. The challenge for organisations was to enable their workforce to develop their existing roles (DOH 2002a), whilst minimising the risks for individuals that a constantly changing environment may engender (Lines 2004). The earlier description of my experience of

being a practitioner in this climate of role change, gives an indication of just how much of a challenge this workforce development might be. This thesis seeks to systematically explore this complexity, in order to inform the work of those responsible for successfully managing future workforce development and change.

Public health policy agenda

Current public health policy aims to improve the future health of the UK population, through a strategy of shared values and collaborative concern (Acheson 1998). However, the concept of public health is open to interpretation, depending upon the theoretical perspectives of the practitioners, researchers and academics working and studying in that field. In order to ensure there is a shared understanding of the concept of public health for readers of this thesis, the following definition will be used:

> *[Public health is] "the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society" (Acheson 1988).*

This definition may be said to bridge the range of potential public health perspectives and is well embedded in post 1998 public health policy documents. Given that this thesis explores the experience of role change within a changing policy context, a policy derived definition is deemed appropriate. Collaborative working for public health requires different professional groups from several agencies to work in partnership with communities to achieve common health goals to meet the needs of populations (Wanless 2004). However prior to this, services had been organised around an individual model of health.

This individual approach had been characterised by the delivery of health education which aimed to help the public make healthy behaviour choices (DOH 1991). The pre 1997 workforce was therefore organised accordingly. As indicated earlier, for health visitors this meant "attachment" to individual GP practices and work focused on caseloads of individual families. Educational programmes also prepared practitioners to work in individualised, health and social care services. It could not therefore be assumed that professionals such as health visitors would have the skills required to

successfully work in a collaborative way. The success of the proposed new, collective approach to redressing health inequalities (Acheson 1998) would be dependent on workforce reform and development. As indicated earlier, both workforce and public health aspects of policy will be further developed in chapter three.

Thesis Structure Overview

Thesis Design

In order to capture the complexity of the changing practice context within which the study is being undertaken, each chapter of the thesis is constructed to contextualise the discussion within a range of issues at both macro and micro level. The discussion also includes my reflections on the research undertaken. This will presented in italics and in boxes. The findings chapters will include supporting data from participants. This will also be italicised to separate it from the more theoretical discussion and the building of the thesis. Additional data to support the discussion is also located in the list of appendices (Appendix 12). The thesis is divided into two sections, the first addressing context, rationale, design and method. The second section presents the models described earlier. It also presents and discusses the research findings and their implications for policy, education and practice. Both sections are subdivided into chapters as follows:

Section One

Chapter One – Introduction

This chapter has set out the context and background to the development of the study. The professional development context of the health visiting role has been introduced. This has been linked to this study through a discussion of my own role and the questions from practice generated from this experience. It also sets out the research question that has focused the study and a summary of the research design undertaken. To begin to contextualise the study, the chapter has also presented a summary overview of UK health service policy in relation to workforce development and public health. It concludes with an outline of the thesis structure and features of presentation.

Chapter Two – Theoretical framework

This chapter provides a description of symbolic interactionism (Blumer 1969), a rationale for its use and a discussion of its application in this study. Grounded Theory (Glaser and Strauss 1967; Clarke 2005) is also discussed in detail in this chapter along with other theoretical perspectives that have informed the thesis.

Chapter Three – Literature review

This chapter discusses the literature review undertaken. In order to provide a benchmark of existing knowledge, against which to judge the contribution of the research findings, this chapter includes literature reviewed throughout the research process. Given the continuous nature of the review and is reflexive relationship with the process of analysis, the review is considered implicitly within the theoretical framework as part of the process of the study.

Chapter Four – The research journey

This chapter illustrates the research process undertaken. Using the key features of the process of constant comparative analysis (Glaser and Strauss 1967), namely theoretical sampling, data collection, data analysis, this chapter describes the study process in detail. As already identified, my reflexive relationship with the research process is illustrated by personal reflections. These are drawn from material from a reflective diary kept throughout the research process.

Section Two

Chapter Five – Presentation of a Conceptual Model

This chapter provides an overview of the key findings of the research and the central argument of the thesis. It sets out the first of three models, a conceptual model developed to illustrate the interrelationship between the key categories of data identified in constant comparative analysis. The subsequent chapters address each component part of the model in turn, supported by data. They also build the second, explanatory process model, which proposes the theoretical relationship between the component parts of the model.

Chapter Six – Professional role in action

This chapter presents and discusses the professional practice experience of the individual study participants. In contrast to the more theoretical discussion undertaken in subsequent findings chapters, this chapter presents largely concrete data in an attempt to provide the reader with as clear a picture as possible of the participants' professional role in action. It establishes signposting threads of theoretical discussion that are picked up and developed in the next three chapters.

Chapter Seven – Professional role identity

This chapter explores the study participants' perceptions of themselves in their professional role. It considers key themes that emerged from analysis such as their feelings about changes, priorities and how this links to their understanding of their changing professional practice context. It discusses the relevance of participants' professional experience prior to the study to their perception of their professional role identity as health visitors in their current practice context.

Chapter Eight – Interprofessional working

This chapter discusses participants' perceptions of their experience of working with others in the local practice context. It explores how this interprofessional interaction influences their professional role identity and their subsequent approach to practice.

Chapter Nine – Practice micro-systems

This final findings chapter discusses the influence of the local systems of practice on professional role identity and the maintenance of its stability in a turbulent professional environment. It explores systems' influence on participants approach to practice, to working with others and the interrelationship between this contextualised experience and their professional role identity.

Chapter Ten – Implications of findings

This chapter returns to the conceptual and process models. It summarises how the participant data presented in the preceding chapters, supports the theoretical propositions of the process model which explains the interplay between the key components of the model. It also presents the third model which, it is suggested, has the

potential to help preserve the identity equilibrium of individuals experiencing role change.

Chapter 11 – Summary and Conclusion

This chapter concludes the thesis by returning to the research question and considering the relevance of the findings for health visiting in relation to policy, practice and education. It culminates in a list of suggestions for further research and recommendations for practice.

Chapter Conclusion

This introductory chapter has provided an overview of the rationale, aims and research question for this study which, as described, was initially generated from my practice experience as health visitor. The chapter has also set out in brief the research journey undertaken to produce this thesis which draws on the theoretical perspective of symbolic interactionism and utilises grounded theory methodology. The research has been contextualised in the UK healthcare system with an outline of the historical development of the health visiting role and a summary of relevant public health and workforce policy. Finally an overview of the structure of the thesis has been set out. The next chapter presents the theoretical framework for the study.

Chapter 2 - Theoretical Framework

Introduction

Symbolic interactionism is linked to the philosophical perspective of interpretavism (Hughes 1990), and holds central the premise that reality exists in the meanings which individual social actors derive from their interpreted social interactions with others (Mead 1934). By basing its premise on the importance of subjective interpretation of meaning at the level of contextualised individual interaction (Blumer 1969), the social science approach of symbolic interactionism rejects the fundamentals of any research approach based on positivism and the search for an objective, absolute, measurable truth or reality (Blaikie 1993). Symbolic interactionism was used in this study to facilitate the generation of a substantive theory that would contribute to understanding the social world of the health visitor participants from their own perspective. This chapter considers the symbolic interactionist (Mead 1934; Blumer 1969) theoretical framework within which this study has been undertaken and provides an overview of the grounded research methodology used (Glaser and Strauss 1967). Given the emergent nature of this study, the initial framework was not a rigid prescription on process. The framework was also informed by other theories in an ongoing sense, adding depth to the understanding of the emerging theoretical issues. This chapter will also make those explicit.

Symbolic Interactionism

Key premises

According to Blumer (1969 p.2) symbolic interactionism rests on three key premises: individuals interact with the objects (i.e. anything that can be referred to) in their world on the basis of their perceived meaning; individuals learn the meaning of these objects through social interaction with others; these meanings are refined and modified as a result of a process of interpretation. Blumer further suggests that any study using

symbolic interactionism must explore some key concepts. These are societal context, social interaction, the nature of objects, the self and with that, the previous experience of the participants in the interaction. An approach for this study that was embedded in symbolic interactionism offered an opportunity to explore the self perceptions of individual health visitors and their interpretations of both their individual practice context, and their interactions with other people through the process of their practice.

Illuminating the interactive and interpretative (Hughes 1990) processes between the key concepts of role, interaction, interpreted meaning, and context, would provide a better understanding of the perceived reality of the participant health visitors, in making sense of their world (Blumer 1969). In order to undertake this task systematically with methodological rigour, a research methodology was needed which could capture these individual perceptions and underlying social processes. Systematically uncovering and understanding these processes would provide the linkages between the relevant concepts emerging from the data and help explain theoretically, the dynamic interaction between them. A grounded theory methodology (Glaser and Strauss 1967) was considered an appropriate choice.

Grounded Theory Methodology

Grounded theory (Glaser and Strauss 1967), underpinned by symbolic interactionism, aims to explicate the reality grounded in social situations by systematically collecting and analysing relevant data (Glaser and Strauss 1967). In doing so theoretical assertions can be produced which may explain the core social processes inherent in social interactions (Glaser 1978). The processes of interest in this study are those which help understand health visitors' engagement with a changing professional practice context and its influence on their self perception and their practice.

Grounded theory involves the generation of theory about social issues and phenomena through the interpretations of both the actors in the situation being studied and those of the researcher (Chentiz and Swanson 1986). This claim places the method within an interpretative paradigm. Grounded theory is reliant on the accounts of social actors to

establish theory (Strauss and Corbin 1990). Theory, it is suggested, is inductively developed through an evolving process of constant comparative analysis (Glaser and Strauss 1967).

The philosophical foundations of grounded theory and the subsequent application of it to the research process has been the subject of much debate. The founders of grounded theory (Glaser and Strauss 1967) have publicly debated the extent to which grounded theory should inductively emerge from data through the constant comparative process and the degree of technicality applied to the process of deductive consideration of theoretical issues as they emerge (Glaser 1992; Strauss and Corbin 1990). Glaser accused Strauss of fundamentally changing the grounded theory intent with the publication of a version of the method (Strauss and Corbin 1990) he calls "full conceptual description". Indeed Glaser holds firm to the assertion that the researcher interprets data to generate the grounded theory. This occurs through deductive hypothesising against existing theory and the use of their theoretical sensitivity (Glaser 1978).

Theoretical sensitivity

Theoretical sensitivity refers to the reflexive, interpretative relationship the researcher has with existing knowledge and theory. This influences their reflexive relationship with the data and emerging theory over the entirety of the research process (Glaser 1978). As a concept it acknowledges that researchers do not always come to research situations without previous relevant knowledge in the field of study (Glaser 1978; Strauss and Corbin 1990). This is relevant to this study given my prior knowledge of the research issue and my experiential understanding of the health visiting role.

Embracing theoretical sensitivity and fostering it throughout the study through ongoing engagement with literature, has been a strength of this study. Each new concept that emerged from the data initiated an exploration of related literature. For example the significance of the change process was only explored once it became clear this was of significance. Subsequently my increased theoretical sensitivity to this area of knowledge, informed the way in which ongoing analysis of both new and existing data

was undertaken. Similarly my own awareness of the policy agenda promoting interprofessional working influenced my perceptions of the significance of data relating to work with others. In essence, my theoretical sensitivity facilitated the identification of theoretical and conceptual linkages, of wider significance than might otherwise have been possible.

Whilst theoretical sensitivity can enhance the constant comparative process, it is also important to acknowledge and make transparent this "insider" position and the reflexive relationship between the researcher and the research (Reed and Proctor 1995). Glaser and Strauss (1967) urge the researcher to step back from the data in order to judge whether or not theory has indeed emerged from it or whether their pre conceptions may have directed the study outcome. The influence on the constant comparative analysis process of my own position as an insider researcher will be evident in the account of the research process.

Constant comparative analysis

As indicated in the introductory chapter, constant comparative analysis is a defining feature of a grounded theory approach (Glaser and Strauss 1967). In order to allow the theory to emerge from the data, the researcher undertakes theoretically driven sampling, data collection, coding and analysis of the data concurrently until the researcher is satisfied that no new data is emerging to add to the different dimensions of the developing theory (Glaser and Strauss 1967).

Theoretical Sampling

Coyne (1997) suggests that theoretical sampling initially involves the purposeful selection of a sample (p.625). The researcher sets out to collect some data from the substantive area for study in order to generate some ideas and concepts which will guide subsequent sampling. Glaser (1978) suggests it is important that the sampling strategy at the outset of a grounded theory study is not based on preconceived ideas of what may

be found. Rather, he suggests, it should be based on the assumption that the sociological phenomena or social process the researcher wants to explore can be located within the chosen group (Glaser 1978). In essence theoretical sampling is:

> *"Sampling on the basis of concepts that have proven theoretical relevance to the evolving theory"* (Strauss and Corbin 1990 p.176)

This will be explored further in chapter four which considers its application in this study.

Data Collection and analysis

In tandem with theoretical sampling, constant comparative analysis involves sorting the collected data into categories which share certain characteristics, examining and re-examining each new piece of information, comparing it with the others and checking back to the original data or data source for confirmation of its significance and its "fit" with the emerging theory (Smith and Biley 1997). This task continues until no new information is obtained and the categories become "saturated" (Strauss and Corbin 1990). Analysis begins with "open coding" which involves fragmenting the data and applying temporary conceptual labels to groups of concepts that seem to have some commonality. For example episodes of verbal interactions with others might be labelled "communication". This progresses through "axial coding" which involves reconsidering categories and their labels as new data emerges and looking for more theoretical links between them that might say something about the social processes inherent in a situation. For example "communication" might become "negotiating" which better describes the purpose of communication and conveys a process. As data categories become less temporary, they can be further analysed in terms of their properties and dimensional ranges to enable an analysis of the contextual conditions that have an influence on them (Strauss and Corbin 1990) and an exploration of links between categories. Constant comparison enables the identification of a "core category" which appears links the other categories in a meaningful way (Smith and Biley 1997). The final stage of analysis is selective coding in which theoretical ideas are firmed up

through selective, theoretical sampling with the specific intent of testing out ideas and looking for "far out" examples of data that may challenge or confirm the developing theory.

Symbolic interactionism claims that each new interaction brings reinterpretation and new meaning. It could therefore be argued, that in a research process reliant on inductive reasoning (Blaikie 1993), the researcher could never be certain that ongoing data analysis would not generate new understanding. In other words it is questionable whether the goal of theoretical saturation (Strauss and Corbin 1990) can ever be fully achieved. Within the limited time frame of this doctoral process there can only be a degree of confidence that the research question has been as fully considered as possible in the time available. The limitations of this are therefore acknowledged at the outset. The process of constant comparative analysis applied to this study will be made explicit in the next chapter.

Judging a grounded theory study

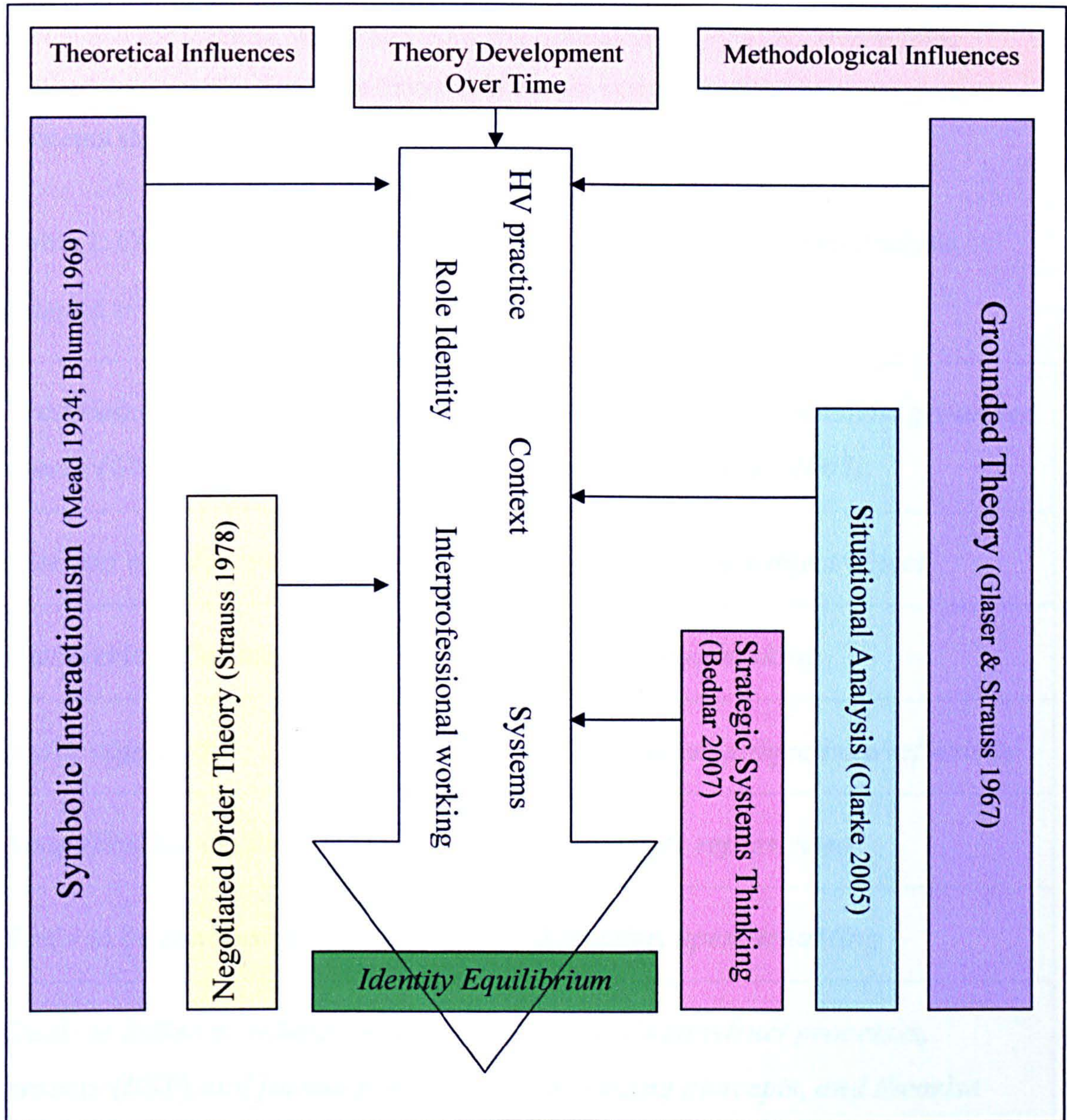
As grounded theory is an interpretative methodology, the canons by which quantitative research studies are judged are suggested as irrelevant without adaptation (Strauss and Corbin 1990). For example, the quantitative research term "validity" is rarely used in grounded theory research, although the concept is integral to the rigor of any study (Strauss and Corbin 1990). Instead of using "validity", grounded theorists and other qualitative researchers, might use terms such as the degree of "accuracy" or "fit" of the resulting theory (Smith and Biley 1997) to the data and to existing theory on the subject. A grounded theory study is one of discovery and is context specific. It does not claim that the results can be generalised to a wider population in a predictive sense. However, if the substantive theory is an accurate reflection of the research findings, then it is likely to have "generality" in the substantive area of study (Glaser and Strauss 1967). This being the case, a well developed grounded theory might offer a degree of "control" (Strauss and Corbin 1990) to those who use it subsequently to inform their own work or investigate it in different settings. Williams (2000) uses the term "moderatum generality". The findings of a qualitative, interpretative research study he suggests, could be judged for their credibility, as "instances" of a broader set of recognisable

features in the relevant field of study. The theoretical propositions generated from this study should therefore be judged for their fit, generality and control, in the context of health visiting and the wider UK healthcare system.

Developing an Integrated Interactionist Theoretical Framework

As described, the study was initially undertaken from a symbolic interactionist perspective using the methodology of grounded theory. However as the study progressed it became necessary to draw on other theories to complement those inherent in the application of symbolic interactionism to the study. My developing theoretical sensitivity over the course of the study, in relation to Situational Analysis (Clarke 2005), Strategic Systemic Thinking (SST) (Bednar 2007) and Negotiated Order Theory (Strauss 1978), added depth and complexity to the constant comparative process undertaken. This will be explained further later. In essence a combination of these different theoretical and methodological perspectives (figure 1) influenced, over the duration of the study, the lens through which I considered the emerging theory and its relevance. This combination I have termed an integrated interactionist theoretical framework:

Figure 1: Integrated Interactionist Theoretical Framework



Each component of this integrated framework will be discussed in turn.

Situational analysis

Situational analysis Clarke (2003; 2005) is an interpretation of grounded theory which perhaps better matches the intent of this particular study than other versions published

by its original authors. In order to understand this claim, it is useful to consider how Clarke's work differs from Glaser and Strauss' original work (Glaser and Strauss 1967). Clarke (2005) produced a table to make explicit some of the key variations between her model and the original, whilst still claiming grounded theory as her overarching methodology (p.32). The table below sets out six examples of the key comparative concepts she uses:

Table 1: Comparison of Traditional Grounded Theory and Situational Analysis

Adapted from Clarke (2005 p.32):

Traditional/Positivist grounded theory (Glaser and Strauss 1967)	***Post modern/ constructivist grounded theorising (Clarke 2005)***
Dualism of subject/object	***Continuities of subject/object***
Discovering/ finding	***Constructing/making***
Naïve objectivity	***Non innocent subjectivity/reflexivity***
Simplification desired	***Complexity represented***
Seeks to be conclusive	***Tentative, open, troubling***
Goal: to delineate a basic social process (BSP) and formal theory	***Goal: To construct processes, sensitizing concepts, and theorise***

The differences between the two versions are apparent in the table. As first glance it might be argued that there is too much of a deviation from the original to call Clarke's version of grounded theory. However, it seems that some of the differences are simply an update of the language used to express similar processes, they are not always mutually exclusive concepts. For example a researcher might "conclude" that their theory is "tentative and troubling". Similarly whilst "simplification" may be desired, the presentation of "complexity" is not precluded. Clarke herself suggests that she does not

wish to end the procedural processes through which theory grounded in data emerges. She suggests that situational analysis simply offers an opportunity to better capture the complexity of grounded theory methodology as it has developed over time. It redefines grounded theory as a contemporary methodology fit for purpose in the current context which is framed as its strength (Clarke 2003).

Situational analysis is articulated as a particularly effective way of examining discourse and power, by illuminating those structural constraints in a situation that traditional grounded theory may not. It has echoes of a process called mesodomain analysis suggested by Hall (2003) who attempted to improve understanding of the significance of negotiating order through linking behaviour to context, structural constraints and collective activity over time and space. By mapping the position of the individual in relation those structures it should be possible to construct a theory through which dominant features in a situation can be challenged (Clarke 2005). This study did not set out to focus on the discourse of participants or focus on uncovering dominant structures influencing the interaction of individuals. However, issues of power did emerge from the data as significant, such as the relative professional standing of medical knowledge in the health and social care system.

The emergence of these issues coincided with the publication of situational analysis (Clarke 2003; 2005) and my engagement with it. However, as I was well into the theoretical stage of the process of constant comparative analysis by this time, situational analysis as a process could only be applied retrospectively to compliment the progress already made. It did however offer an opportunity to address some of the tensions I was experiencing in applying a more procedural approach to grounded theory (Strauss and Corbin 1990).

For example, I was at that time preoccupied by decision whether or not to use a conditional matrix to add complexity to the analysis of the data (Strauss and Corbin 1990). Compiled from participant data and other available information sources, the conditional matrix summarises the variants in conditions in the context of the participants that could affect the inherent social processes and the grounded theory that has emerged. Different levels of relevant contextual issues are usually depicted in a layered circular diagram indicating levels of context from micro (e.g. individual

participant values) to macro (e.g. broader policy or organisational issues of relevance). A completed matrix would organise the conditional issues of relevance in each level (Strauss and Corbin 1990). This in theory facilitates greater depth to data analysis and the links between properties and dimensions of categories (Strauss and Corbin 1990).

Glaser (1992) however, did not support the use of a conditional matrix which he suggested, delivered "full conceptual description" and may result in a verification process that was not in keeping with the original tenets of grounded theory. Clarke (2005) also criticised the conditional matrix for its implication that the conditions in context that have a bearing on the emerging theory, are somewhat external detached from the data and the participants (Clarke 2005). In this study, the changing conditions of practice were acknowledged in the research question. In addition, variation in contextual conditions in the form of "systems for practice" also emerged as a significant data category. Therefore the use of a conditional matrix to add analytical depth was considered an unnecessary duplication.

Clarke (2005) suggested that a better technique for capturing context in grounded theory is to treat contextual elements as part of the whole picture, depicted as a situational "map", that includes all issues of relevant to the emerging theory. Thus in situational analysis, contextual, "non human" elements of data are considered as part of the spatial picture alongside other factors of value. This map would consist of all data categories, their properties and other objects of relevance portrayed pictorially, with proximity and linkages identified through lines and arrows. Situational analysis therefore offered a method which justified everything of relevance being potential data, including policy content and protocols.

As the constant comparative process progressed it became evident that the practice context of participants was characterised by a complex interplay of networks, systems and information flows which affected how they viewed themselves as practitioners in the system. As the writing of the thesis progressed, my reading took a necessary route into organisational theory in an effort to better understand the influence of complex structures and context on the behaviour of individuals and collective groups. In essence ongoing engagement with the literature was a source of my theoretical sensitivity to

emerging issues of relevance (Glaser 1978). Negotiated Order Theory (Strauss 1978) offered an opportunity to add further depth of understanding in exploring this dynamic.

Negotiated order theory

Strauss (1978) suggested that some form of negotiated order is necessary for smooth functioning of the organisation. As a method, negotiated order has been used to explore how doctors and nurses negotiate their healthcare practice environment which is characterised by co-existing collaboration and conflict (Svensson 1996). Negotiated order is said to be a product of interaction between individuals, the organisational structures and processes such as policies, procedures, historical norms and informal agreements between actors in the situation. Whilst published somewhat earlier than Clarke's (2005) work, the parallels in theoretical position are evident. Strauss suggests that any change to the usual order of things will always require renegotiation, (Strauss 1978 p.5) by individuals in relation to their place in the order of things. He further suggests that other theorists have made the distinction between the structures of organisations and the interpreted realities of individual, as sources of formal and informal, role legitimacy and support. Strauss' negotiated order theory blurs those boundaries, considering everything in a given situation to be negotiable at an individual level in terms of its significance and meaning (Strauss 1978).

This perspective may be considered by some to be naïve and simplistic in that it ignores the potential dominance of organisational structures in sustaining the coercion of individuals for the benefit of the organisation. In addition, the perpetuation of forms of discrimination within organisational structures may be played down in a theoretical perspective focused on individuals. However, Strauss (1978) suggests that that the negotiation or structural context needs to be made explicit in any study of the position of individuals in organisations, in order to establish the potential parameters of their social interaction with others. Thus it has relevance for the study of health visitors and their interaction with their changing professional practice context, the latter being boundaried by several constraints such as professional code of conduct (NMC 2008b) and their pre defined organisational role. Once the parameters of negotiation are understood, this knowledge may become the foundation for more emancipatory research

theoretical frameworks, assisting individuals to challenge this order, through a more action orientated route of enquiry. This thesis will show that understanding the organisational position of the participants and their changing professional practice context, lays the foundation for proposing a positive approach to workforce development and change in the UK healthcare system.

Strategic Systems Thinking (SST)

The final component of the theoretical framework that informed this thesis stems from soft systems methodology. Through the process of constant comparative analysis, it became apparent that the context of the participants was a series of overlapping, integrated systems that supported their practice. Chapter nine of the thesis will show that these micro systems for practice influenced participants' ongoing negotiation of their role and identity. In considering some theoretical literature on systems, one framework seemed particularly pertinent to the final stage of analysis I was undertaking. Strategic Systems Thinking (SST) requires the investigator of complex systems to undertake three levels of analysis: intra-analysis, the study of individual perspectives; inter-analysis, the study of interrelations in the organisational context; and value analysis, a study of the cultural norms and values inherent in the context of interaction.

Applying this retrospectively to my analysis at the point of writing up it was evident that these three foci existed in the data. However this was not an explicit framework into which the data was "forced", a process which Glaser (1992) warns against in grounded theory. SST is applied in the context of this thesis, not as a tool for contextual inquiry as its originator intended. Theoretically it presented a way of refining the already well developed relational links between the individual, inter-relational and systemic data. Through a discussion of this dynamic, the thesis will argue the importance of supporting the maintenance of equilibrium in individual identity formation, in a professional practice context characterised by uncertainty and change.

Whilst theoretical perspectives and processes other than symbolic intercactionism and grounded theory have been introduced, none of these additional theories could be said to have been used in their truest form or in a way that replicated their original

methodological intent. Rather, consideration of the data in relation to their key theoretical assertions, added an opportunity to refine, develop and add something to the outcome of this study that basic grounded theory would not have. Whilst they consider research findings in slightly different ways, situational analysis, negotiated order theory and strategic systems thinking, all consider individual interaction, interpretation, context and behaviour. Thus in their different ways, all have an underlying framework of interactionism as a way of viewing and understanding the world. The core theoretical premise remained constant, in that **the study participants' reality is interpreted by them through their social interaction with others, and this is influenced by the systems and context in which it occurs**.

Chapter Conclusion

It is suggested that the course of any research study will be directed in terms of method and methodology by both the research questions to be addressed and the researcher's assumptions about society (Bowling 2002). These assumptions are coupled with the need for research credibility, gained through undertaking a research process that is systematic and rigorous and one which will be valued through the process of peer scrutiny. Symbolic interactionism (Blumer 1969) has been described as an appropriate overarching framework for this study which seeks to understand the meanings attached by individual health visitors to their interactions in a changing professional practice context. This framework has been augmented over the course of the study drawing on elements of Situational Analysis (Clarke 2005), Negotiated Order Theory (Strauss 1978) and Strategic Systems thinking (Bednar 2007). Given the focus on interaction, and on understanding the dynamics of professional practice in context, grounded theory (Glaser and Strauss 1967) has been justified as a useful research design. As outlined, the form of this has evolved over the study to make explicit the influence of context on the perception of the participants. Key aspects of operational detail within a grounded theory approach have been discussed, including theoretical sampling and sensitivity, constant comparative analysis and the tenets by which the rigour of a grounded theory study can be judged.

The following chapter considers the literature that informed this study's theoretical development. The decision to set out the theoretical framework of the study before presenting the literature review is intentional. In keeping with the Integrated Interactionist Theoretical Framework as discussed (Figure 1), data in the study has been derived from participants' perceptions of their experiences, my observation of their role in action and other contextual information of relevance. The latter includes relevant literature that has been developed for and from practice. Existing knowledge does not sit objectively outside of the work of the participants or indeed, the course of this research study. My reading of the literature as the study progressed and my individual interpretation of its meaning, directed my reflexive actions as a researcher. In the same way, my ongoing analysis of the data directed the course of my subsequent reading. The literature review as set out in the next chapter will show evidence of this through reflection on my own practice experience and in my interactionist interpretation of the significance of the literature to the study.

Chapter 3 - Literature Review

Introduction and Rationale

This chapter represents a collation of the literature reviewed to inform the whole research study, from the formulation of the initial research question to the completion of the thesis. In a grounded theory study it is suggested that the researcher should not be predict its outcome by undertaking a comprehensive, initial literature review (Glaser and Strauss 1967) prior to sampling and data collection. This would increase the risk that data would be "forced" to fit existing theory, instead of allowing the grounded theory to emerge (Glaser 1978). However, as discussed entering the field of study without prior knowledge was not possible given my practice role as a health visitor and inevitable theoretical sensitivity to the practice context of the participants. It is suggested that theoretical sensitivity, derived in part from knowledge of relevant literature, gives the researcher the insight and understanding necessary in order to differentiate between data for its relevancy (Strauss and Corbin 1990). The influence of this will be evident in my interpretation of the literature considered in this chapter, as will the influence of the theoretical framework set out in chapter two.

There have been two distinct phases to the literature review. One focused on the broad range of unanswered questions that emerged from my professional practice experience. The other focused on understanding the links between unpredicted, emerging theory and existing knowledge. Both phases are identified pictorially in the search strategy section of the chapter.

Several themes of relevance emerged from the review and are set out in this chapter. Each of these is discussed for its relevancy to understanding the research question:

"How are health visitors' interpreting and interacting with their changing professional practice context and how has this influenced them and their practice"?

These themes included: the professional and policy context of health visitors; concepts of profession; professionalism; the politics of identity; and the link between identity and role. Studies which have considered these concepts applied to professional practice are considered. The chapter concludes with the final theme of relevance, managing professional role change, which emerged as important toward the end of the constant comparative process. Given the emerging complexity of the study, exploration of all available literature, in depth, was not possible within the scope of this thesis. This review is characterised by breadth rather than depth. It represents a signposting mechanism to the potential relevancy of the emergent theory to a range of different academic and practice fields and not an exhaustive review of all that is known.

Search Strategy

At the commencement of the PhD process, an initial search of the following databases was conducted: CINAHL, MEDLINE, ASSIA, BIDS and the UK Department of Health publications library on line. The initial search was limited to the period 1974-2002 and sources in the English language. Phase two became increasingly theoretically driven requiring a broader search to include literature from social psychology and organisational management. The search period was also extended to include more up to date material. In addition the University library catalogue search facility was used to locate theoretical texts that could add depth to my understanding of issues such as identity, knowledge and the sociology of professions. Figures two and three below give a pictorial representation of the keywords used to focus both phases of the search, indicating an increasing complexity:

Figure 2: Initial Literature Review Search Terms

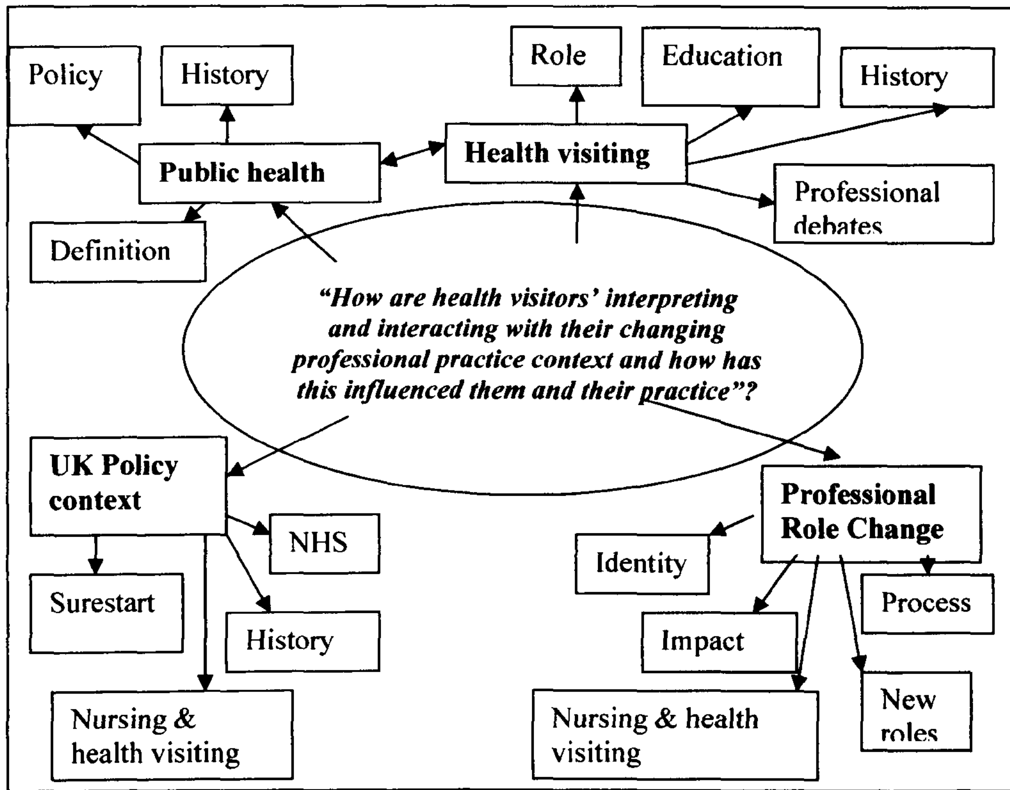
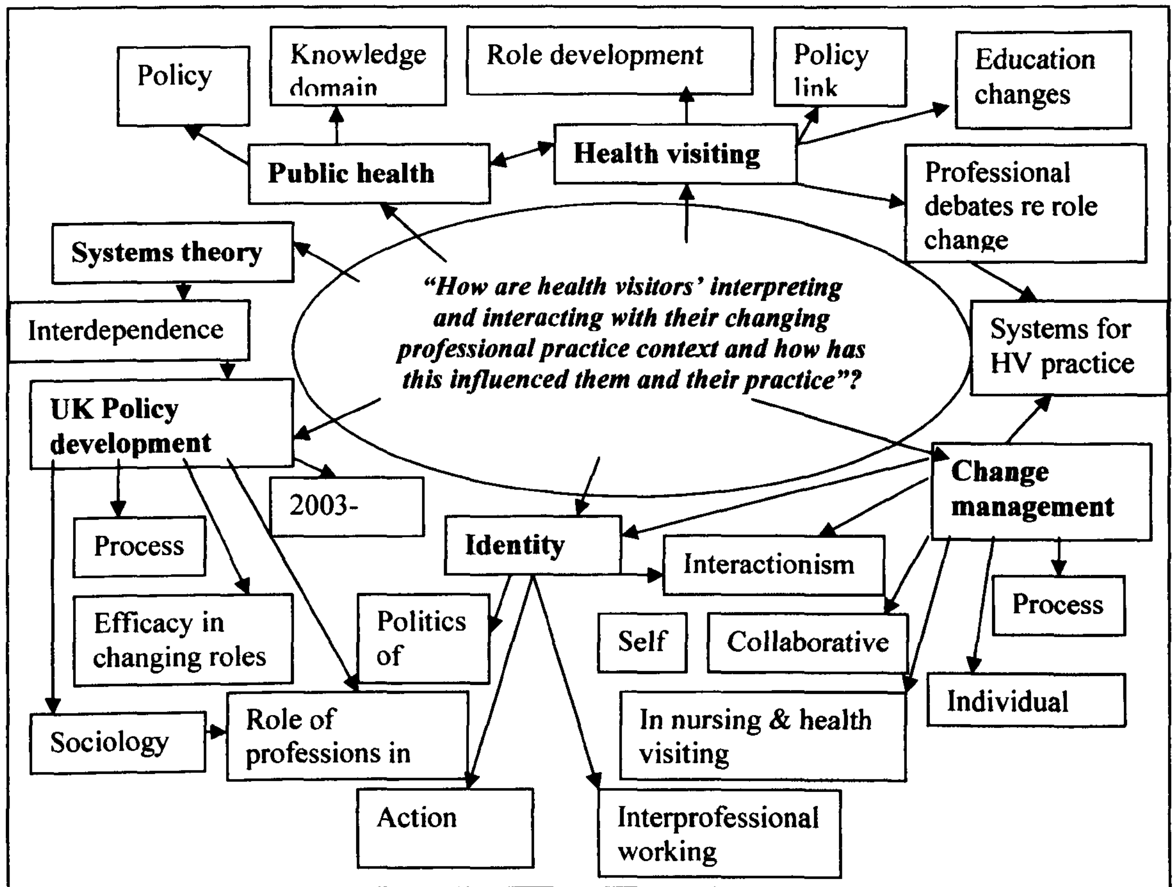


Figure 3: Ongoing Literature Review Search Terms



Thematic Review

Professional Role Context

Since the 1980's the "new public health" policy impetus to work in a collaborative, population based way has afforded health visitors the opportunity to develop their role (Home Office 1998; De Witt and Carnell 1999). As discussed ongoing policy development has contributed to the changing practice context of health visitors (Appendix 1). This section explores the degree to which health visiting as a profession has embraced the impetus to develop their public health role and the implication of that for the profession.

Public heath and health visiting

"Making a Difference" (DOH 1999a), the Governments' vision for nursing, identifies health visiting as the key nursing role for public health work, supporting an earlier acknowledgement that health visiting was public health "in its entirety" (SNMAC 1996). As discussed in the introduction, the publication of the Surestart initiative (Home Office 1998) advocated a new family centred public health role for health visitors which anecdotally caused some consternation in the local context. To facilitate role clarity, a resource pack was produced which outlined health visiting public health work on a continuum, encompassing a broad range of practice from work with individuals to populations (DOH 2001a). Public health work with individuals was depicted as individual needs assessment and facilitation of access to wider community resources in an empowering approach. Strategic public health work in health visiting was depicted as targeting whole systems working collaboratively to improve the health of population groups. The boundaries between those employed to do strategic public health work, and those less explicitly involved in it, are blurred in the course of normal practice. Carr (2005), from a qualitative study of a range of professionals' perceptions of public health work, produced another continuum that established levels of practice within a primary care-public health context (p.255). She identifies the continuum as more complex than

that in the resource pack, highlighting issues of blurring and overlap between levels of involvement in public health work in health visiting.

As defined public health work involves proactive, preventative, health promotion work with individuals, families and communities, drawing on the community as a resource (DOH 2001a; Carr 2005). This work is not primarily dependent on referral from others such as doctors which suggests a degree of health visiting professional independence. However, effective mobilising of community resources to meet client need requires interdependence with other systems, and some degree of collaborative working. Given the increasingly integrated healthcare practice context (DfES 2003), the significance of the latter to the participants will be explored further later.

The relevance of public health work in health visiting has been reaffirmed in a recent role review (Lowe 2007) which was welcomed as much needed role recognition (Cowley 2007). This review aimed to clarify the health visiting role and its future in the modern context. It suggests health visitors should take a leadership role for public health, in the delivery of either a family focused child health programme or an intensive programme for vulnerable children and families. This has echoes of the model used in Scotland, where two discrete roles, family health nurse and public health nurse (NHS Scotland 2000), continue to evolve. The review report has been endorsed by the Government (DOH 2007a). They support a health visiting focus on children and families, as key professionals in the delivery of Children Centre focused integrated children services (DfES 2003). Strengthening the health visiting role in leading the implementation of the Child Health Promotion Programme (DOH 2008a) has also recently been recommended. However, health visitors have not traditionally been educated for the role of multi disciplinary team leader. A need for caution and clarity in their development of this role is identified, in order to ensure health visiting remains practice not managerially focused (DOH 2007a P.10).

A survey of the national health visiting workforce suggested that over fifty percent of respondents worked in corporate teams (Craig and Adams 2007), involving groups of health visitors responsible for bigger pooled caseloads. In theory this should assist in efforts to work collaboratively with a wider population. However, the change to this way of working has also been used as a way of managing the pressure on the system

resulting from a reduction in the health visiting workforce (Craig and Adams 2007). Another strategy employed to use resources more effectively has been the implementation of skill mix. Nursery nurse support for health visiting services to families with young children is becoming increasingly common. However, a recent qualitative study of health visitor nursery nurse teams (Young-Murphy 2006) identified a need to acknowledge the limitations of delegating the "technical" aspects of health visiting to nursery nurses. It suggested that the preventative, holistic, intuitive nature of health visiting may be compromised in this model of practice. The significance for participants, of resource driven changes to practice systems, will be returned to later in the thesis.

A lack of understanding of the health visiting role and its potential contribution to public health, has potentially contributed to a decrease in the national health visiting population (DOH 2007a; Craig and Adams 2007). Despite efforts to clarify the role (Home Office 1998; DOH 2001a; Lowe 2007; DOH 2007a), policies could be criticised for a lack of guidance on issues such as the optimum staff to population ratio needed to be effective. In reality, the contribution of health visiting to public health will always be constrained by the resources available. This is compounded by difficulty in demonstrating effectiveness in a service focused on preventative working (Campbell et al 1995). There is a now a national commitment to increase the numbers of health visitors (DOH 2007a) which can only be a positive boost for the profession. However, concurrently with this positive message, another report, Modernising Nursing Careers (DOH 2007b) is consulting on a different future. If adopted, the proposed career pathways are set to significantly change the nature of roles and career pathways for nursing and health visiting. One proposed career pathway is called "children, family and public health" (DOH 2007b) which is the logical place for health visiting, given the recommended re focusing on families with children (Lowe 2007a). Whilst the proposals locate health visiting within what might be termed an advanced practitioner occupational group, the proposal umbrellas all roles into the professional group of "nursing". Health visiting, as a distinct profession, is noticeably absent in this future vision.

Significance of health visiting role title change

Cowley and Frost (2006) consider the demise of the title of "health visitor" from the professional register (NMC 2004a). Whilst practising health visitors are still regulated by the NMC, they are registered on a new part of the register, for Specialist Community Public Health Nurses (SCPHN). The creation of the SCPHN by the NMC was an attempt to group together and regulate, nurses working in public health roles such as school nurses, occupational health nurses and others with the required proficiencies. Registration as a nurse remains a requirement for entry to part three of the register (NMC 2004a).

Cowley and Frost (2006) suggest that in making this change the NMC ignored the majority of practitioners. The latter, they suggest, were in favour of health visiting being a distinct professional role, with direct entry to the register. However this opinion was not a consensus within the profession. This disagreement perhaps leaves it vulnerable to challenge from those outside the profession. The removal of the title of health visitor from the register is another practice context change of potential significance to practitioners and to public perceptions of the health visiting role. Cowley (2006) suggests that subsuming health visiting into nursing, will impede important work with colleagues from other sectors such as education and social care, due to a lack of recognition of the role overlap in the practice context. There is also the potential for health visiting to become confused about its own public health contribution and its relative value in the healthcare system. Williams and Sibbald (1999) suggest that changing roles in primary care have resulted in a climate of uncertainty, one dimension of which is identity uncertainty. They further suggest that where identity is challenged, this can result in a feeling of powerlessness and low morale which may ultimately affect the care given to service users. There is evidently a lack of health visitor consensus on the notion of health visiting being a profession distinct from nursing. In order to begin to understand whether or not health visiting is a profession in its own right, the concept of profession and professionalism will now be briefly discussed and summarised in relation to the present study.

Professional Status of Health Visiting

Characteristics of professions

In any consideration of the context of changing professional roles it is important to first establish what it means to be a profession in the modern context. Macdonald (1995) suggests professions became increasingly influential in society as a result of the need for the services they provided and that their development was made possible through the deliberate status negotiations of those occupying a professional role. If successful this status was maintained by the state. There are several characteristics that are generally attributed to professional roles to distinguish them from other occupational roles: control of a discrete body of knowledge (Macdonald 1995); autonomy to direct their own work (Giddens 1989; Payne 2000); making a positive, ethical contribution to society (MacDonald 1995) and professional regulation of education and practice (Jackson 1970; Freidson 1970; MacDonald 1995).

Professional knowledge

If a discreet body of knowledge is a defining feature of a profession, health visiting would need to differentiate its own from that which underpins nursing, or at least articulate a difference in the application of shared knowledge to practice. However, Castells (1997) suggests that in an increasingly complex world, with the globalisation of knowledge through information networks, the ownership of this unique body of knowledge has become less significant. Most healthcare practitioners might be said to utilise several purist sources of knowledge to inform their work. In essence "theory for" the profession only becomes "theory of" the profession through systematic consideration of its efficacy as applied to a distinct professional perspective and approach (Machin and Stevenson 1997).

Related to this, a distinct, formal, nationally recognised education programme is also suggested as characteristic of a profession (Jackson 1970). Having been subsumed under the umbrella of SCPHN in the register change, initial preparation for the health visiting role is not as distinct from other specialist nursing roles as it has been

previously. This potentially challenges any claim that health visiting is a profession distinct from nursing. Jackson also acknowledges a tension between the development and teaching of the knowledge underpinning professional practice and "training" for its application in society (Jackson 1970). This dual ratification of preparation for most professional roles, including the professions of nursing and health visiting, remains true in the modern context. Education for both nursing and health visiting are undertaken and endorsed by universities. However licence to practice can only be granted through the professional body, in this case, the Nursing and Midwifery Council (NMC 2004b; NMC 2004c). This aspect may not be of such significance to professional status as it first seems, but more related to a beaurocratic means of state control of a valuable resource.

Autonomy and power

Giddens (1989) suggests that the long term development of specialised professional knowledge in higher education (HE) setting and its endorsement by nationally recognised bodies, means that the function of a profession is less easily reduced to task orientated work that could be divided between others in an organisation. This results in a characteristic professional autonomy and a degree of power within an organisational context. The concept of autonomy as applied to healthcare settings is complex.

Keenan (1999 p.558) undertook a concept analysis, identifying the defining attributes of the concept of autonomy as:

> *"independence; capacity to make decisions; judgement; knowledge; and self determination".*

The consequence of autonomy is identified as "accountability". She suggests that several factors need to be in place before a profession or group can claim autonomy such as experience, education, and an ability to exercise professional judgement in independent decision making, based on a process of prioritisation. Finally, possession of self discipline and the acceptance of responsibility for decisions made and action taken, are described as necessary antecedents of autonomy (Keenan 1999 p,560). Alternatively

autonomy may also be perpetuated through the successful negotiation of the position of the profession in an organisational structure (Strauss 1978) and by the way in which professionals are managed in their organisational system (Giddens 1989).

Giddens (1989) suggests that doctors were likely to be managed by other doctors, thus retaining the professional monopoly within that domain of practice. Nurses on the other hand, were not necessarily managed by other nurses. This increasingly became the case following a landmark change in the organisational structure of the NHS (Griffiths 1983) around a model of the "internal market", a policy of the then Conservative government. In that market economy the function of "management" was disassociated from the nursing profession resulting in line management arrangements through which nurses could be managed by people who were not necessarily from nursing or indeed any other healthcare discipline The medical profession resisted this move successfully (Dopson and Waddington 1996) perpetuating their high status in the system.

Turner (1995) suggests three types of dominance of one profession over another, "sub-ordination, limitation and exclusion". It could be argued that in relation to medicine and nursing, the nurses have historically been dominated in all three ways by medicine: by the organisational systems they work in; by limitations in the clinical work they are "permitted" to do; and through being denied the legitimacy to undertake certain aspects of practice. Interestingly the powers of prescribing would once have excluded nurses. However this is now not the case (DOH 2005b) giving an example whereby hierarchy power between professions may be changing.

Professional conduct

Health visitors are bound by their registration to an ethical code of practice. However this not exclusive being shared across all roles registered with the NMC (NMC 2008b). It may be argued that this again challenges the notion of health visiting being a distinct profession. However the ethical codes of conduct of different health and social care professions are also very similar (HPC 2004, GSCC 2004, GMC 2007). Indeed other codes of professions outside of the health context, such as teachers and solicitors, indicate similar expectations from registered professionals (GTC 2007; SRA 2008). Maintaining confidentiality, affording respect to service users and colleagues,

"evidence" based decision making, partnership working and non-discriminatory practice are all evident across the codes. All of those reviewed also include the adherence to the general principle of a duty of care towards those using their service. This fits with the noted characteristic of a profession being to provide a service to society in an ethical manner (Jackson 1970). This is further supported by Macdonald (1995) who suggested that it is not only the possession of a unique body of knowledge that defines a profession, but that those individuals in that professional role can be trusted to use it ethically. A lack of a separate code of practice for health visiting may not then be that significant, given the similarity of all professions and the shared values that being a "profession" entails. Recent versions of the ethical codes reviewed, give a higher profile than those in place previously, to a professional's obligation to empower service users to make their own decisions. This is of significance in the National Health Service (NHS) where as already identified, service user and carer involvement at all levels of service design, delivery and evaluation is a requirement. This has the potential to shift the balance of power from traditional professions toward service users thereby affecting the characteristics of their professional status (2004b).

The changing status of professions

As suggested, there is a notable move in the NHS towards reducing the autonomy of professions. The emerging model of professionalism is increasingly characterised by the sharing of knowledge and decision making in collaborative working in partnership with service users (DOH 2004b). This notion challenges the status of professions as "social movements" with the autonomy, power and control to self perpetuate for their own benefit (Jackson 1970). The change is towards an acknowledgement of the potential influence of well established service user groups, as powerful social movements in their own right, who challenge the dominance of the health care systems within which they have been historically disempowered. A successful example is the disability movement which has influenced legislative change in its favour (Disability Discrimination Act 2005). In addition, it is suggested that the rapid increase in private sector professionals, who own and control large self serving corporations, has affected the commonly held perception that professionals provide a "service" to society with altruism as a value (Perkin 1996). Given the increasing multiplicity of health and social care providers in

the UK the altruism which has traditionally underpinned professional practice may be eroded through variation in employment conditions within professional groups and open competition for contracts. These changes are likely to lead to different public perceptions of the value and worth of different professions, including health visiting. They are also likely to affect how professionals view themselves, through their interactions with other professionals and service users in their work setting. In essence there is the potential for professional identity, both of individuals and professional groups, to be challenged by the changes in the professional practice context of those working in healthcare setting. It is therefore important to further understand the notion of professional identity and how it might relate to the experience of the study participants.

The Politics of Identity.

Castells (1997) gives a lengthy, interactionist, consideration of the notion of identity and its power in navigating and facilitating social change. Focusing on the notion of collective identity in social groups, three types of identity construction are identified: "legitimising"; "resistance"; and "project" (P.8). Each will now be summarised.

Legitimising identity

This form of identity, Castells (1997) suggests, is generated from the dominant structures in society, leading to order, predictability and the perpetuation of the social structures from which it is generated. In this thesis' context, it could be argued that national policy and its integration into NHS system structures, is designed provide a framework of stability and compliance across the groups of actors in the healthcare system. As such, the policy framework as a dominant feature impacts on NHS employees providing a mechanism to impose identity and a mandate for individual role behaviour. Indeed the policy framework within which the health visitors are working has legitimised their public health role and other aspect of practice, such as work with children and families (DOH 2001a; NMC 2004b; DOH 2007a). It could be argued however, that the structure of the NHS also legitimises the relative identity status of different professionals, supporting the maintenance of traditional professional

hierarchies such as the dominance of nursing by medicine (Roberts 2000; Latter 1998; Giddens 1989). Clearly this is of significance to the study health visitors' development of a public health role which is characterised by collaborative working.

Resistance Identity

Castells describes resistance identity as the building of a defensive identity against the dominant oppressive forces in society. This is of relevance, given the earlier discussion of the relative dominance of some professional groups within the system and the potential dominance of individuals by policy makers in a climate of policy driven change. Where a collective defensive identity is not successful in rebuffing challenges from dominant forces, the result can be fragmentation across the collective groups and the development of "tribes" or communities (Castells 1997). In this vein, the difference of opinion within my own health visitor peer group, on the relative importance of public health work to health visiting, had the potential to fragment the collective identity of the health visitors in the local context. This could increase the risk of the formation of separate "tribes" (Castells 1997 p. 9), or in this case separate roles and identities within the same occupational group. A lack of clarity on identity within the profession may also lead to further confusion in a collaborative working situation.

Project Identity

Castells suggests that "project identity" is less common in modern society as a form of social change. In essence this describes a situation in which a collective group deliberately sets out to project manage a change in their position in society and its associated identity. An example of this is the women's movement. Once clearly about project identity, Castells suggests its function now is more about the collective maintenance of an established resistant identity than one of project. In some ways, the historical development of a profession, could be attributed this form of identity building which is described as transformational. Calhoun (1994) puts forward the view that to some extent, identities are always projects. He suggests that individuals have varied levels of power and influence over the course of their identity development which is influenced by their personal resources.

Related to this is the concept of autonomy which as has been discussed, is commonly held as a defining characteristic of professions. In this case both individual and collective identity resources such as self-determination would need to be involved in creating a drive for social change (Keenan 1999). Roberts (2000) considers professional identity in nursing and its historical oppression by medicine, proposing a model through which nursing could begin to break the cycle of oppression. Latter (1998) also discusses the subordination of nursing to medicine identifying the need to empower nurses as a professional group, before their own efforts at social change through health promotion can be successful (p32). As nursing is a pre requisite for health visiting, this discussion of nursing identity is of relevance and will be returned to later in this chapter.

Calhoun (1994) also makes the point that the pre occupation with identity is a feature of modern society in which we have developed an expectation that individuals are reflective and self aware. Indeed self awareness and reflection are well established requirement for practice in both nursing and health visiting (NMC 2004b; NMC 2004c). This process, he suggests, represents a need to seek out sources of relative self worth, through a process of self recognition in relation to others. Calhoun further suggests that the decline of kinship, a source of identity inherent in traditional societies, has resulted in the need to identify with other individuals through other collective similarities (Calhoun 1994) such as occupation, leisure and personal interests. Therefore there is a need for health professionals to seek out others in the same group to affirm their own identities.

Putnam (2000) develops the idea of "bonding social capital" and "bridging social capital". He suggests that whilst bonding social capital is beneficial in terms of having a sense of belonging and security, bridging social capital generates new development possibilities for individuals, through sharing of identities and resources (Putnam 2000 p.23). These concepts have been applied to a professional context in a recent conference presentation (Machin and Machin 2007). It was proposed that "bonding social capital" could be used to describe the process of professional socialisation i.e. the identification with the norms, values and practice of a particular professional group. Bonding enables individual professionals to feel part of the group thereby gaining mutual strength and support, through the opportunity to share mutually beneficial

professional knowledge. Bridging social capital as an applied concept, describes the process whereby professionals from one group, build an outward reaching network or "interprofessional bridge", with others from other professional groups. The aim of such an activity, as a deliberate strategy, is to achieve a healthy balance between bonding and bridging thereby enhancing the reciprocal benefits of sharing professional social capital (Machin and Machin 2007).

This section has largely considered the notion of identity from a political, sociological perspective. Identity formation is also evidently bound up in the interactive experiences of individuals, as they negotiate their position and status in relation to structural influences and other people. It therefore not only important to understand the position of health visiting as a professional group, but also to consider the notion of identity as it applies to individuals' experiences of change in their professional practice context.

Identity – An Interactionist Perspective

Individual identity

Burke (1980) explored the concept of identity in detail, focusing on the development of a tool for its measurement. He cited a previous study he had undertaken with a colleague in 1977 (p23). In that study the tool was quantitatively tested with a large group of university students (n=640) to establish its efficacy in measuring the link between role and identity. By drawing on this and earlier seminal work from interactionists such as Mead (1934), Burke suggested that identity is a sub set of the concept of the "self" and is something which can be referred to, thereby rendering it an "object". Importantly, the meaning attached to oneself as an object, directs ones actions. He further suggests that identity is developed through dialogue, partly with others and partly internalised. Identity is framed as a reflexive, self verifying, relational concept and as a source of motivation developed through a process of social interaction with others (Burke 1980). Rapport (2006) attributes the term "self authentication" to describe the process through which individual validate their worth and identity. This is an important consideration for health visitors and others in an increasingly collaborative

professional practice context, which has an increased potential for others to influence their identity.

Collier (2001) applied the earlier work of Burke (1980) in a study involving one hundred and forty six college freshman. Through this study which involved self rating scales and other measures, he proposed a model of "Role Identity Acquisition". This model suggests that shared meanings relating to a role, allow individuals from different backgrounds to recognise the role. In addition, whilst individuals occupying similar roles may agree on the role meaning and characteristics of a role, they may not agree about the relative priorities and the value of each component part. This is an important perspective in considering the effect of others in the work context of health visitors. Collier (2001) also suggests that the acquisition of identity is based on the actual experience of group members. This lends further support to the theoretical link between role and identity and in the context of this study of health visitors, the link between identity and practice.

Collective identity

According to Blumer (1969), for collective action to occur, the interpretative processes of individuals must be made transparent to others through interaction to facilitate the emergence of a new shared understanding. Joint action is the outcome of this process. However, from a symbolic interactionist perspective joint action should not be considered as an anything other than the linked acts and interpretations of the different participants (Mead 1934). This is achieved only through the interactive and interpretative process in a social setting.

In his theoretical work entitled "Mirrors and Masks", Strauss (1959; 1997) discusses the importance of language as a vehicle to establish shared meaning and norms. Through language, individuals can identify their similarities with others in a group and conversely, their differences with others. As discussed earlier, language in the form of policies, as dominant structures in the health care system, can add complexity to the development of professional norms. This will be especially significant where there is a perceived clash between terminology and language, between different policies applying to the same group. Through the lack of clarity of the health visiting public health role in

policy, there appears to be no associated stable cultural norm as yet that has directed an identifiable collective response (Pearson et al 2000; Carr, Procter and Davidson 2003; Abbot et al 2004; Brocklehurst 2004; Goodman-Brown and Appleton 2004; Smith 2004). This lack of collective identity has the potential to affect the success of public health policy and the necessary collaborative, organised effort needed to tackle health inequalities (Acheson 1998). Collier (2001) suggests that where different groups use the same role in different ways, it is likely that this will result in the norms of the role, or the role "standard", being reconfigured differently. Such a development may affect the ability of health visiting to convey a cohesive public identity in a collaborative working situation.

Public identity

In a qualitative, interactionist study of midwifery identity in America, Foley (2005) makes a distinction between image and identity. The results showed that there was variation in the midwives views of their midwifery colleagues that related to views about their proximity to a "medical" model of practice and their historical development as midwives. The American midwives were critical of some colleagues qualified as nurse-midwives, who were considered to be more medical in their approach. This suggests a perception from the midwives that nursing was allied to medicine, reinforcing the view of medicine as the dominant professional group. Traditional midwifery was suggested to be more distant from medicine and on the margins of the mainstream healthcare system (Foley 2005). However, this group of "marginalised" midwives appeared to have a better developed sense of collective identity between them as distinct from the other type of midwives who had come to the profession via the nursing route. This separation perhaps reflects the notion of the development of "tribes" (Castells 1997) in the process of seeking to differentiate themselves between the dominant forces of medicine.

The final point of note is that midwives articulated different identity claims depending on the context. Goffman (1959) makes a distinction between the "performances" individuals give in an interactive setting, and their true "self". In essence, he suggests, individuals act in a way they think others expect them to, which links to Mead's (1934) concept of role taking.

Goffman (1959 p.20) suggests misunderstanding can occur because of the unintentional impression individuals "give off" rather than the deliberate impression they "give". In a group situation he suggests individual members tend to keep their true opinion hidden and behave in a way they feel will "fit" with their understanding of the rules of behaviour in that group. Conversely, a departure by an individual from the norms of a group may be perceived by themselves and others as a form of deviance, with those deemed to be deviant often being happy to be seen to be different. Goffman further proposes that any collective understanding in a group is temporary and located in the present, in the context of the interaction. This is captured in the following quote (Goffman 1959 p.21):

> *"It is to be understood that the working consensus established in one interaction setting will be quite different in content from the working consensus established in a different type of setting".*

Whilst every individual interaction may produce new meaning for the actors, the structure, systems and cultural norms of society or to use Goffman's term, "social institutions", will have an influence on the way in which individuals choose to perform and importantly, influence the way in which their actions are perceived by others. Indeed it is suggested that any micro level analysis of interaction cannot discount the influence of the social structures in which the interaction takes place and the reflexivity between interaction and context (Cast et al 1999). The issue of context and its link to identity will be considered later. This section has considered the concept of individual identity and how interaction can influence its ongoing development. The next section considers this in the context of professional identity.

Professional Identity

All of the health visitor participants in this study were also qualified nurses therefore it was important to consider literature relating to a nursing identity.

Understanding the nursing concept

Ohlen and Segesten (1998) undertook a concept analysis of nursing identity, identifying concepts of "caring, compassion and competence" as core to a nursing identity. Another study explored the importance of values in the formation of a nursing identity (Fagermoen 1997). In this large scale survey, two groupings of values were established. "self orientated" and "other orientated"(Fagermoen 1997 p.436). Interestingly autonomy, as one of the key attributes of a profession discussed earlier (Macdonald 1995), is not an identified self orientated value, despite the sample of interviewees being senior nurses. Respecting the autonomy of patients was, however, identified as core value inherent in nursing practice alongside altruism and human dignity.

Ohlen and Segesten (1998) make the link between personal and professional identity. This reflects an interactionist perspective, that self and role are inextricably linked (Blumer 1969). Significantly, it is suggested that a nursing identity meant "feeling" like a nurse not just working as a nurse (Ohlen and Segesten 1998). They conclude that self image and self esteem are part of a personal identity, the latter being the foundation for a professional identity and role function. Fagerberg and Kihlgren (2001) suggest that nurses put the needs of their patients first and are unconcerned that their work might be questioned (p.143). This also implies a high level of confidence and self esteem, presumably safe in the collective knowledge that nursing is based on altruism and as such is a profession in its own right.

Understanding the Health Visiting Concept

Whilst none of the literature reviewed made an explicit consideration of the health visiting identity, themes emerge from the literature that might be said to constitute its defining characteristics.

Relationships

De Le Cuesta (1994) emphasises the importance of an "enabling and mediating" practitioner-client relationship to the outcome of a successful health visiting interaction. Others have also examined relationships in health visiting concluding that effective visits will only be achieved where client participation is promoted (Kendall 1993). The empowerment of patients and clients was also identified as key value of nursing, and whilst empowerment is a complex concept (Kendall 1998), it perhaps represents a potential overlap in the identity between nursing and health visiting. This was reflected in the earlier discussion of the code of conduct. Normandale (2001), in a study of mothers' interactions with health visitors, also concluded that the relationship was an important contributory factor to the success of the work, from both the health visitor's and client's perspective. Craig and Smith (1998) suggest health visitor relationships with vulnerable families as the key to tackle poverty. More recently, Smith (2004) used focus groups to explore health visitor perceptions of their developing public health role. The participants in the study emphasised the importance of their relationships with clients. They also expressed concern that new ways of working triggered by policies such as Surestart (Home office 1998), would reduce their home visiting which they viewed as a crucial context for relationship building.

Cowley and Frost (2006), through a reconsideration of the principles of health visiting, have attempted to further define the characteristics at the core of health visiting, Whilst acknowledging the principles remain current, they have added some explanatory words in an effort to better clarify the scope of practice of health visitors. Several of these words such as collaboration, dialogue, advocacy and partnership (Cowley and Frost 2006 p.19) imply a focus on relationships as core elements of health visiting practice.

Universal service

A key area which may distinguish health visiting from nursing is its commitment to being universal. Since the implementation of the statutory Notification of Births Act (1907), every family with a new baby receives a home visit. This responsibility has largely, though not exclusively, fallen to health visitors (Dingwall et al 1988). Since health visiting services were reconfigured around GP practices in 1974, a universal

service has become one defined by universal access to the health visitor for every individual registered within a GP practice (Robertson 1991). Recent policies use the phrase "progressive universalism" to describe a situation where there is the potential for universal access to health visiting services, but that input is based on indicative need of some sort (Lowe 2007). However, given that it is proposed health visitors focus specifically on families with young children, the universal health visiting service "from cradle to the grave" may no longer exist. Cowley and Frost (2006) discuss the concept of universality suggesting that whilst it would require further clarification, if it is so important to the health visiting role, then perhaps it should become one of its principles for practice.

Importantly for this discussion, access to a health visitor does not generally require referral from a medical practitioner. In contrast, nursing practice has traditionally operated on a reactive, referral based process. The emergence of new nursing roles such as nurse consultants and nurse led services has begun to shift the balance of that power. However for the most part, the medical profession remains the gatekeeper to nursing services, especially those requiring access to healthcare resources. In considering the notion of professional autonomy, as described by Keenan (1999), it might be said that health visitors generally have more autonomy in the healthcare system than nurses, a fact which could be one differentiating it a profession distinct from nursing.

Values

Pritchard (2005), in a study of health visiting as women's work, used a qualitative approach embedded in a feminist theoretical framework. She suggested that health visitors use their personal knowledge and resources as women, to capitalise on a shared view of the world with women clients, in establishing an effective context for partnership working. This could be challenged on the basis that health visiting is not exclusively a female profession. Indeed one of the health visitor participant contributors to this thesis is male. However, a recent survey of the health visiting workforce identified that 99% of the eight hundred and sixteen participants were female (Craig and Adams 2007). Pritchard's (2005) study does however suggest an explicit link between personal and professional identity and the practice approach undertaken by the participants. This echoes the work of Appleton and Cowley (2008) who established in

their study, the link between assessment, professional judgement and practitioners' personal values (p240).

The standards for proficiency for registration as a health visitor (NMC 2004b) include no general statement of values that underpin health visiting practice. Whilst "principles" and "values" are sometimes used interchangeably, there is perhaps a difference when considerating their influence on individual identity. A set of professional principles could be described as a code, as beliefs, standards or a set of rules underpinning practice. A value however, considers the relative worth of those things. It is perhaps more likely to stem from the personal perspective of individuals, their thoughts and feelings. Turner (1995) suggests that in general, professions are value orientated. However he suggests, their practice is goal orientated presenting a dilemma which is at the heart of a lot of conflict within organisational systems.

Given that the meanings individuals attach to their past experience are likely to be very different, values are potentially subject to greater variation than principles for practice, which are manifest in action. As an example, the principle of non-discriminatory practice might be underpinned by the value of respecting the equal rights of the individual. However, it is feasible that an individual might practice in a non discriminatory way whilst not necessarily personally believing in the value of it. Carrying out an ethical action based on a principle, does not necessarily mean it can be assumed to be one of a set of personal values that make up an individual's identity. It follows however, that where actions based on principles are closely aligned with personal values and identity, the more likely the individual will feel comfortable in a role, or that they "belong" in that role. Implicit within the NMC (2004b; 2004c) requirements for both nursing and health visiting, are values such as respect for others and a duty of care. However, these are written as a code of practice rather than clear underpinning personal values.

Preventative paradigm

The final characteristic that could be viewed as differentiating health visiting from nursing is its work within an occupational paradigm that focuses in the main, on disease prevention and health promotion (Craig and Smith 1998). Whilst health promotion is

also a domain of nursing practice (NMC 2004c) it is only one area of work within the parameters of nursing practice. Whilst clarifying this differential is complex, because of diverse roles within nursing, the latter are perhaps is more likely than health visitors to focus on secondary and tertiary prevention than primary prevention (Caplan 1961). As a discrete focus for health visiting, primary level health promotion becomes less of a role function and more about an underpinning philosophy. This then could be considered an integral component of a health visiting identity. Craig and Smith (1998) suggest that working with a preventative public health approach, provides a clear link between the policy agenda for public health and the medically focused, GP attached practice model, in which the majority of health visitors work, thereby giving it legitimacy. This is also reflected in the principles of health visiting (Twinn and Cowley 1992; Cowley and Frost 2006).

Work with younger age groups as the prevailing model for practice in health visiting, is perhaps also indicative of a professional identity that values the opportunity to prevent ill health, in an epidemiological sense. In its perpetual struggle to measure its value (Campbell 1995) it is understandable that health visiting is welcoming the focus of its effort being with young families, where it can make the most identifiable impact on the public's health (Lowe 2007). This reinforces a commitment to preventative working and the belief in its worth, as one of values inherent in a health visiting identity. Importantly this value is not one of those identified in any study on nursing professional identity discussed earlier.

Identity implications in the current professional practice context

In a recent editorial on professional identity in nursing, Scholes (2008) suggests that the nature of healthcare is changing rapidly and with it the need for healthcare professionals to reframe their identity. Health visiting is no exception. The link between role (action) and identity (self) has been established in the earlier part of this chapter (Mead 1934). The earlier interactionist discussion of identity sets out a view that identity formation, change or maintenance is context specific. The significance of context in understanding social interaction is also noted by Lazega (1977) and in the earlier mentioned work by Strauss (1978). Lazega further suggests that any study of interaction that involves

complex networks, requires the exploration from the perspective of individuals to the system and back (p.130). It is important therefore to understand just how much the professional role context of the health visitors had been subject to policy change since 1997 and the potential significance of this. The next section sets out the changing policy and professional context and explores this in relation to the relevance for individuals and the profession of health visiting.

Policy Context of Health Visiting Practice

The New Public Health

Following the "Victorian" and "Cure and Prevention" phases of public health policy (Baggott 2000), global directives (WHO 1978; WHO 1981; WHO 1999) and domestic health and social care policies (DOH 1991; DOH 1997a; DOH 1999; DOH 2004) have increasingly acknowledged the importance of a primary care led, preventative approach to healthcare. The beginning of the "new public health" phase is said to have begun with the Alma Ata declaration (WHO 1978) which signified international agreement on principles for global population health. This included: health is a fundamental right; the should be equity in the distribution of health resources; health is a multi-faceted concept; preventive health policy is key; there should be a community wide collaborative approach to health; health services should be primary care led; and there should be an emphasis on sustainable health developments. The need for a strong evidence base, continued intelligence and surveillance, education and research can also be added to the list (Dobson 1997). In the UK, the need to facilitate the development of this new, collaborative approach to public health resulted in an extensive programme of policy driven organisational change.

National Healthcare Policy 1997-2008

Appendix 1 provides a chronology of relevant policy and a summary overview of the extent of policy changes affecting the professional practice context of participants. Of particular relevance are those relating to the primary healthcare context in which most

of the participants worked. In 1997 the New Labour government implemented Primary Care Trusts (PCT) as the main employing organisations for health visitors. In separating their function from acute Trusts, PCTs were also required to be independently accountable for public expenditure, responsible for undertaking a health needs analysis of its population and for providing appropriate primary care services. A focus on primary care was identified as an essential step toward the Government's commitment to tackling health inequalities through public health (DOH 1999b). The higher profile given to a preventative approach notionally gave greater legitimacy to the identified health visiting commitment to preventative healthcare.

The potential contribution of nurses and health visitors to public health work in primary care has been acknowledged (DOH 1997a; Health Select Committee 2001; DOH 2001a; DOH 2002a). It is expected that they make a significant contribution to the PCT through full representation on the Trust Board with those working in a public health role, such as health visitors, taking the lead in facilitating collaborative public health initiatives (Health Select Committee 2001). As suggested earlier, new services are required to be focused less around the needs of professional groups, and more around the needs of service users (DOH 1997a; DOH 2000a; DfES 2003; DOH 2004b; DOH 2005a). To deliver the best service within the resource available, professionals are no longer able function independently from one other (Quinney 2006). This commitment to collaborative and interprofessional working has generated the need for interprofessional education (IPE) provision that equips practitioners such as health visitors, to more effectively work in that way (DOH 2001b). In IPE, students from two or more different professional groups learn interactively with, from and about each other (Freeth et al 2005). The central aim of this activity is to improve students' capacity to provide a better, more effective service to the people they will work with once qualified. There is now a well established body of evidence that IPE is effective in achieving this outcome, although a direct cause and effect remains difficult to measure empirically (Barr et al 2005).

The rapid succession of policies moving services and the primary care workforce towards a model of greater integration has generated a working environment that could be perceived as challenging and unpredictable. Health visiting has evidently been affected by a succession of general healthcare and professional policy changes. Coping

with service redesign and increased collaborative working, in addition to changes to the professional register, may cause particular identity issues for some health visitors. Urry (2000) suggests that the rapid pace of change, a perceived speeding up of time and space in the post modern context can dissolve a clear sense of identity. In recognition of the potentially negative impact of change, NHS workforce development policy acknowledges the importance of empowering staff to develop the knowledge and skills to enable them to cope (DOH 2002a; DOH 2004a). A key goal for the NHS is the reduction the steady attrition of recent years which has resulted in a loss of talent from the healthcare system. The extent and pace of the change in the healthcare system presents a particular challenge to those with management responsibility for staff groups who are particularly affected by it. The next section explores the impact of role change on identity and considers different approaches which could be used to successfully manage role change.

Role Identity Crisis and Change

Challenges to nursing professional identity in a climate of role development are well documented. There is evidence that relatively new nursing disciplines such as the community psychiatric nurse, nurse practitioner and nurse consultant (Berragan 1998; Godin, 1996) have had role identity crises. In health visiting, the directive to develop a new public health role has clearly led to much professional debate (Abbott et al 2004; Brocklehurst 2004; Goodman-Brown and Appleton 2004). Indeed changes to the health visiting service and its provision nationally, have recently been described as a "crisis" (Craig and Adams 2007).

Crisis can be viewed as a temporary condition from which to effect positive change on a personal level (James and Gilliland 2001), and as an opportunity for personal growth. It is acknowledged that realisation of this opportunity may need to be facilitated by a skilled helper (Caplan 1961). There are some clear parallels to be drawn from this work in a psychiatric setting, when considering health visiting as potentially a profession in crisis. Brammer (1996) uses the term "existential crisis" to refer to a situation in which an individual expresses inner conflicts or anxieties and questions their sense of self and purpose as an individual. He suggests that the individual in this state is unsure of: their

terms of reference in relation to their responsibility; their independence; their autonomy; and their expected level of commitment to their situation and role in life. Where the source of role crisis is external, as might be the case with the policy driven role change health visiting is experiencing, existential crisis might be felt by individuals in that role. However James and Gilliland (2001) caution that whilst people and crises share some commonalities, each crisis experience is unique (James and Gilliland 2001). Following this argument, helping a group of individuals such as health visitors within a profession to maintain their identity through effective change facilitation will need an approach that can be flexible to their individual needs.

Ohlen and Segeston (1998) studied the effect of role change on identity. From their data emerged a perspective on the importance of stability. One participant expressed a view that her nursing identity was strong enough to withstand any changes and challenges to it (p.723), using the terms "permanence" and "foundation" to make her point. This links to the "equilibrium" model of crisis intervention (Caplan 1961). Psychological equilibrium is defined as:

> *"A state of mental or emotional stability, balance or poise" (Caplan 1961)*

The aim of this approach is to help people restore psychological equilibrium following a crisis experience. Equilibrium in the health visiting professional identity could be said to enable individuals to cope better with the stress of a changing environment perhaps minimising the risk of a psychological crisis.

Role clarification in times of uncertainty

In a time of role change or uncertainty, it is suggested that there is a need to achieve a balance between three elements: role legitimacy; role adequacy; and role support (Shaw et al 1978; Machin and Stevenson 1997). Applied to this study, role adequacy relates to the skills and knowledge health visitors need to carry out their ascribed roles. There is an acknowledgment that education programmes need to equip nurses with the skills they need to work in the changing world of healthcare (DOH 1999a), including those needed for public health work. Indeed, the earlier discussion of professional status (MacDonald 1995) and autonomy (Keenan 1999), suggested that a sound underpinning

knowledge, developed through both education and experience, is an essential pre requisite for autonomous professional practice. De Witt and Carnell (1999) also stress the need for a sound theoretical basis for public health work and for practitioners to be able to demonstrate skills necessary to be clinically competent in carrying out such work. A public health skills audit (Burke and Meyrick 2001) attempted to determine the level of public health skill health visitors had. Using mainly self reporting mechanisms the audit developed and tested a list of core public health skills identifying a perceived skills gap amongst their participants which needed to be addressed. One barrier to public health role development was the lack of understanding of the concept of public health (Burke and Meyrick 2001).

A study done for the English National Board (Pearson et al 2000) examining the preparation of specialist practitioners in community nursing, concluded that there needed to be more of an emphasis on public health in the curriculum. Student respondents in this study considered the time constraints of doing the professional course a hindrance to their development of an adequate skills base for public health practice. This was consolidated by the fact that Community Practice Teachers, whilst responsible for providing the students with a framework for public health work, perceived that their own public health role was constrained by mainstream practice (p.154). Several initiatives have attempted to address a perceived skills deficit amongst health visitors working in primary care (DOH 2001a; DOH 2001c; DOH 2002a). The revised proficiencies for part three of the register and the role of SCPHN also make much clearer, the links between public health policy agenda (NMC 2004a; NMC 2004b) and health visiting.

One criticism that could be levelled at any of the public health skills development initiatives aimed at the existing workforce, is that they made the assumption that health visitors did not already have the skills for the public health role. Earlier discussion of my anecdotal experience and the professional debate in the literature relating to the public health role of health visitors, indicates mixed opinions as to whether the public health role is a new role or not. If not, then existing practitioners who are fit for purpose and practice (NMC 2004a) must already have the requisite adequacy for their role. It is perhaps likely that those practitioners, who have identified with the public health approach to practice, may already feel adequately equipped to the job but that others do

not. There is a danger then in developing workforce change initiatives, such as the Whole Systems Pilot (DOH 2001c), in assuming that all practitioners need the same degree of professional development.

It is evident that historically, the public health role of health visitors has developed to accommodate prevailing health policy discourse. The legitimacy of public health work as a core aspect of practice has been higher at some times than at others. Currently public health work in health visiting is being afforded a high level of role legitimacy from health policy. However as the discussion has shown the exact nature of that proposed role, is ambiguous and open to different interpretation by different individuals. In addition the introductory chapter described a situation where at the level of practising individuals, there was no consensus as to the relative value and legitimacy of public health work. The notion of legitimacy in identity development (Castells 1997) and negotiation (Foley 2005) also relates to the discussion of crisis theory where an individual might experience crisis when their self legitimacy is challenged by either internal or external sources (Brammer 1996). At the level of individual health visitor it is difficult to glean from existing literature, any differences in the perceived legitimacy of public health work and a link to ongoing formulation of professional identity. To achieve a balance of role adequacy and legitimacy across a professional group, in a way that facilitates the development of a redefined collective identity in a given context, is a challenge. However it is suggested that organisational support for the role is essential to achieve optimum role performance (Machin and Stevenson 1997). In order to begin to understand the complexity of managing change successfully, to provide this support, some literature on change theory will now be explored.

Facilitating Change in Organisations.

It is not within the scope of this review to undertake a comprehensive analysis of the extensive change literature available. However several studies reviewed appeared to have significance to the emerging theory, especially those which considered an interactionist perspective on change. Of particular interest were studies focusing on the individual's experience of change and those that considered implications of change for

identity. Issues of power, leadership and approaches to change facilitation are also discussed.

Empowerment

As discussed the development of an empowered workforce, is a central aim of government policy (DOH 2004a). Empowerment as a concept implies the passing of power from one individual to another and with it, the transference of decisions making and ownership. Kendall (1998) makes the point that empowerment is generally assumed to be a positive concept. She also makes the point that the extent to which empowerment at an individual level can redress the balance of power in complex health care systems, without structural level change to support it, is debateable (p.2). In addition, differentiated levels of empowerment may have an impact on the professional identity of individuals and their perceived level of independence, as in the case with doctors and nurses (Latter 1998). That said, power and the freedom to act independently, were key components identified in the concept analysis of autonomy discussed earlier (Keenan 1999).

Sturt (1998) supported by the work of Bandura (1977), studied primary care practitioners' perceptions of the notion of "self-efficacy" as a framework for health promotion work. One of the key determinants of the perceived success of the work was linked to the outcome expectations of practitioners. This links to the concept of "expectance theory" (Vroom 1964) discussed in relation to change management (Line 2004). Expectance theory suggests that having clear, shared, realistic expectations of outcome is fundamental to the success of the change initiative. It has been suggested that health visitors strive for a successful practice outcome, based on the perceived reward it may bring to them (Chalmers 1992). In other words, their actions are based on their expectations of the reaction of others. There is clearly a link to empowerment and independence here. Individual practitioners could be said to be exercising a choice in deciding how to act in different situations. These actions may be for example, practice related or alternatively, action orientated towards engagement in change.

A recent study explored the notion of empowerment through an analysis of a change initiative in a primary care organisation (McDonald 2004). Of particular interest was the

fit between organisational identity and that of the individuals employed by the organisation. McDonald criticised any change initiative that assumes powerful senior managers can change their workforce without consideration of the active role individuals play in determining their own identity (p.929). She further suggests that the assumption is often wrongly made, that the goals an individual employee has, match the goals of an organisation and that there will be a genuine willingness to collaborate for the benefit of the organisation.

Ardern (1999) in a grounded theory study of change in a day hospital for dementia care sufferers, suggested that a process of change based on the premise of valuing employees and making them feel secure, is more likely to be successful than one in which individuals feel insecure, isolated and disempowered (p.1375). In Ardern's study, where the respondents perceived proposed changes as challenging the care they were able to give, a fundamental aspect of their role identity, they displayed increased resistance to the change. This was described as "safeguarding" their position in the setting. McDonald (2004) also made the point that the primary care staff in her study often rationalised their actions through recourse to the patients and clients they worked with. Actions were sometimes justified on the basis of what was best for the patient, making any challenge to course of action more difficult. This being the case, the importance of relationships in health visiting may potentially become a way of rationalising their resistance to role change where practitioners feel their identity has been compromised. This supports earlier discussion of the work of Smith (2004) and health visitor perceptions of the impact of the public health role.

Any approach to change that is based on an assumption that individuals will behave in a predictable way once they have the facts, can be said to be based on an empirical-rational approach to change (Chin and Benne 1976). Respondents in McDonald's study suggested that their immediate working relationships were more likely to be important to their identity formation than the over arching organisation. In seeking to effect change therefore, the local context within which empowerment takes place is an essential consideration. This fits with the theoretical perspective that individuals develop meanings based on social interactions in the context in which they occur (Blumer 1969). It follows that if an initiative takes individuals out of their local context in an effort to change their perspective, the sustainability of that change once they return

to their local context cannot be assumed. This is an important consideration for managers of health visitors leading change where practitioners work in a variety of practice settings with a range of different professionals, all of which may impact on the success and sustainability of any change initiative.

Approaches to facilitating change

Ford (2006) considers linear models of change, power-coercive in their approach (Chin and Benne 1976) as do Mento et al (2002). Linear models can criticised for assuming a degree of consensus over time in the management of identifiable stages of change. Earlier discussion of an interactionist perspective on the development of identity and meaning in collective situations indicated that this cannot be assumed. Team members reinterpret their experience and its meaning in the course of social interaction, over the course of time. Therefore having had time to reflect on their initial decisions and on their ongoing experience of the change process, individuals may resist the early decisions made, despite the fact they were included in them.

Despite this, models such as Lewin's (1951) model of change are still much referred to. His "unfreeze – change – refreeze" model has simplicity in that there are only three phases to it, with the potential for different strategies to change behaviours implemented at the different stages. It could be argued that focusing on the individual to effect wider change can be unwieldy in a complex organisation such as the NHS. However, others have suggested that to be effective, individual empowerment needs also to be supported by wider system change to have a sustainable effect (Weick 1995). Weick's (1995) model reverses Lewin's, proposing stages of "freeze – adjust – unfreeze". This is proposed as a mechanism for diagnosing systemic problems and making the necessary adjustments to allow the system to continue running effectively. "Unfreeze" implies that the change is not necessarily summative, that the system can be frozen again at any time to make further adjustments. This has echoes of the service improvement approach currently being advocated within the NHS as a way of making continuous improvements to the healthcare system (NHSI 2007).

Karp (2005) proposes a model of "transformative change". This model acknowledges the complexities of the different levels of influence needed for change to be successful

in a complex adaptive system such as the NHS. These levels are described as: organisational, conceptual, collective and cultural. Taking a case study approach, Karp explores the influence of the individual on the change process at all levels. It focuses on the importance of facilitating individuals within an organisation to become "self-learning, self-organising and self-energising" (p. 153). Karp's model is characterised by action, indicating a dynamic relationship between the organisation as a collective and the individuals within it. This makes it very relevant to understanding the research question which considers the experience of individual practitioners and their interaction with change in their practice context. Similarly, Higgs and Rowland (2005) produced a complex model of differentiated change based on a mixed method case study of forty informants from seven organisations. Their model of "emergent" change is suggested as more likely to succeed in a complex organisation because it acknowledges the unpredictability of human behaviour and the possibility of unintended outcomes of the process (p123). This fits with the theoretical framework of this study.

Dopson and Waddington (1996) in an extensive study of change in the NHS also focus on the inevitable unplanned outcomes of any change process. Like Higgs and Rowland (2005) they suggest that a model of change is needed that is able to cope with and use positively, unpredictable change outcomes as they emerge. Shaw (1997) takes an interactionist approach, focusing on the "shadow systems" of organisations, or put differently, their culture. He suggests that it is the day to day conversations between individuals that influence the outcome of a change initiative not the pre-planned process. McDonald (2004) supports this view suggesting that assumptions cannot be made about the degree of power that can be asserted with individuals in attempting to change their attitudes. She suggests that resistance and non compliance are important factors in the formation of an identity, which supports the earlier discussion on resistant identities (Castells 1997).

Bryar and Bannigan (2003) consider practice development in a community nursing context. They suggest that a strategic approach that combines elements of a "top down" approach based on power and a "bottom up" approach based on interaction is needed to effect change in an efficient way (P.69). Their work promotes the use of an action orientated approach to practice development which fits with the notion that individuals re-evaluate themselves and their position in their setting, through a process of

interaction and interpretation (Blumer 1969). Again this is of relevance to understanding the interactive situation of the study health visitors in negotiating their changing role and identity.

Values as a driver for change

Linked to the concept of culture, Sullivan et al (2002) suggest that aligning the personal values of individuals with those of the organisation, can be an important step in successfully facilitating change in which employees can be fully engaged. This links to the previously cited early change theory work by Chin and Benne (1976) and a "normative-re-educative" approach to change. This approach acknowledges the influence of culture and context on the decision that individuals make. It also has echoes of the use of reciprocal-relational power suggested by Ford (2006) as necessary to maintain balance in an organisational system and culture.

A values led change approach presents a challenge in a complex organisation such as the NHS. The earlier discussion of nursing and health visiting values as a component of their identity indicates a potential difference between them. This is likely to be amplified in considering the diverse range of professional groups, each comprising individuals with personal values. Managing a consensus of values as a starting point for organisational change is therefore likely to be difficult. However values are embedded in identity which in turn underpins the way in which individuals behave. Thus whilst establishing a shared set of values might be difficult, it is likely to be an important step in facilitating successful change in professional role across a large, well established staff group such as health visitors. If efforts are made to achieve this with health visitors they may find that despite their different interpretations of the relative value of public health work, they are in fact underpinned by similar values, such as the importance of a preventative approach to health. Recognition of shared values may increase tolerance of their differences in its practice application, thereby maintaining a more cohesive group identity. This will be explored further later in the thesis.

Ford (2006 p.517) makes explicit the link between identity and change, considering the impact on individuals. The following quote captures the magnitude of this potential challenge to identity and perception of the self:

> *"to admit to themselves that the world, their self and others are not quite what they thought, undermines the very attribute they need: belief and esteem in self"* [in resisting change, individuals] *"desperately protect quite ineffectual conceptual systems, in order to maintain a favourable perception of self and others in different situations"*.

The impact of poorly managed change is likely to be the strengthening of the aforementioned "resistant identity" (Castells 1997). Only through interaction and altered perception can that identity become one of "project" and susceptible to change. Clearly it is not simply the choice of change model that is important, but also the leadership of the change process and the skill of the leader in helping individuals avoid role identity crises.

Leadership For Change

The discussion of the complexity inherent in managing organisational change indicates a clear need for effective leadership of some description (Higgs and Rowland 2005; McDonald 2004). This is echoed in the literature considering the development of the public health role in health visiting (Abbot et al 2004; Brocklehurst 2004; Carr et al 2003; Goodman-Brown and Appleton 2004; Smith 2004). The previously mentioned whole systems pilot initiative recognised this need, through the identification of change activists from within the staff group, to stimulate local teams to develop new ways of working (DOH 2001c). Ardern (1999) uses the term "influencers" to describe individuals who can help facilitate successful organisational change. The status of these individuals will have an influence on their credibility as leaders of change. The participants in this study had varied perceptions of their managers and their influence on their practice, again this will be discussed later. With the diverse range of change management approaches as discussed, comes a wide range of potential leadership issues which also need to be understood.

Creating a receptive environment

One of the key roles identified for the leaders of change is that of creating an environment in which change can flourish. For example Higgs and Rowland (2005) suggest that creating a situation which protects the psychological safety of individual is essential. Individuals need to feel free to make mistakes without a punitive response. Similarly the NHSI approach to service improvement, aims to facilitate an environment in which individuals are supported to try out new behaviours and study their impact, before attempting to embed that change into whole systems (NHSI 2008). Fostering this safe environment requires a leadership style that is facilitative and built upon sound communication and interpersonal skills. Higgs and Rowland (2005) suggest that a leadership style focused on "framing" change rather than directing change is more likely to be successful. This fits with their support of an emergent change model. An emergent model does not predict or direct outcomes to any great degree and facilitates changes from within the group expected to change.

Lateral leadership

Kuhl, Schnelle and Tillman (2005) discuss the importance of lateral leadership in facilitating change in complex adaptive systems such the NHS. In situations in which there is an intertwining of many agendas, perspectives and identities, a lateral leadership style is needed that can manage change without hierarchical power (Dopson and Waddington 1996). Lateral leadership aims to influence participants whilst making them feel safe, valued and not coerced into decision making and change. Several strategies are suggested for lateral leadership (Kuhl, Scnhelle and Tillman (2005) including, establishing shared terminology and decreasing the threat of change through projecting to the future.

Encouraging participation

Top down linear change models also imply that participation in the change process can be mandated, leaving little choice for recipients of the change. This potentially results in dissonance for individuals who do not readily agree or identify with the change and a requirement for the organisation to manage this. It is important to note that individuals

can, on the face of it, be seen to participate whilst at the same time being resistant. This links to the earlier discussion on the potential lack of congruence between personal values and engagement with practice principles. McDonald (2004), in considering the notion of participation in an empowerment initiative in a PCT setting, suggested that any change is likely to challenge dominant cultural norms and values in some way bringing a degree of resistance. This further endorses the notion of resistant identities discussed earlier (Castell 1997). McDonald further suggests that a change process needs to be established that is capable of reducing this resistance, through a leadership style that manages it as an object within the process.

Lines (2004) undertook a quantitative study, which supported the hypothesis that the higher the level of participation in change, the more positive the outcomes would be. However, the outcome also suggested that the compatibility of the change with the existing culture of the organisation was a moderating factor in its success. This supports the earlier discussion of the effect of culture on change. Building commitment to change and establishing trust in change leaders are identified as essential tasks for those charged with managing change. Significantly for this thesis the following quote from a large quantitative study of a participative change process (Lines 2004 p. 210) captures the requirements for successful collaborative change leadership:

> [Successful change is dependent on] *"authentic participative processes in which solutions are developed in a collaborative manner with genuine consideration of each participants' input, values and views"*

Chapter Conclusion

This chapter has detailed the literature review undertaken throughout the constant comparative analysis process of this study, within the integrated interactionist framework set out in chapter two. In order to establish the changing professional practice context of the study participants, the current position of health visiting in a historical, policy and professional context has been set out. As a result of changes to the professional register and the policy depiction of their role, with their directive to develop a more collaborative public heath way of working, there is clearly a potential

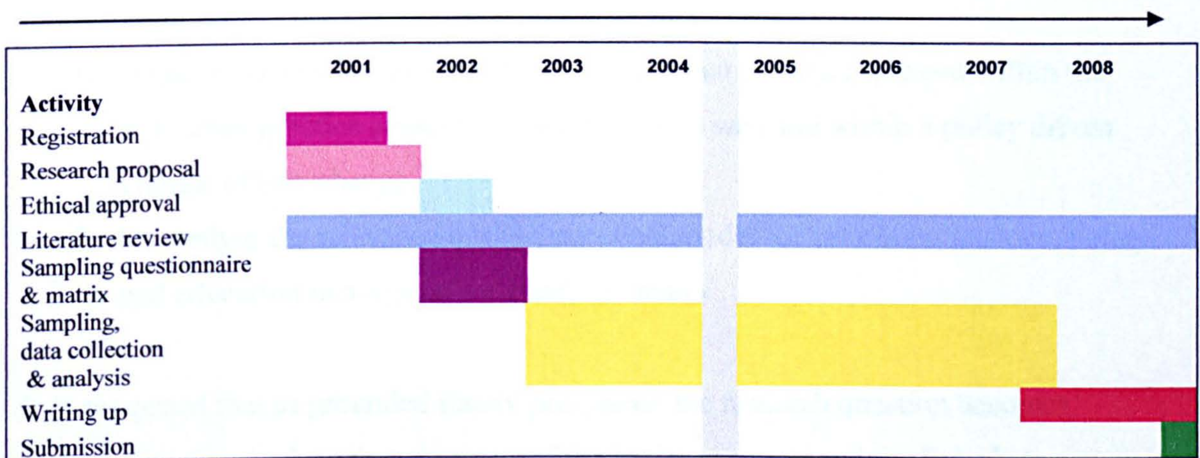
for health visitors to feel that the value their professional identity is being challenged. Some of the literature on the concept of identity and its application to a professional context has therefore also been considered. Given that the context of the health visitors is one of change, the literature on the concept and its link to identity has also been presented. In particular a range of approaches to change facilitation and the importance of leadership for change has been considered. As explained earlier, the process of uncovering existing related knowledge has both guided and been guided by the theory that emerged from the data. From a theoretical perspective, the literature will be further considered in the later discussion of the research journey undertaken, and the findings that emerged from data collection and analysis. From a methodological perspective, this relationship will also be explored in the next chapter which considers the research journey undertaken address the research question.

Chapter 4 - The Research Journey

Introduction

This chapter presents the research journey undertaken during this study. As discussed in chapter two, core to any grounded theory study is the process of constant comparative analysis (Glaser and Strauss 1967). The table below (Table 1) sets out the research process timeline of this study which included concurrent theoretical sampling, data collection, analysis and literature review. The previous chapter has discussed the process and outcome of the literature review. To facilitate a transparent explanation of the stages of sampling, data collection and data analysis they have been delineated in this chapter. Issues of my reflexivity during the course of this study will be reflected at appropriate places during the discussion, separated from the main body of the account by using italicised text in boxes. The discussion begins with an account of the development of the research question.

Table 2: Research Process Timeline



The Research Question

Rationale

Articulating a research question as a focus for grounded theory is a useful mechanism for having a research area that is broad enough to allow issues of relevance to emerge from the process, yet focused enough to produce a meaningful study (Strauss and Corbin 1990) in the time available. In the initial stages of the study however, these were framed as aims and objectives to allow issues of relevance to emerge:

Study aims and objectives

Aims:

1. To explain how health visitors are interacting with current changes in healthcare policy context which advocate a public health approach to their practice.
2. To use the experience of health visitors as an illustrative example to explain the experience of practitioners working in a constantly changing, policy driven, practice context.

Objectives:

1. To develop a model to explain the interactional processes present within the individual practice contexts of health visitors working within a policy driven climate of role change.
2. To analyse the relevance of the theoretical model for informing practice, policy and education in a dynamic climate of change.

It is suggested that as grounded theory progresses the research question becomes necessarily narrowed, as the relevancy of the initial concepts and the links between them are discovered (Strauss and Corbin 1990 p.38). What became clear in this study was the importance of the professional context in general, not just that which was explicitly related to public health. This was compounded by the evidently different perspectives of the participants in relation to the aspects of practice that could be categorised as public health.

In order to help focus the final stage of the research journey, writing this thesis, these aims and objectives were collapsed into the question already identified in the introductory chapter, namely:

"How are health visitors' interpreting and interacting with their changing professional practice context and how has this influenced them and their practice"?

The next section outlines the theoretical sampling process undertaken as the initial stage of constant comparative analysis.

Constant Comparative Analysis -Theoretical Sampling

Identifying the potential population from which to sample

This study aimed to understand health visitors' perceptions of their changing professional practice context and its influence on their professional role and practice in relation to public health work. However, in the early stages of sampling health visiting was not separated from nursing, the significance of this issue emerged from the data. All nurses working in primary care were considered the potential sample population.

Reflection on research 1:

June 2001: A research diary extract from before my first supervision session reads: *"Thoughts on research direction, "what are the shared characteristics of nurses working in public health and what are the common features of their practice".*

Another diary entry three months later suggests the study aim to be:

"an exploratory study which aims to describe and explain the effects of current public health policy on the professional identity and practice of nurses working in primary care".

This initial aim guided the early stages of theoretical sampling. In order to find out the key related issues for nurses working in primary care, data needed to be collected within the substantive group. However there are inherent difficulties in assuming nurses to be a homogenous occupational group. There are clearly different roles within nursing, some of whom were perhaps more likely to be affected by the health policy shift. Given the lack of clarity of the public health role in nursing and its potential impact on all nursing roles, assumptions could not be made about who was or was not being influenced by the largely policy driven, changing practice context. However, my own theoretical sensitivity to the context meant that I was already aware of the potential implications for health visitors in particular.

The study was cleared through the Local Research Ethics Committee (LREC) with permission to undertake the study with staff in two Primary Care Trusts (PCTs). The ethical issues considered as relevant for this study will be explored later in this chapter. In order to determine a potential population for the study and sample in such a way as to minimise the risk of incorrect assumptions, a postal questionnaire was used to identify some basic characteristics of the potential population (Appendix 2).
This was also accompanied by a letter and the "Information for Professionals" sheet (Appendix 3). One hundred questionnaires were sent out and forty completed and returned. In order to facilitate systematic theoretical sampling, the answers to the questions asked were coded and transposed onto a sampling matrix (Reed et al 1997) (Appendix 4) which despite the crudity of its design, provided a useful summary from which to select the early study participants.

Choosing the first participant

The choice of the initial sampling unit is considered a vital step in determining the future direction of a research study (Reed et al, 1997). Theoretical sampling demands the researcher to make use of their developing theoretical sensitivity to the phenomena being studied and to sample those data sources on the basis of: providing the richest data; researcher access; and willingness to participate (Reed et al, 1997). Following preliminary data analysis the researcher selectively samples from the matrix, in keeping with the pace of data collection and analysis (Strauss and Corbin 1990). Whilst the

relevant importance of the characteristics of the participants should not be pre determined (Lincoln and Guba 1985), realistically, unless the initial data sources are able to fulfil the need for in-depth relevant data, the subsequent theory that is developed may not be fully substantive (Cutcliffe 2000). Therefore a purposeful sampling strategy was used initially. In order to establish a baseline for what practitioners understood public health work to be, the initial respondent was a practice nurse who indicated that her entire role was public health work.

Reflection on Research 2:

24/2/03 *The participant chosen was also someone I had previously worked with and my perceptions were that she would be able to articulate the rationale for her approach to practice and her understanding of public health. I was also interested in her "non health visiting" perspective, public health being perceived locally as a health visiting issue. This proved to be the case and through an "open coding" approach to initial analysis several lines of enquiry for subsequent interviews were established. However I was also aware through analysis that as a practice nurse she was unable to give a health visiting perspective on the public health role issue. The health visiting perspective, I knew from my experience in the role, would be essential in addressing the aims of the study which were at that time broad and focused on establishing an understanding of the range of public health work undertaken in primary care nursing practice. Therefore a second respondent who was a health visitor was selected to broaden the initial lines of enquiry related to the study aims.*

Subsequent sampling

As theoretical lines of enquiry began to emerge from data analysis, the use of the matrix to select participants became more limited. It soon became clear that public health work, on which the matrix focused, was only one dimension of the changing practice context of study participants. Once the utility of the sampling matrix diminished, informal networks within the PCTs were used to identify and select participants. However, the

sampling strategy remained theoretical and participants were approached on the basis of their potential contribution to the emerging theory. The process and direction of the analysis undertaken will be explored in more detail later. However in order to provide a transparent picture of the direction of sampling over the time of the study, a table has been produced that sets out in more detail the theoretical selection of participants (Appendix 5). This provides a timeline of data collection and a detailed picture of the way in which questions arising from analysis influenced the theoretical sampling direction. Table two below is a summary of the participants' key characteristics and the data collection undertaken from each. It is intended as a point of reference for ongoing discussion of participant data in the findings chapters, where participants are referred to by "P" followed by their participant number. Data examples in the findings chapters also identify whether its source was an observation e.g. "Ob1" or if from an interview, the line number is indicated.

Table 3: Summary of Participant Characteristics

Participant	Observation	Interview	Re interview	Key characteristics
P1	√	√		Female, practice nurse (PN) with transient families, PCT employed, experienced, said her role was 100% public health, PN rep on PCT executive committee (PEC)
P2	√	√		Female, health visitor (HV), less than 5 years experience, previously school nurse, GP attached, not based in practice building
P3	√	√		Female, HV, change activist, community practice teacher (CPT), GP attached based on practice premises, over 20 years experience.
P4	√	√	√	Female, HV, GP attached, smaller caseload, strong commitment to public health despite negative feedback from colleagues, post natal depression and smoking cessation, CPT, More than 5 years experience
P5	√	√		Female, part time health visiting caseload/ part time clinical nurse lead. On PCT PEC.
P6		√	√	Female, worked part time in GP attached caseload at outset of study. Later moved roles to work with transient and homeless families. More than 10 years experience.
P7	√	√		Male, District nurse, less than 5 years experience. GP attached, team leader.
P8	√	√	√	Female, HV, CPT, GP attached in single GP practice at study commencement. Paediatric liaison role. Moved roles to work

				in GP attached corporate caseload team during the study.
P9	√	√		Female, HV GP attached to practice in affluent area, change activist, over ten years experience.
P10		√		Female, HV GP attached also in affluent area but a different one. High percentage of ethnic minority families on caseload. More than 15 years experience.
P11	√	√		Female, HV, GP attached in same area as P10 but different practice. Less than 5 year experience.
P12	√	√		Female, HV, GP attached in deprived area with high number ethnic minority families. Worked in corporate team.
P13		√		Female, HV, recently qualified though extensive nursing experience. Worked in corporate team.
P14		√		Female, registered HV in a PCT management role, more than 10 years experience.
P15		√		Female, registered HV working as health co-ordinator with Surestart, over 5 years experience, previously held HV caseload.
P16		√		Female, registered HV working in acute trust in specialist public health role. Worked part time on PCT bank undertaking health visiting caseload work during staff shortages. 10 years since qualifying as a health visitor
P17		√		Male, registered HV working in acute trust in specialist public health role. Cross agency working key to the role.

Changing theoretical sampling direction

During the course of the study there have been two key changes in sampling direction based on emerging theory and changing contextual issues. My analysis of data from participant one confirmed my own expectations that a health visiting perspective was likely to be needed in order to capture the breadth of public health work. Clearly these assumptions were based on my own practice experience as a health visitor and my understanding of the practice nurses role. They were also based on my theoretical sensitivity to the emerging public health role in nursing and health visiting. Despite inevitably having some expectations, I went into the observation and interview setting with an open mind, prepared to be surprised by any unexpected dimensions of the role which may have emerged.

Concurrently with the emphasis on public health in health visiting (NMC 2001a; Health Select Committee 2001), there was a move to deliver more acute clinical services in primary care settings (DOH 2000a). The management of the care of people with long term chronic illness in the patients' own home increasingly focused the role of district nurses and practice nurses toward more clinically orientated work, normally carried out in hospitals. In the context of finite resources in PCTs this meant less time available for them to engage in preventative public health work. This study was not a comparison of different nursing roles in primary care relating public health. With the broad initial sample population, there was a danger that an attempt to encompass all roles may limit the depth of understanding required to facilitate the development of substantive theory. The decision was taken to focus specifically on health visitors, though not excluding other nursing roles if they were required to augment the theory developing through constant comparative analysis.

The second key change of sampling direction was also linked to the decision to explore the emerging theory in depth rather than breadth. Due to the extended time frame of this part time study, exacerbated by my suspension of studies, and the rapidly changing context of healthcare practice, the decision was made to re-interview some participants instead of increasing the number of participants. This was a theoretical sampling decision based on the emergence of "temporality" as an issue of significance.

Participants had provided data about their previous experiences, how practice had changed, how expectations of their role had changed since they'd qualified etc. Some were known to have changed jobs during the course of the study. The decision was made to explore the significance of changes in perceptions over the course of time. In addition, re-interviewing provided the opportunity to explore and confirm emerging themes with some of the participants. In keeping with grounded theory methodology, however, there also remained a need to check out potential "far out" comparisons to add to the variation within emergent data categories (Strauss and Corbin 1990). Therefore new participants in a-typical roles continued to be approached to participate. Despite the variation in sampling direction, all sampling decisions were based on the constant comparative process and were theoretical in nature (Chenitz and Swanson 1986).

Sample size

A total of seventeen participants provided a range of in depth data through observation, initial interviews and some re interviews. It is suggested that where a qualitative study aims to identify and describe recurrent themes in the data, a sample size of six to eight participants is sufficient (Kuzel, 1992). However, where a deeper analysis of all of the available variations in the data is the aim, a sample twice that size would be necessary (Kuzel, 1992). Other authors on grounded theory suggest that between twenty and thirty participants may be required to achieve theoretical depth (Sandelowski 1995). Fundamentally, in grounded theory, sampling and data collection should continue until no new data is emerging to augment the theory being developed (Glaser and Strauss 1967).

Constant Comparative Analysis - Data Collection

Direct observation

The initial chosen method of data collection for the study was participant observation. Glaser (1978) recommends observation of the study participants in their natural setting in an effort to capture the interaction of participants and the meanings attributed to

incidents and actions. Within the method of participant observation it is suggested that there are various data sources including direct observations, indirect observations, interview (formal and informal) and secondary data sources such as records and notes (Jorgensen 1989). This is in keeping with a grounded theory methodology (Glaser and Struass 1967) and the theoretical framework of this study (Clarke 2005) which suggests data to be anything of relevance in the situation of participants (Strauss and Corbin 1990).

The sampling questionnaire indicated a difference in the percentage of time participants perceived to be spent on public health work, despite some occupying the same organisational role. In order to explore this, direct observation in the practice setting was undertaken. Condensed field notes were taken during the observations. These were developed into an expanded account as soon as possible after the observation (Spradley, 1980 p.69) (Appendix 6) in an effort not to lose any of the detailed observation and interpretative thoughts and memos. A "reflective diary" was also used to record key occurrences and learning points in the research situation. This helped in reflecting on the research process and in understanding my position in the setting as "insider" or "outsider" (Spradley, 1980 p.56). It also facilitated self awareness in my role as researcher/ actor in the social situation and its effect on the interaction. It is suggested that it is important for researchers to undertake such "critical reflection" on the nature of their participation in order to facilitate an evaluation of the quality of the study and the validity of its findings (Davies 1999 p.70). For true reflexivity (Davies 1999) and not just simply reflection, it is important to understand how the researcher both affects and is affected by the interaction that they are part of (Alveson and Skoldberg 2000). A reflective diary extract on my first experience at observing read as follows:

Reflection on research 3:

Observation took place 18/2/03 P1

This was my first observation setting. I had read literature on making field notes, what to observe etc but I still wasn't sure of my role in the situation. I had also worked with the nurse in practice so it took a while to get properly into what I might term "research" mode. I felt like I was waiting for something to happen to observe for example a patient arriving, I suddenly realised that I had chosen this nurse because she

said her work was 100% public health so I should be observing everything she was doing. I felt a bit intrusive as there wasn't a corner I could sit in. To me it felt like I was in the way although the nature of interactions within the room did not seem to be affected. The nurse kept saying things like "you know me...." So it was necessary at times to probe to get the full picture.

I wasn't sure how much questioning (informal interviewing) to do but it did seem relevant in seeking clarification of public health perceptions. When I observed the consultation with the patients I felt uneasy. Although the nurse explained my presence English wasn't his first language so I was not altogether sure he understood why I was there.

When writing my field notes I wasn't sure how much detail to write down. I decided that going for more rather than less would be the best strategy.

Whilst observation provided some descriptive data it became clear through analysis that this had limited use in understanding the participants' perceptions. The aim of the observations was not an analysis of interaction between health visitors and their clients. This would have been a different study altogether. Added to that, interaction with potential contextual influences such as protocols and policy was not usually visible through direct observation, unless the practitioner verbally made that link. The focus of this study was on the perceptions of the practitioners being studied i.e. the meaning they attached to different aspects of their interactions in context. The plan was not to elucidate an "objective" view of what they were doing in their practice. However, the observation process did provide the opportunity to "informally" discuss issues noted during the observations, thereby providing explanation for particular activities, though this was not without its problems:

Reflection on research 4:

Reflective Diary 25/5/03 P3
.... also generally how much informal discussion should be undertaken is difficult to judge. We spent the first hour of this observation visit talking in the office with the nursery nurse also contributing. I made sure the NN knew why I was there but felt a bit uncomfortable – should I have consented her, should I have included her perspective in things?

......I'm still not altogether certain as to what I'm supposed to be observing. All of the frameworks I've read about don't seem to fit. Really I am wanting to explore the interaction between policy and practitioners/ practice. As the policy is invisible this is more difficult to capture. I definitely need to follow up these observations with more formal interviewing to explore their perceptions of the policy agenda

Observation was useful in sensitising myself to the context of their practice and through that, the development of a research rapport.

Reflection on research 5:

05/06/03 – P4 – Reflective Diary
This was a tricky one. The participant is one of my best friends. Not only that, I had also worked with her so had some preconceived notion about what she thinks about public health etc. I was aware of this though and tried to stand back where possible. Observing the baby club I found myself going in and out of research mode. For instance when she was talking to clients, doing paperwork etc I felt that I was in the field so to speak. Observing and making notes at a distance. Sitting next to the clients listening to what was going on and observing the HVs practice. Asking myself what is she doing? I also asked informal question like why are you doing that? What is the value of what you're doing? But there were times when I put my notebook down and just "chatted". On reflection however I felt I was putting the HV at ease. She actually said she felt under pressure more so because I knew her. She said she felt nervous. So any strategy to develop a different sort of relationship with her was bound to be beneficial.

It also served to confirm that my own understanding, or theoretical sensitivity (Glaser 1978), relating to health visiting practice was contemporary and accurate.

Reflection on research 6:

RD030403- P9 *Difficult being an "insider" researcher in a clinic setting and not participate. Tendency to get drawn into conversation often by parents and children who seem to want to interact with the stranger in the corner. This may be because I was introduced as a health visitor as well as researcher. I find it difficult not to go into HV mode because of the need to make clients as comfortable as possible in the setting.*

Following the first observation a formal individual interview was undertaken to explore in more depth the perspective of the participant. For pragmatic reasons, with some participants, the interview came first then the observation. Different data collection methods with the same participant in different context may influence their expressed perceptions. It may have been the case that having developed an observation rapport with the participants, they were more willing to give their "private accounts" (Cornwell 1984) of their experiences of their changing practice context, i.e. a "truer" account of what they really thought. Alternatively, having been offered an opportunity to reflect on their practice at interview, some participants may have altered their approach to the work I was observing.

Blumer (1969) suggests that in a symbolic interactionist study, understanding social interaction must be set in the context of what has gone before. He states that each time an interaction occurs, even with the same objects in similar contexts, the interaction will be different, because of the influence of past experiences. For the participants in this study, it may not be the case that they kept their "true" feelings or practice until the follow up interview or follow up observation, but rather that their perceptions changed in the time between the two events.

Reflection on research 7:

RD030403-7P9
As I arrived the HV in question said she'd realised that we did our training together. Her demeanour towards me was much more relaxed than at the observation. Partly because I'd spent time with her in the clinic but there was also a "shared experience" dimension to the whole interview. When it came to asking about her education she was a bit nervous about answering given that I'd done the same training. However I definitely felt she was opening up with me because of that shared background. After the interview was finished she gave me some useful contextual information framed by her as "gossip" that I don't think I would have got in a more formal research relationship. She was interested to know my perspective on the PH agenda. However, given that I may need to interview her again I focused my response on the study rather than my personal subjective opinion.

For the first nine participants this constant comparative process was repeated (theoretical sampling, observation & interview, analysis, theoretical sampling). As theoretical assertions began to emerge from the data analysis it became evident that the direct observation was adding nothing new to the identified categories of data.

Reflection on research 8:

Reflection RD060403 P8
This observation felt superfluous after the interview session. In a way it confirmed that this HV had the approach to her practice that I had interpreted from the interview. However, no new information was gained from it. If the idea had been to observe/ evaluate HV client interaction it would have been useful. The aim of the study is to identify practitioner interaction with the changing policy agenda, such an interaction being invisible. Therefore future data collection is likely to focus more on interviews with only selective interviews where there is a clear purpose

Each observation had new and different practice contexts, practitioners, clients, areas of practice. However, once analysed, the emerging concepts and themes were adding

nothing new to the emerging theory. In effect, the data category relating to description of practice, the category where observation of practice had influence, was "saturated" (Glaser and Strauss 1967). As discussed in chapter two, in an interpretative paradigm it is difficult to claim to know everything there is to know about something, i.e. achieve "saturation", as one can never predict whether a new interaction would result in new meaning. It is suggested that data can never be complete in that sense (Clarke 2005). To make the best use of time available the decision was made to stop direct observation and focus on the perceptions of individual participants as expressed through individual interviews.

Interviews

A total of twenty individual, formal taped interviews were used. Whilst an unstructured interview might have been the aim to allow issues of relevance to emerge (Glaser and struass 1967), it has been suggested that because an interview is based on interaction between two people, it is always likely to be structured to some degree by both the interviewer and interviewee, however hard the researcher tries to maintain their objectivity and flexibility (Hammersley and Atkinson, 1983). It is also suggested that successful interviewing uses whichever method suits the purpose of the interview whilst still maintaining an open mind and allowing the respondents freedom of expression (Rose, 1994).

An interview guide was used in this study in order to ensure that data was collected relevant to emerging theory. The guide comprised of broad areas for discussion and was based on the cumulative analysis of previously collected data. As the study progressed and analysis became more relational-variational (Strauss and Corbin 1990) the guide changed and became more focused on the emerging issues (Appendix 7). However, in order to establish their prior understanding and a context for the discussion, some questions were similar with every participant such as their understanding of the concept of public health. Using some similar questions when re-interviewing, also provided an opportunity to look for changes in perception over the time of the study which, being a part time PhD, was elongated. The study was not however, designed as a longitudinal study and data from different sources were not separated. Where issues relating to

change over time were identified as important to the developing theory, these are highlighted in the discussion of the findings.

Constant Comparative Analysis - Data Analysis

Coding

Constant comparative analysis was undertaken throughout. The data from the preliminary observation field notes and taped interview were analysed using an "open" or "substantive" coding technique (Glaser and Strauss 1967). The interview was transcribed verbatim using a word processor and the lines numbered (Appendix 8). In order to build up the "picture", each line of the data was scanned for information relevant to the research area. The margins were used to allocate conceptual labels to each new piece of information and facilitate preliminary grouping of the concepts. This early work informed the selection of the next study participant and the content of the interview guide (Strauss and Corbin 1990). In carrying out the early analysis my theoretical sensitivity (Glaser 1978) to the relevance of the emerging issues inevitably influenced the direction of the data analysis. For example:

Reflection on research 9:

Reflection on interview with P7 Nov 05

This participant had changed jobs. I remember the last interview being quite difficult as she didn't have much insight into the PH role or the policy agenda. However once the interview commenced I remember thinking she was "like a different person". In a more strategic multi agency role she talked animatedly about how her role fitted with the PH agenda especially in relation to mental health. She fluently related policy to changing practice. I wonder if my pleasure at this change was because of my role as an educationalist. There had clearly been a lot of learning & development. One thing I was struck by was the emphasis on Interprofessional Working and cross agency working. It was described as a necessity for the role. Before it simply enhanced her individual model of practice. But again, in my work as IPE Director, I'm probably very sensitised

to issues of IPW. But it has got me thinking about the significance of IPW to PH working, especially at a strategic level.

Memo: Is there something about as HVs move along the PH continuum does the work become increasingly collaborative?
Is it easier to identify themselves in a PH role at the more strategic end even when the job title does not make PH explicit?

In order to ensure that the emergence of interprofessional working as an issue of significance was not something that had been "forced" from the data (Glaser 1992), the existing data was re-examined for its relevancy. In all of the interviews interprofessional working was evident, though had previously been labelled "working with others", "teamwork", "communication". This line of enquiry further developed in subsequent interviews and emerged as a key data category (see chapter eight).

Data handling using computer software

Handling of the data during data analysis was, in the main, undertaken manually. For a brief period an attempt was made to engage with the qualitative data software handling programme NUDIST. However, this process did not prove to be particularly facilitative in this research context. The following reflection illustrates my decision making:

Reflection on research 10:

January 2006
Following my suspension from studies for one year for personal reasons, I felt quite daunted by the amount of data I had already collected and analysed, especially as data collection was not finished.. At the suggestion of others who had undertaken qualitative research, I gave consideration to the use of "NUDIST" as a method of electronically handling the data. I began the process of transferring data already manually coded data into a NUDIST project. However, although I learned to use the software, this

activity highlighted some limitations of using IT as a medium for looking at data so I decided to stop and go back to manual handling.

These perceived limitations were perhaps more about my own analytical thinking style. My own personal philosophical perspective means that I prefer to solve analytical problems and generate ideas from seeing everything relevant in its context, holistically. I felt that using a software package that fragmented data, precluded the ability to look at that data in a holistic way, though this may have been because of my lack of experience. In some ways, working with paper and manually handling the data, better facilitated my understanding the participants' situation in its broadest sense, and as such I felt more in control of the process. In addition, once data categories, properties and dimensions were labelled in the NUDIST project, they felt fixed and summative (though of course I could have changed them) which I was uncomfortable with. In grounded theory the labels given to categories need to be continually refined through constant comparative analysis to ensure they continue to accurately reflect emerging data (Strauss and Corbin 1990). However, the experience of engaging with NUDIST wasn't a completely negative exercise.

Without a doubt, the process of re reading the transcripts prior to data inputting facilitated my re engagement with the data after the suspension my studies. It has also provided an opportunity to "step back" from the data to ask different questions of it. The decision was made to continue the process of manual coding and labelling, with a constant check back to previous data as new concepts emerged as relevant. Having complete hard copy transcripts at hand for reference enabled a check of the data in the context of it original articulation. These transcripts were regularly re read after the emergence of new ideas for evidence within the data. This process enabled a separating out of concepts and an exploration of their relevance in relation to other similar and different data, but always in relation to the whole picture.

This became more significant as analysis progressed and the theoretical framework became more significant. Through this interaction with the data, there was recognition that the categories identified were all of significance. However the category of professional role identity emerged as core, providing linkages to the others (see chapter seven). The linkages between categories and their properties were of particular interest

as they represented social processes, the uncovering of which is at the heart of any study framed by symbolic interactionism.

Emerging importance of symbolic interactionism

One of the most significant developments in my thinking was the emergent significance of symbolic interactionism. As data analysis progressed, the emerging data categories were indicating an inter play between factors both internal and external to the practitioners. They appeared inextricably linked to contextual issues for individual practice, which was also developing as a category in its own right. This interplay between "self" and "others" in context is central to symbolic interactionist theory. Additionally, despite significant changes in health and professional policy, emerging data suggested variation in the degree to which practitioners are engaging with the changes. Symbolic interactionist theory addresses the concept of collective action (Blumer 1969) and its relationship to individual interpretative processes. Therefore whilst symbolic interactionism was acknowledged as the theoretical framework for the study, underpinning grounded theory, its significance did not become apparent to me until data analysis had progressed significantly. The next chapter presents the conceptual model developed at this stage to represent these interactive processes. Having outlined the constant comparative process undertaken in this study the next section considers ethical issues inherent in and arising from the process.

Ethical Issues

Gaining LREC approval and PCT approval took longer than anticipated due to the administration process and the subsequent clarification required before approval could be given. One of the key areas for debate in the ethics of this study was whether consent from clients was needed when observing practitioners in settings in which they were present. Clearly there was a consideration of the potential risk to confidentiality and the informed consent process. Through supervision sessions the decision was made that in the diversity of potential observational settings, getting written consent from clients

would be impractical. We were also concerned that this process might have made the study unnecessarily intrusive for clients, raising unnecessary anxiety when the focus of observation was the practitioner. However their need for information was recognised. For their clarity and reassurance, the decision was made to give members of the public who may be present in data collection situations, an information sheet setting out the purpose of the research. This gave reassurance that no data would be collected that would identify them (Appendix 9). Where the observation settings were planned, service users also had the opportunity in advance to decline my presence. Where contact was opportunistic, both the client and the participants could request that I leave. This plan was eventually approved by the LREC after initial clarification of intent.

Over the course of this study the research governance requirement of ethical committees and Trust R & D committees have been increasingly standardised to protect the situation of service users in research (DOH 2007c). It is likely that were this proposal to be submitted to an LREC now, written consent of the clients would be required and a more substantial information sheet needed. Over the course of the study there were no situations that arose in the observation sessions that caused me to question the decision not to get consent. Additionally, as my presence was explained by participants to clients as being both a researcher and a health visitor which appeared to give extra reassurance for clients in relation to their level of trust of my presence. However this did cause me some dissonance at times in the data collection situation. This discomfort related to a general lack of clarity relating to my role in the situation and clients expectations. An example is as follows:

Reflection on research 12:

Reflective Diary 25/5/03 P3

Another concern for me was how much to participate. At the first visit I sat back. I decided not to make notes whilst I was there as it may be construed as intrusive or worse the client may have thought I was there to monitor her. I stayed quiet apart from interacting with the 3 year old who wanted to know who I was. At the second visit however the mother and father were asking questions of the HV that she was unable to answer. I knew the information and found myself taking part in the visit. During the visit I was happy that as a registered practitioner it was Ok to do that. Certainly I felt that

my presence was less intrusive. However afterwards I felt uncomfortable that the HV might have minded me doing that. She said she didn't mind but I can't help thinking it was because she knew me as a practitioner. In similar circumstances with someone I didn't know they may have been unhappy at me doing that. I think I will make it a strategy to ask before doing home visits what the practitioner's expectations of me are.

On reflection what I was struggling with was my professional role identity. By that time I was working as an academic, though still registered as a health visitor. In addition, given my lack of experience, I was not fully comfortable with an identity as a researcher. This supports the dimension of this study which suggests working context and feedback from others influences the maintenance of role identity equilibrium.

Written consent to participate was sought from all practitioner participants (Appendix 10). Practitioners were assured of anonymity in any written work. They were also assured that their participation would be confidential and that they had the right to refuse or withdraw at any time. Given the nature of public health work it was anticipated that other professionals not intended to be participants in the study might have been present in the situation being studied. This proved to be the case for several of the observation settings. For example with participant eight there was an opportunity to observe a multi-agency locality meeting in which the health visitor played a significant part. The information sheet was distributed to attendees and any questions needed for clarification invited. Another example was with participant two who invited me to observe a planning group exploring a smoking cessation planning group. A smaller group this time but involving people who may not have been at my introductory presentation to the PCT. An information sheet was provided to all present to afford them with the same reassurance and research governance protection as the participants (Appendix 10). The information sheet ensured that they understood my presence in the setting and that I would leave at any time if they deemed my presence to be inappropriate.

Chapter Conclusion

This chapter has set out the constant comparative analysis process (Glaser and Strauss 1967) in order to make explicit the research process undertaken in this study. In reality the stages of sampling, data collection and analysis happen concurrently.
The process of refining the research question has been articulated and the research question that frames this thesis made explicit. Theoretical sampling is a core component of grounded theory and it is clear that this was the process undertaken in this study. The data collection methods of observation and interviewing, under the umbrella of participant observation, have been outlined along with the evolving method used over the course of the study. The process used to guide the ongoing analysis of the data has also been discussed. Through this process the theoretical framework of symbolic interactionism was reaffirmed as significant, validating the use of grounded theory methodology. As detailed in chapter two, over the course of the study the theoretical framework evolved to include aspects of situational analysis (Clarke 2005), negotiated order theory (Strauss 1978) and Strategic Systems Thinking (Bednar 2007). These developments were driven by the constant comparative process and continuous reconsideration of literature relevant to the emerging findings from data analysis. The following section of the thesis considers the findings that emerged from the study and their relevance to practice, education and research in a UK healthcare system context.

Chapter Five – Clarifying the Thesis Direction

Introduction

Three models have been produced in this thesis. This short chapter contextualises and presents, the primary conceptual model constructed to support the argument of this thesis. The model represents the interactional relationship between the four key categories that emerged from the data as significant: professional role in action; professional role identity; interprofessional working; and local practice micro systems. Each will be discussed in subsequent chapters. This chapter introduces the process of "maintaining identity equilibrium" as important in a complex, collaborative, professional practice environment. Subsequent chapters present and discuss the two other models produced, both of which have the key elements of the primary conceptual model as their foundation. The integrated, interactionist, theoretical framework of the thesis, as set out in chapter two, also both implicitly and explicitly frames the remainder of the thesis.

Contextualising the Model

Policy and professional context – Key points

The development of an efficacious primary care, public health led NHS is central to current health service policy (DOH 1997a). This has culminated in an integrated strategy requiring a collaborative, whole systems approach to maximising the health of the UK population (DOH 2000a; DOH 2001b). In response, major changes in the wider NHS workforce strategy have necessitated professionals to work more collaboratively, demonstrating core knowledge and skills for practice at all levels (DOH 2004a). A key factor of relevance emerging from the changes, is an expectation that health visitors will

refocus and change their role to be more explicitly linked to public health work (Home Office 1998; DOH 1999b; DOH 2001a; DOH 2002a; Lowe 2007; DOH 2007a).

The literature review chapter has explained that the professional register for nurses, midwives and health visitors has changed to facilitate the regulation of all nurses working in public health roles, including health visitors. Part three of the register (NMC 2004a), establishes a new, all encompassing title of "specialist community public health nurse" applying to all practitioners registered on it. However, there remains a lack of clarity on the nature of public health work, in both nursing and health visiting. A continuum for public health work in health visiting was produced (DOH 2001a) to help practitioners interpret public health role expectations. However, this continuum is very broad, open to a diversity of interpretations. Evidence suggests different models for health visiting public health work are emerging (Carr et al 2003). "Whole Systems Pilot" sites were established (DOH 2001c) to facilitate the development of public health work in community nursing teams. However, the discussion in subsequent chapters will show that for the participants in this study it did not facilitate an obvious sustained change of role. In addition, the diversity of individual experiences in this initiative indicated perceived differences in its value and impact their health visiting identity.

Professional identity & change

The data in this study suggests that the lack of specificity in policy of the nature of the public health role in health visiting has created professional role confusion and uncertainty amongst the health visiting staff group. The discussion in subsequent chapters will show that participants perceived the efficacy of their current role which included public health work, was being challenged and devalued. In part this was attributed by them to the process of change occurring in the local context, driven from their perspective, by the Whole System's Pilot initiative. Exploration of policy driven change management as an emerging issue, indicated that responsibility for its local implementation was devolved to local teams, resulting in a range of approaches to change being undertaken. This has implications for the wider profession of health

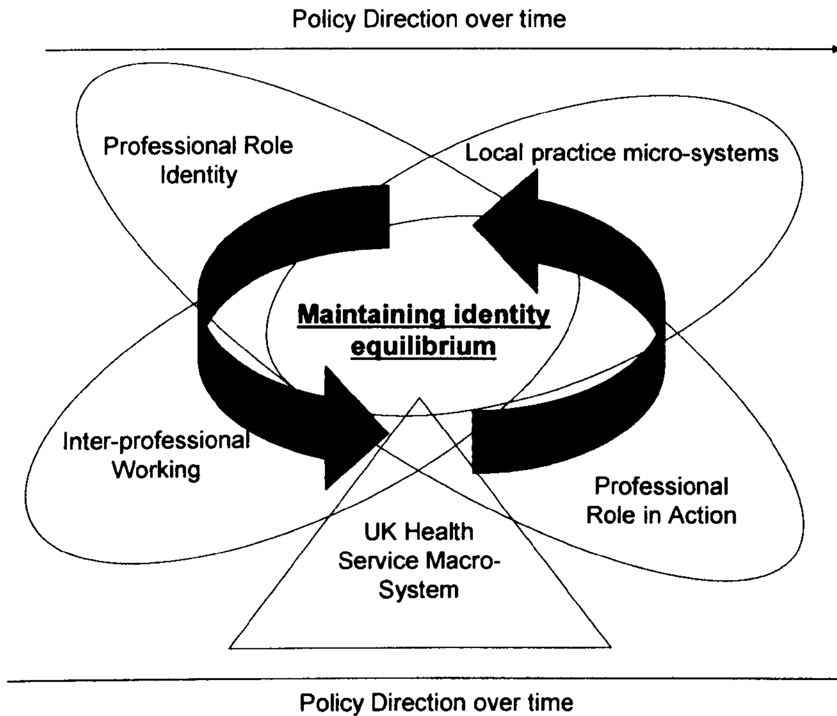
visiting where roles develop differently in different local contexts. It also has issues for the individual and the transferability of their role and professional skills from one context to another, within their local organisation or more widely. Being able to confidently articulate the contribution of health visiting to integrated healthcare provision is essential to successful collaboration and in ensuring service users can have consistent national public expectations from health visiting services. It is clear that the experience of the participants over the course of this study was a very individual one, providing little evidence of a consistent, collective role perception within the staff group of health visiting.

Participants' experience of working in their changing professional practice context varied and was influenced by many factors. How policy was implemented was linked to how their previous experience, self perception in role, their identity as a health visitors and whether or not change was perceived as a challenge to what they believed was core to health visiting. The importance of their identity as a nurse, for example, appeared to affect their perceptions of public health work. Some viewed it as additional workload demanding significant change. However some viewed is core to their existing practice, requiring little role change. Participants for whom the latter was the case conveyed a greater degree of equilibrium in their professional role identity. Those health visitors, who felt that the legitimacy of their current practice was being challenged by the public health agenda, conveyed instability or disequilibrium in their professional role identity and felt undervalued in their work with others.

Maintaining Identity Equilibrium – A Conceptual Model

The following primary conceptual model presents the component influences on the professional role identity of the participants:

Figure 4: Maintaining Identity Equilibrium - A Conceptual Model



The following four findings chapters will discuss in more depth the component parts of this model.

Professional role in action

Chapter six focuses on illustrating the nature of the professional role in action of participants. This descriptive chapter discusses the practice observed and reported on, in relation to the previously discussed national picture of health visiting. In order to underpin more theoretical discussion in the subsequent chapters, chapter six establishes a picture of the health visiting practice of the participants in this study which has both similarities and differences to that depicted in the literature.

Professional role identity

Chapter seven discusses participants' perception of the meaning and relative value of their role in action to their identity as professionals. In particular the focus is on the

influence of the changing agenda toward a public health model of working. As data collection progressed it became apparent it was not possible to separate out the public health policy changes from other professional and contextual changes. This being the case the discussion does not focus exclusively on what might be termed collaborative public health work. In order to understand the process through which identity equilibrium is maintained at an individual level, the first stage of the second more process orientated model is introduced in this chapter.

Interprofessional working

Chapter eight builds the process model further and considers the relevance of professional role identity in a collaborative, interprofessional working situation. Given the increasingly integrated nature of healthcare service provision, the process of maintaining identity equilibrium cannot be understood in isolation from interaction with others in the course of daily practice. Feedback from others inevitably influences how individuals view themselves in their role. It also influences how they view themselves in relation to their own professional group and the fit between their identity and the collective identity of their peers. The way in which identity equilibrium is maintained, by reference to others in the local context of interaction, is outlined in this chapter.

Local micro systems for practice

Chapter nine is the last stage in constructing the process model which theoretically explains the interaction between the components parts of the conceptual model proposed in this chapter. The focus is on the local practice micro systems that support the participants' work and their influence on the process of identity maintenance. The notion of "system" is used loosely to mean any constructs that can be referred to that help individuals to operationalise their professional role in action. In chapter nine these systems are in the main external to the individual but operate by reference to them, such as human resource systems, and policies and protocols for practice. However, the individuals themselves are not static objects and can also be viewed as complex

adaptive systems through their interaction with the external systems identified. These issues are considered in this, the last data chapter.

Conclusion

This short chapter has set out the direction of the remainder of the thesis. In essence it has provides a bridge between what is known about the area under investigation and the discussion of the findings from this study. Some of the key contextual factors identified in the literature review have been revisited. The discussion has also set out a conceptual model, the components of which emerged as significant in the constant comparative analysis process in this study. These are professional role in action, professional role identity, interprofessional working and micro systems for practice. The intent of each chapter of data findings and discussion has been set out, which includes the incremental construction of a process model to explain the relationship between the components of the conceptual model set out in this chapter. This process model represents the grounded theory developed in this study to understand the participants' interaction in their professional practice context and the ongoing importance of maintaining identity equilibrium in a complex, dynamic UK healthcare system.

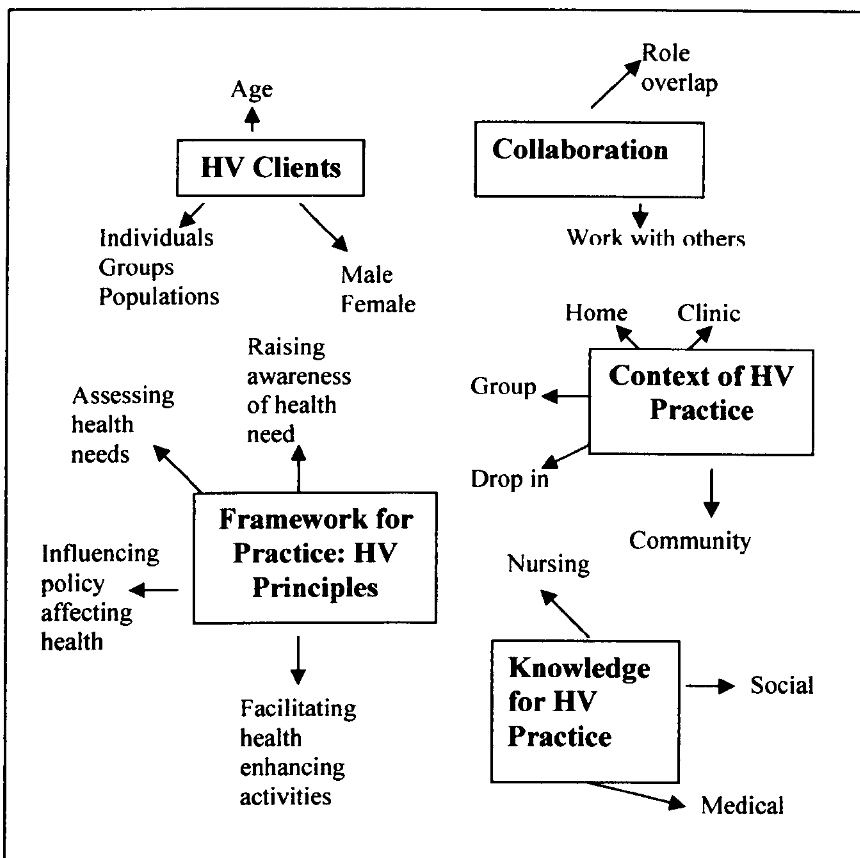
Chapter 6 - Professional Role in Action

"People always ask me "how do you approach a role?" Well, I don't know. I approach it first by saying yes, then getting on with the bloody thing"
(Dame Edith Evans – Actress - (attributed).

Introduction

This chapter presents an analytical description of the data category "Professional Role in Action". Despite the broad range of client groups, specific functions and practice environments in which the participants interact, it was possible to categorise their work in such a way as to capture an overview of their role. This provides an important contextual backdrop for subsequent chapters which are more theoretical in nature. The chapter is by no means an exhaustive description of the scope of practice of health visiting or indeed their public health work. In light of my area of research interest, the practice examples discussed do have a leaning toward those which the participants considered to be public health work. Explicit in the theoretical framework for this study, is the now well established link between action, self and identity (Mead 1934; Blumer 1969; Strauss 1978; Castells 1997; Burke 1980). The discussion of "Professional Role in Action" in this chapter explains only one component of the primary conceptual model (figure 4 p.99). The category and its properties are represented pictorially below (figure 5):

Figure 5: Professional Role in Action – data category properties



In considering the notion of a "situational map" or "messy map" (Clarke 2005), this pictorial overview of the category and its properties (figure 5) could be viewed alongside that of the literature developed in chapter three (figure 3), to represent the beginning of a holistic representation of the interactive practice situation of the participants. The data in this category will now be presented and discussed with reference to the wider policy and professional context considered in chapter three.

Approach to practice

The focus of health visiting work

Individuals

The data suggested that the majority of participants' work was targeted toward meeting the needs of individuals. Home visiting as a location for work with individuals was common to most of the participants, reflecting the national picture (Craig and Adams 2007; Lowe 2007). The purpose of this work appeared to be largely about baseline assessment in addition to identifying need:

> *I mean I normally visit somebody as a primary visit and then I would visit them probably weekly for three or four weeks till they had to come to the clinic for their six day week check and in those three or four visits at home, I now know what they're like as a family. Not just what the baby is doing or anything like that because I can suss out the family dynamics in those three or four visits, and it means that when they come then to the clinic, which is quite false setting, I can usually spot what was or appeared to be, you know, a happy, straightforward family, that suddenly they've gone a bit sort of stressed or whatever (P9 312-320)*

In the latter example, home visits were also used to establish longer term relationships with individuals in need of support. Given the central importance of relationships to health visiting work (Chalmers 1992; De la Cuesta 1994), it is perhaps unsurprising that the home context was that favoured by the participants. Their perception of the relevance of this to their role and identity is explored further in the next chapter.

Home visiting was not the only context for individual work. Data indicated that whilst clinics and groups may on the face of it appear to be about a collective approach to practice, often they were simply an efficient system for facilitating individual access to the health visitor. The purpose of such work varied. Some clinics were proactively

targeted at the needs of individuals from specific client groups such as parents with babies, as a means of providing ongoing, proactive, individually orientated support. They were also a means of facilitating access to the health visitor for immunisations, developmental screening and other, health related needs such as prescribing:

> *Babies weighed.....developmental screening, family needs assessment, health promotion, dietary advice.....Discussion re medical advice for minor complaint and whether client should see GP or not. (P12 Ob1)*

"Well baby clinics" were engaged in by all participants with caseloads and there appeared to be a common understanding of their format, to the point where they could stand in for one another in times of sickness. Therefore whilst home visiting as a model is important to individual work, clinics are also an identifiable, stable construct in health visiting practice, contributing toward what might be considered the collective identity of the health visiting group.

Other clinics facilitated individual work that was reactive, referral driven and focused on particular health promotion intervention work with individuals from a range of client groups. Whilst these clinics sat with a preventative paradigm in terms of health promotion, they were specifically targeted at more medical health need:

> *We screen our children who are sick, if they're sick they need a doctor, if they're losing weight because of what research says, the biggest reason for children losing weight naturally is low calorie and poor routine, then they're not ill, it's a nursing issue and that has to be addressed to dietetics and health visiting. And that's how we do it, so we address the growth of children through the health visitor/nurse. (P16 58-64)*

> *I do a smoking clinic (P3 Ob1)*

Clinic work is not exclusive to health visiting. It is also carried out by other nursing groups in the community, for a range of assessment and intervention reasons. As a context for practice, clinics may represent part of a wider understanding of role and function across the healthcare system, especially where the work leans more towards that which is medically focused. Through this shared understanding amongst different healthcare practitioners, clinics as a practice context for individual work are likely to be afforded some shared legitimacy (Machin and Stevenson 1997). The influence of the perceptions of others on the legitimacy of the health visiting professional role identity will be developed further in later chapters.

Other practice approaches targeted at individuals, focused on assessment, screening and advice work. These sessions were proactive, required no referral, were open to a range of age groups and were described as "drop in" sessions or workshops. This differentiated them from clinics and by implication, from routine health visiting work:

> *The HVs and nursery nurse had a stall in the local supermarket to discus smoking cessation with members of the public. Lots of interest. Information given about the availability of NRT on prescription. Most people thought you had to pay for it. Used carbon monoxide monitor on people. (p2 ob1)*

Whilst these sessions were considered to be public health initiatives they weren't viewed as mainstream practice. Neither were they called "clinics". This supports the view that this sort of work might be considered to be something different, more on the margins of health visiting work (Craig 2002).

Groups

The individual model of practice was the most reported and observed. However, several participants talked about group work that they were involved in or planning to do in the context of their developing public health role. Some groupwork still involved individual work, largely in response to clients' expressed need. However groups were in the main

set up both as a conduit to relationship building between group members and as a "population" group at which health messages could be targeted:

> *Baby club premises funded through Surestart equipment bought from Whole Systems Funding.....open to all... breakfast available..used by B&B population as well as more affluent parents. Presentation of requested health topics, one to one social support & networking facilitated. (P11 Ob1)*

The example above provides some evidence of the changing policy agenda for children (Home Office 1998) having a positive impact on the work of health visitors. Perhaps the model of working described, a group approach in a community setting, is a model of working that both Surestart and traditional health visiting share to some degree. Not specific role overlap but certainly an overlap in approach to practice. This has echoes of the earlier discussion on clinics as a shared practice context. Finding common ground for collaborative, inter-professional working is essential to its success (Meads and Ashcroft 2005).

Implicit in the previous group example is the social support that results from getting people together in situations that promote social interaction. This was explicitly viewed by some, as the rationale for choosing a group approach to practice, the added value being the facilitation of social networks:

> *Then that group hopefully will gel and then they remain and you know, having never known anybody in the street with a baby, they've never known their neighbour because they're at work all day, they actually have met new mums and gel and then meet somewhere, so to me it's a sort of a social get-together, getting a group together to give them some sort of em, networking, which I think is important (P9 386-389).*

Interestingly, it could be argued that the health visiting emphasis on the importance of relationships in enabling individuals to meet their own health needs (Cowley and Frost 2006), is what motivates practitioners to facilitate the development of social networks.

In essence these networks result in peer support relationships and promote social bonding (Putnam 2000). In addition to relationship building, the groups identified in the data focused mainly on supporting families with young children. Again, in keeping with the individual practice emphasis discussed earlier. The next chapter explores whether or not this sort of activity, as a public health activity, was given the same legitimacy across the staff group.

Some participants were keen to do group work because, in their opinion, it was a good use of resources and an effective way to practice. This was especially true for the smoking cessation group where research is quoted as the evidence underpinning the choice of practice approach.

> *The latest research has shown that if you do smoking cessation in groups the chances of succeeding are higher than if you do it on a one to one basis which is why we decided to deliver that service. (P2 45-51)*

> *So I choose to spend more time doing the group work, em, but I do feel as well that is a cost effective way of spending the time because of the benefits of the group work (P8 206-208)*

Having a rationale for their professional role in action, based on some form of external "evidence", links to the later discussion in this chapter, that considers the type of knowledge underpinning practice. It is important to re emphasise, however, that having a knowledge or "evidence" based rationale for their work is an important factor in promoting health visiting as a profession in it own right (MacDonald 1995). It also links to the following chapter which picks up on the issue of practitioner autonomy to define and legitimise aspects of their own work, another attribute of professional practice (Giddens 1989).

Populations

Strategic public health work has been identified as one aspect of public health work in health visiting (DOH 2001a; Carr et al 2003). However, unless an individual is employed in a specific role with a clear job description, it is no easy task to define what might be considered to be strategic public health work. It could be argued that working strategically gives priority to the principle of health visiting "influencing policy affecting health" (CETHV 1977). The influence of the principle on practice will be discussed later in this chapter.

Some examples of strategic work identified in the data involved project planning. The scale of the initiatives varied as to the size, nature and degree to which they were inter-professional. Some work was evidently first stage planning of a new group:

> *I personally have two bids in at the moment for money for public health work that I'm developing at the moment (P8 39-41) (group work)*

> *I applied for a health development fund (P2 103) (for funding for a baby massage group)*

Other strategic work aimed to influence policy through the initiation of a change of some description. To do this, some health visitors were engaged in such work which involved inter-professional working at a cross organisational, strategic level. These health visitors described being members of ongoing strategic groups around safety, housing and domestic violence. Their role within those groups was described as giving health visiting health perspective on cross agency working:

> *Member of local "public health group". This is a multi-disciplinary cross organisation group looking at policies etc across the PCT. This involves health,*

LA, HAZ, PALS, police, carers and transport. Role in that is to provide a HV perspective (P3 Ob1)

I'm involved in the multi-agency child accident prevention...
*group, em, which has been going for quite a number of years, so that's a multi-agency strategy group looking at developing initiative on a regular basis em, in accident prevention in ******(P8 114-118)*

I'm also em, on the Domestic Abuse advisory board, (P6 205)

Other examples were of strategic projects aimed at targeting specific populations for public health/ health promotion activity:

We are going to be targeting [the local school]*... as they have special status for sports and its in their interests t look at health and well being, the school looks like its a coronary waiting to happen so hopefully do some prevention work and also on obesity.....we get dieticians involved, the exercise co-ordinators and the director of sport....(P3 170-177)*

These descriptions of strategic work reiterate the importance of relationships in health visiting practice. However in strategic work, it is relationships with other professionals and community groups that were described as influencing the success of this approach to practice:

Yeah, very, I'm also a member of the foster panel as well, em, but no, it's all about linking and maintaining good relationships with em, trying to maintain good relationships with people from other disciplines (P17 98-101)

We are working with local authorities, support workers, health development workers, I think that is excellent. It is good for our role and it is community based and that is what we are there to serve – the community. (P2 9-11)

One health visitor was in a management role, responsible for leadership of the health visitor group and was able to articulately make links between local practice and national policy:

> *It's thinking about that public health continuum and identifying whereabouts they operate on that and if it is just on a one to one basis and it's that interfacing capacity building with one person or with that locality, with that sort of family rather, or is it on a population base (P14 287-231)*

Arguably the post that this participant held in the organisation could be considered to be the type of strategic post proposed as a model for public health work in nursing and health visiting (Carr et al 2003). Strategic leadership for change was a performance indicator in her job description and therefore a requirement for the role. This strategic work might therefore be considered to have a high level of perceived role legitimacy (Machin and Stevenson 1997). Systems for practice such as policy and human resource management had an influence on professional identity and emerged from analysis as a data category. This will be presented and discussed in chapter nine.

Attempting to influence others' practice through an interprofessional teaching role might also be said to be strategic. This sort of strategic work aims to bring about change in practice through changing the perceptions of others:

> *I do a lot of education for* [HV] *colleagues. I also do training em, across all the disciplines in recognising that it's not just a medical issue* [growth and nutrition], *so I do teaching with the medical students ..(P16 398-340).*

Whilst this example suggests that education work is targeted at both health visitors and medical students, there is no indication that this learning happens concurrently. As discussed, the Government drive for interprofessional learning has the strategic intent of improving collaborative working for better service provision (DOH 2001b). Raising awareness of the contribution of the health visiting role to public health work with specific client groups will help promote collaborative working, an essential

characteristic of the new public health approach (Acheson 1998). Other issues related to collaborative working emerged from data analysis.

Issues of Collaboration

Role overlap

Clinic based individual work, in particular that with clear link to medical need such as smoking cessation, immunisation, nutrition and growth, was a practice area shared to some degree by most of the participants of this study. However, examples have also shown that health visitors differentiate this from other activity using terms such as "workshops" or "drop in sessions". Arguably separating out some work from that which might be considered to be in a shared practice with doctors, nurses and other healthcare professionals, is likely to be a small but important strategy in establishing health visiting as a profession in its own right, distinct from its nursing roots.

In addition to clinics, other aspects of practice also appeared to overlap in some way with colleagues. The district nurse participant described home visiting as a model of practice. However this was largely driven by medical referral as opposed to proactive work with the well population:

> *Work organised through patient allocation. Work involves home visits and clinics. Linked to GP practices. Lots of contact with reps from pharmaceutical companies. Liaison with hospitals over discharge. Work largely driven by referrals from GPs and hospital. (P7 Ob1)*

This supports earlier discussion on the position of the nursing profession in relation to medicine, the latter often being viewed as gatekeepers to the nursing service. One of the defining features of health visiting is its focus on proactive work in a preventative domain (Cowley and Frost 2006). The parameters of the practice of many health visitors' are defined by a GP practice population however the work undertaken is largely undertaken independently from the direction of medical professionals. Some

public health directives do provide a common aim and sense of shared priorities for both groups (DOH 1999c; DfES 2003). This being the case health visitors might be said to be working in parallel with medical colleagues, independently addressing similar issues in different ways.

Despite the emphasis on pro-active work in health visiting it is clear that at least some of the work of participants is referral driven, indicating a degree of overlap with nursing practice domain in their local context:

> *All of the requests for the health assessments come through our office, em, we produce what's called a health action plan for each child and that goes to social services after the health assessment's carried out (P17 64-73)*

> *We* [health visitors] *visit the MIs, we do the ………………, we visit the coronary artery bypass patients, so in fact we have more input into that group of patients that the district nurses do because they don't see them, (P2 85-86)*

Both nurses and health visitors can also refer to the medical professionals they work with, where the management of the medical need of clients is beyond their scope of practice.

It has already been shown that health visiting remains a progression route for nurses and closely tied to the nursing role through proficiencies for practice (NMC 2004b). As discussed, in rejecting a direct entry route to the part three of the register, the NMC have affirmed the perspective that health visiting should be underpinned by nursing. This despite the suggestion, that most of the health visiting profession were in favour of a separate direct preparation route to maintain the distinctiveness of health visiting (Cowley and Frost 2006). Indeed, midwifery, once also a progression route from nursing, now has a direct entry route and a separate part of the register, thus arguably more clearly delivering and maintaining its independent professional status (NMC 2004a).

Articulating with verisimilitude, the distinctiveness of health visiting and its contribution to society is important in establishing and maintaining independent

professional status (MacDonald 1995). In addition, being able to articulate that which differentiates their role from their previous nursing role, is an important step in developing a robust and resistant professional identity (Castells 1997), capable of withstanding external challenges in times of change. This will be discussed further in the next chapter. Whilst much of health visiting might be described as "one to one", an increasingly integrated health service context (DOH 2000a; DfES 2003) and a focus on collaborative public health (Acheson 1998) means that practitioners can no longer work in isolation, even where they are working with individual clients (DOH 2001a).

Working with others within and across agencies and organisations is demonstrated in data examples already presented and in the following:

> *I also visit people who have been placed from out of the area so I'm liaising predominantly with housing, em, community mental health teams, GPs, er, social workers, schools, (P6 87-93)*

> *And the child protection work is multi-agency, but again around the individual or family work. (P8 127-128))*

The work described here is characterised here by liaison and referral, to and from other agencies, thereby characteristically multi professional not interprofessional (Barr et al 2005). Interprofessional working in, for example, integrated children's service, should be less reliant on referral mechanisms and more focused on face to face interaction to promote better communication and joint working. It requires shared assessment, shared decision making, and an ongoing collaborative practice relationship across the professions, jointly working with families (Machin and Graham 2008). This does not appear to be the model of practice described by the health visitors in this study, especially when working with individuals.

Whilst health visitors' individual work (DOH 2001a) has been legitimised, as public health work it needs to be located in the context of available community resources that can be mobilised collaboratively. The only data examples of practice with individuals that could be said to be inter-professional and collaborative, with professionals as well as with clients, are those provided by the health visitor who worked as a health co-

ordinator with Surestart. Her frequent use of the term "we" to refer to any member of her multi-professional team who evidently work together with shared intention, implies a shared team identity that is not often expressed by other participants:

> *So **we** looked at actually some target work (P15 86)*

> ***We** have health events (P15 222)*

There were, within the data, several examples of cross-professional strategic work. However, the extent to which this work was collaborative and interprofessional varied:

> *We're also closely involved in the Surestart, em, programmes, because we're, well we're working into two, possibly three or more here and because models, yes we're working into those two Surestart programmes, (P12 123-127)*

In the above example, using the phrase "working into" Surestart, does not necessarily mean "working with" in an interprofessional way, sharing goals and interventions. The example below describes an activity that was uni-professional, within the health visiting team. However the activity was cross professional to the extent that it was generated from a request from the school nurse, a referral almost:

> *And from a health questionnaire that the school nurses did em, the actual pupils were asking for help in stopping smoking, so we're actually going to try and bring out a pilot now, the far area, to do smoking cessation in the schools, ...trying to adapt our group work we do with the adults to fit the children. P4 427-432)*

The process of this referral has involved an assessment of school population need by the school nurse who has made the decision that the health visitors are better equipped to do smoking cessation work, albeit with older children. The health visitors have responded to the request which might be said to have confirmed the legitimacy of that intervention. As an activity, smoking cessation work appears to have significance in that it is closely allied with medicine through NICE guidelines (NICE 2008), yet very firmly expressed

as a legitimate health visiting role by several participants. The significance of this will be discussed in more detail in subsequent chapters. The characteristics of the individual clients with whom health visitors work, may also be of significance in understanding the health visiting professional role in action.

Characteristics of client group

Age

As indicated in the literature review, recent discussions on the future of the health visiting role have directed the profession to refocus on work with families with young children (Lowe 2007), in addition to those older children with complex needs or disabilities (DOH 2007a). However, this prompted a response from those health visitors who were working with groups such as older people who felt their work was being devalued (Randolph 2007). The recent survey of health visiting activity (Craig and Adams 2007) indicated that health visiting practice and the participants' practice was in the main, child related work. However, reflecting the national picture there were still a minority of participants in this study who also worked with older people. For example, one health visitor visited an elderly person to do an assessment of her coping ability, after referral from a GP:

> *Walking stick was ordered. This visit is to see if other services have been started and to deliver walking stick. (P2 ob1)*

However, when asked about the extent of her elderly work this health visitor did not regard it as priority. The work was driven by the historical practice in the local context :

> *"I only do the elderly because the previous HV did. So one of the GPs refers everything to me. That's all well a good but it's a bit much when I've got lot of new mums and clinics and things to do. Plus I don't really know what I'm doing. I'm having to play it by ear. A lot of what I need to know I've found out by asking social services."(P2 ob 1)*

This participant felt unskilled in the area of work with older people and evidently and only engaged in the work as a result of referrals from the GP. She clearly felt inadequately prepared for a role with older people. Role adequacy has been described as being essential for optimum role clarity and performance (Machin and Stevenson 1997).

Another health visitor talked about the concept of an "active" health visiting caseload the implication being that work was targeted at certain individuals and families and that some received no health visiting input being deemed "inactive". This concept deviates somewhat from the previously discussed notion of universal access (Cowley and Frost 2006). As suggested in chapter three, corporate working is increasingly a model used to organise health visiting services in teams (Craig and Adams 2007). The active caseload here described consisted of work with children and families and made no mention of work with older people:

> *The active caseload consists of all children under the age of one and any children's' special needs, any child protection case, and children in need and the " looked after children", any children or families where there are ongoing health needs and a health visitor input, active health visitor input (P8 2:54-58)*

It is interesting to note that this participant, whilst suggesting she does not actively work with older people, had indicated in an earlier interview that she undertook older person's health assessments:

> *I'm also involved in an initiative which involves district nursing, practice nursing and the GP in following up the elderly in terms of doing health assessments. Em, so, then we share that equally with the practice nurses, see the elderly who are able to walk to the surgery, district nurses would be the ones at home that they are nursing, (P8 389-394)*

During the course of the study this participant had remained a health visitor in the same PCT but had changed jobs. The significance of systems such as job roles and employer expectations to professional role and identity, will be discussed in a later chapter.

Other population characteristics

A small number of the participants worked with client groups on the basis of perceived need not their age. For example the health visitor who worked in a Surestart context described her preventative health work with local school children in an area where many families have a low income and complex problems:

> *Every half term we go into each nursery class and we're doing dental at the moment, so, and we get toothbrush and toothpaste and make it a fun affair but it's the first step, I mean a lot of these kids haven't got a toothbrush, then we do keeping yourself clean, we're going to do some safety, you know the different things but it's a, it's enjoyable but we're trying to get the messages across (P15 213-219)*

This health visitor also described work with young mothers from the area:

> *We do sort of cooking, cooking on a budget, healthy eating, em, (P15 219-220)*

Another participant talked about her work with the Bangladeshi community, her GP practice having a high number of people from that community registered with them:

> *We've recently had a talk with project doing exercise. So 20 said they were interested, we've had 14 over the twelve weeks, the maximum we've had is eight, at one session with a crèche, which I was a bit despondent at the numbers but it's early days and it's something very, very different for their community, very, very different, so we've had women come in who've never done any form of exercise (P10 78-82)*

Work with these groups has a clear link to public health targets and priorities such as: the prevention and reduction of coronary heart disease (DOH 2000b); the promotion of healthy living (DOH 1999b); and a reduction in inequalities (Wanless 2004). However, in the same way that work with older people might be vulnerable in current policy, the work described above is not exclusively with families with pre school children. That said, in taking a community focus to the work it can be argued that work with people of

any age in a community, can have a positive affect from which children will ultimately benefit. However if health visitors, either individually or as a group, are not able to justify and legitimise this link to those controlling their work remit, it may become work they are no longer permitted to engage in.

Other population groups with whom the respondents worked, again not exclusively families with young children, focused on specific health targets. These targets were also aligned with NHS priorities such as obesity, coronary heart disease and smoking cessation, which fit the priorities of the PCT:

> *We'd already started mothers groups.........some of us has already been involved in doing hypertension and exercise and weight management, things like that ......and doing it on groups rather than doing it on a one to one (P3 20-23)*
>
> *We are also now doing a group clinic* [smoking cessation] *(P2 45)*

In the resource pressured context of healthcare practice, it is likely that all health professionals will need to justify their involvement in areas not explicitly aligned to their role. One method of doing this will be through the demonstration of effective outcomes and an argument that work of equal value could not be done by other less costly roles. For example, it might be suggested that participant fifteens' work on dental hygiene could be done by school nurses, who are mostly employed on a lower pay grade than the health visitors in the local context. Similarly, participant ten's work on exercise with women from the Bangladeshi community could be done by someone in the role of health trainer (DOH 2008b). The health trainer role is one of many emerging roles in the health care system that have the potential to overlap with the health visiting role and others in the system such as physiotherapists. The emergence of new roles is likely to present a significant challenge to those in existing roles unless their implementation is handled in such a way as to maintain equilibrium of professional role identity across those in the system impacted on by the change. Subsequent chapters discuss this in more depth.

From the data, two other levels of understanding emerged as important. Both of these have the potential to help practitioners to understand whether their role might overlap

with others and conversely where their role alone can enhance the experience of service users in the healthcare system. The first of these areas is the principles of health visiting (Cowley and Frost 2006).

Principles of Health Visiting

As discussed in earlier chapters, in an attempt to articulate the contribution of the health visiting role as distinct from other specialist nursing roles, the principles of health visiting have been published (CETHV 1977) and reaffirmed (Twinn and Cowley 1992; Cowley and Frost 2006). They have also been embedded as a framework into the preparation for the role of Specialist Community Public Health Nurse (NMC 2004b). As the constant comparative process continued there was evidence of work that could be attributed to and categorised by the four principles of health visiting: assessment health needs; raising awareness of health needs; facilitating health enhancing activity; and influencing policy affecting health. Each will now be discussed.

Assessing Health Needs

The process of assessing health needs was clearly evident in work at all levels. In work with individual families as discussed earlier, assessments focused on the needs of individual family members and the family as a unit:

> *.....then based on my assessment of that, couple, family or individual person would em, depend on what I did next (P6 289-290)*

Assessments took place both in the home and in clinic settings. No explicit model or framework for assessment was used, however the documentation used with individual families was observed to provide some consistency in their approach to practice. The structure of the documentation itself was akin to that used to facilitate the nursing process, in which assessment is the first stage (Gera Yurick 1980). These assessments are described in broad terms. They are holistic assessments used as a means of

proactively determining health needs, providing a baseline for future assessment work and for understanding the family context. One participant described health assessment as being their main work in their role in the "looked after children" team:

> *All of the requests for the health assessments come through our office, em, we produce what's called a health action plan for each child and that goes to social services after the health assessment's carried out (P17 64-73)*

This example was interesting in that the assessments were done at the request of the social worker who needed the health perspective to enable an effective package of care to be put in place for the children in local authority care. Whilst this participant had a health visitor background and registration, the role he was in was framed as a public health nurse role. Participant sixteen was in a similar type of role in a specialist nutrition service and described her assessments in a similar way. The implications of organisational role on identity will be discussed in chapter nine. A formal "job description" and "person specification" are examples of systems for practice that can determine action and subsequently influence identity. They also specify the level of adequacy required for the role and make explicit organisational role legitimacy (Machin and Stevenson 1997). The method of assessment described above was evidently a requirement of the role. The individual, specific, medically orientated nature of these assessments is in contrast with the holistic, proactive, family assessments described earlier.

Other examples of more targeted assessment within the health visiting role include those linked to disease oriented public health, such as blood pressure monitoring:

> *We have health events .....the ones that I've picked up with hypertension have been young, you know, didn't have a clue and the elderly are fine (P15 222-226)*

Other examples include carbon monoxide monitoring as part of smoking cessation (P4) and weight management (P12, P3). Such methods are essentially screening as a form of

assessment. Other forms of screening include those very much linked to the health visiting role such as developmental screening (Hall and Elliman 2002). Of note is the explanation by two participants that child developmental checks can be used as a means of accessing a family for a fuller assessment:

> *Child health surveillance viewed as a legitimate part of practice but has only ever been a small part and a way of accessing families to identify broader health issues such as smoking, mental health, home safety, sudden infant death syndrome. (P9 Ob1)*

This echoes the suggestion by Cowley (1995) that health visiting work is characterised by its unpredictability and that visiting can only be described as routine once the intervention is over. Another key feature of several health visitors' work was ongoing screening for post natal depression using the Edinburgh Post-Natal Depression Score (EPDS) (Holden, Sagovsky and Cox 1989):

> *Afterwards we discussed EPDS. A protocol had been devised in the PCT by a multi-disciplinary group and based on best evidence. All women are screened by the health visitors at 6wk, 12wks and 8 months. There is an expectation that at least one of these contacts is person to person at home. The HVs are getting training in PND support. (P2 Ob1)*

Maternal mental health screening was also described by a participant working in another locality:

> *Yeah, ...we follow agreed standards that have been developed for support and make contact primarily at three months, six month .....it's the only one that there's formal protocol set, maternal mental health (P12 492-495)*

In both examples screening and assessment for post natal depression is an embedded aspect of practice. This raises an interesting point in relation to independent practice as a key feature of a profession. Clearly the opportunity for autonomous decision making is potentially reduced by the existence of a protocol, although this can be exercised to some extent when involved in its production. This issue, along with the earlier mention of assessment documentation, introduces a line of enquiry as to the influence of embedded organisational systems on the practice and professional role identity. This will be explored further in chapter nine.

Assessment was not an activity restricted to an individual approach to practice. Practice examples already presented indicate that assessment of health need was an implicit activity in a group setting, for example assessment of progress and behaviour change in stopping smoking (P2, P4), in understanding of issues addressed like cooking (P15), weight loss (P3) and rehabilitation support following a heart attack (P2). It was also an activity observed in the baby club setting (P4, P11). That said, in discussing the group approach to practice it was evident that assessment in that setting was often less about group needs, and more about a group "setting" for individual practice.

When taking a strategic approach to practice, health needs assessment was focused on population groups and communities:

> *We're becoming more involved in really assessing the health needs of communities. Em, analysing those needs and deciding what initiatives em, and actions can be taken to actually improve the health needs of the community (P8 14-19)*

At a strategic level, the assessment function of the health visitors appeared more likely to be done collaboratively:

> *Member of a local "public health group". This is a multi-disciplinary cross organisation group looking at policies etc across the PCT.....also represents this*

groups at the health development network. Role is provide an HV perspective (P3 Ob 1)

Assessing health needs is a principle of health visiting and essential to their function, as indicated in the data. However, assessment is a core skill used by all health professions and is not therefore a unique, defining feature of the health visiting professional role in action.

Raising Awareness of Health Needs

The health visiting principle "raising awareness of health need" is also evidenced in the data. This work is clearly visible in the broad range of health promotion type work done by the health visitors. The principle itself does not give guidance as to the specific focus of this work, thus leaving its application in practice to the interpretation of individual health visitors. Individual opportunities to raise clients' awareness, was particularly evident in work that focused on public health priority areas (Wanless 2004) through promoting a healthier individual lifestyle. Examples of this work already presented in this chapter include smoking cessation (P2, P4), nutrition and obesity (P3, P16). Other examples of awareness raising work included resuscitation (P9), breast feeding (P8) and dental hygiene (P15):

HV uses opportunity to discuss health issues/ potential health issues. Gave advice re weaning with a view to sustaining breast feeding.... (P8 Ob1)

We do keeping yourself clean, we're going to do some safety, you know the different things but it's a, it's enjoyable but we're trying to get the messages across (P15 218-219)

We talk about key things like weaning, resuscitation, scary, but that's the public health thing (P9 389-390)

The mechanism by which information was given varied. Verbal, direct advice and information from the health visitor was used which relied on the health visitor as a resource. There was also evidence of the use of information leaflets (P3, P6, P11). Raising awareness of health needs utilised the personal knowledge resources of the health visitor. However it was often also about giving information about other community services that could help service users help meet their identified need.

At a strategic level and with other inter-professional work, health visitors raised awareness of other professionals by acting as advocates for a specific client group or the broader populations with whom they work. For example participant three's membership of the local health development network described her role as being to:

> *"provide a health visiting perspective" (P3 Ob 1)*

However, what exactly constitutes "a health visiting perspective" is unclear. Participant seventeen described his role in the looked after children team as being about bringing health needs of children to the attention of other services, in other words raising their awareness of the health needs of clients. On some occasions in an advocacy role there was a clear focus and client group in mind, such as the client group of participant six who were in bed and breakfast accommodation. This health visitor sought to advocate for better living conditions and services for her client group, to help others understand the potential risk to their mental health:

> *I'm a believer in supporting women for their own mental health, which will in turn help them perhaps parent their child..... so I'm liaising predominantly with housing, em, community mental health teams, GPs, er, social workers, schools, (P6 2:87-93)*

As in the case of assessment of health needs, there was evidence of raising awareness in most participants' practice. The form that this took, whether in direct contact with

clients or in interaction with other professionals, would depend upon the particular role of the participant and their chosen approach to practice.

Facilitating Health Enhancing Activities

Another health visiting principle, "facilitating health enhancing activities", is also evident throughout the data in the practice of all participants. Few activities in which a health visitor engages, involve the client as a passive recipient of care. Indeed "partnership" is described as one of the features of the role that supports the application of principles in practice (Cowley and Frost 2006). In the previous chapter, the discussion of empowerment indicated that in both nursing and health visiting, empowering and enabling patients and clients were important professional values (Chalmers 1992; Ohlen and Segeston 1995; Kendall 1993). In addition the use of theoretical frameworks such as self efficacy theory, for empowering clients in health promotion practice (Sturt 1998), required a facilitation role rather than a "teaching" role. In working in partnership with clients, the public health role of health visitors involves ongoing interaction and negotiation of health need priorities and mobilisation of available community resources to help families address their own needs (DOH 2001a). From the data in this study, this facilitative role was evident, as was its link to the two principles already discussed.

Facilitating health enhancing activities with individual clients was closely linked to the process of information giving discussed earlier. The practice seen and reported was often about giving people information about resources available and how to access them (P2, P3, P4, P9). However, in a group setting it was about facilitating access to social networks that the client might otherwise not have had:

> *We do good work here and people come, just sort of like parent groups, you know, post-natal support groups, I suppose really, em, and then gives you the group situation. Actually for me I think the most important thing about it is to get a group of people together and if you're lucky and it usually works (P9 386-390)*

Group offered opportunity for breastfeeding mum's to meet and give each other support, swap ideas & experiences. The group largely now runs itself with support from the HV (P8 Ob1)

Whilst this sort of activity might be seen to be more about social care than healthcare, one of its expressed aims was to enhance the mental health of group members through tackling social isolation:

"Well the Mum's mental health was at risk. If the right sort of early support isn't there then this will impact on wider society" (P4 Ob1)

In taking a strategic approach to practice, participants provide evidence of making changes to services that are designed to be health enhancing for clients:

There are a couple of community groups, we are working together to develop things.....they were pleased to see me as I has been some of the women's health visitor....I helped get them some safety equipment for the premises they were developing, this enhanced our relationship....we've got a lovely group that can influence public health work (P3 310-317)

Through the more collaborative work undertaken, such as the local child safety group (P8) or housing initiatives (P3, P6), improvements are being made to the broader structural influences on public health and well being. A problem for health visiting identified in the literature review, is demonstrating that the work they are involved in does indeed make a difference to the health of the population (Campbell et al 1995). The very broad principles underpinning health visiting practice present a further challenge in articulating the unique, professional contribution health visitors can make to the health of individuals, families and communities. Conversely, too much structure in the form of protocols for managing caseload work might be construed as a mean of

limiting professional claims to unique competence. The influence of protocols on practice will be discussed further in chapter nine.

Influencing Policies Affecting Health

The final health visiting principle, "influencing policy affecting health", appeared to be explicitly evident only when working strategically. Membership of collaborative groups as described earlier, clearly had a link to local policy development, whether that be for example, local child safety guidelines (P8), housing policy (P3, P6) or policies for meeting the needs of looked after children (P17). Other examples of strategic work include the compilation of an obesity strategy for the local area:

> *Yes we do have an obesity strategy written* [by the participant]*........I feel quite passionate about the work I'm doing on childhood obesity, (P16 357-367)*

In another area, one participant was influencing policy development and chairing the local community action group, which aimed at influence both health and social policies in the locality:

> *Chair of Locality Advisory group – multi-disciplinary group aiming to develop needs led community services. Part of the aim to have devolved resources and equity in targeting needs (P5 Ob 1).*

Others were also on groups that are about policy development:

> *I'm on the homeless strategy group (P6 2:165)*

Interpreting the word "policy" loosely, facilitating sustainable change and improvement in service provision could be seen to fit with this health visiting principle. Changes to the policies in the healthcare structural system for the benefit of service users, will inevitably require a change in the working practice of those within them:

.... I have developed the service. I initiated the change from it being a purely medical model where all of the assessments were done by doctors, (P17 156-160

So I have set it up [new baby massage group].... it is really working, and I get referrals from lots of health visitors for that. (P2 113-116)

Arguably, some of the health campaign type activity that was inter-professional in nature, also sought to influence both individual behaviour and policy, such as the high school initiative to target young smokers identified earlier (P4).

Some health visitors were in organisational roles that were strategic. The influence of defined role on perception, practice and professional role identity will be discussed in more detail in subsequent chapters. However, there was clear evidence that for the participants in those roles, influencing policy affecting health was a key area of work. For example, one participant discussed the reorganisation of the health visitor service in the area:

If I go back to the co-ordinated facilitation and the development of nursing strategy and that ran from 2003- 2006, one of the core things for us was around addressing public health and providing accountable care ......to the local population (P14 152-153)

Whilst this is not policy directly linked to service users, reorganising the workforce to enhance its effectiveness, should in theory benefit service users. However not all change is an improvement.

Another participant in a leadership role was involved at a committee level influencing policies affecting health, not just in a general sense, but in support of local population with whom she worked.

*I know on the PEC [professional executive committee of the PCT] you're not meant to be representing a locality but I do feed back from the locality and I'm conscious that when anything's being discussed and they're looking at basing another service in ***** town, that I'm constantly saying "think about the ** locality" (P5 194-198)*

Another participant took on the role as advocate for her client group, clearly working to influence policy at the highest local level in order to improve services:

I was very concerned about the level of families in bed and breakfast ....And I found this em, as a practitioner very stressful because I would be raising issues and I would just be keep being told they were desperate and there was no where else to put them......... But I didn't feel that was something that I could actually just ignore, so with the support of em, another colleague that I worked closely with, we started to raise the issues more and more and I ended up going to the top of the, to the top of the nursing hierarchy and then to the top of the local council, (P6 2:174-184)

Some participants did not explicitly demonstrate that they were involved in work that was aimed at influencing policy affecting health. Those who undertook work which was strategic demonstrated clear evidence of working within this particular health visiting principle.

The public health continuum of practice (DOH 2001a), strategic work is at the opposite end of the continuum to work with individuals. The earlier discussion has shown that the majority of the health visiting work observed and reported on in this study, was work with individuals. It is perhaps unsurprising then that the first three principles discussed are more commonly evident in the data. In undertaking a more public health approach with individuals, it could be argued that individual work such as helping clients challenge housing decisions (P8) or obtain nursery places (P5) could be described as influencing policy "implementation", whilst strategic work focuses more

on its "development". This fits with the historical perspective on the health visiting role previously discussed, in which health visitors were employed to implement policies focused on improving family hygiene and the care of infants (Dingwall et al 1988). Whilst policy implementation and development that benefit the community, are both legitimate aspects of health visiting practice, there is a distinction between the two in terms of the level of professional autonomy needed for the role. Influencing policy development implies a greater level of health visiting autonomy and professional power, than that associated with implementing a policy developed by others.

Personal reflection on analysis

The development of this data category around the principles of health visiting has been influenced by my experience of and theoretical sensitivity to, the utility of their application in practice. The open coding phase of constant comparative analysis generated a broad range of conceptual labels to categorise and practice, such as "assessment", "health promotion", "information giving", "support" "facilitation" and "advocacy". From the first data collection from a health visitor, I was aware of the link from the data to the principles of health visiting. As discussed earlier, I had also noted that a health visiting perspective was missing from participant one who was a practice nurse. However, I had resisted attaching those labels to the data in an effort to "step back" (Glaser and Strauss 1967) and disassociate my own views from the emerging theory. It became apparent that the range of practice examples generated from data collection was so diverse, they needed to be categorised in a more meaningful way. A memo extract from my research diary captures my dilemma:

Reflection on research 13:

"Is needs assessment a core function and as such a basic process within the category? What about awareness raising? Evidence of both in all of the data collected. How do I make it explicit in a more theoretical way? .....need to revisit other data to explore.....REFLEXIVITY ISSUE HERE...the principles of health visiting are in my mind. I've deliberately not imposed that structure on the analysis but maybe I've

restricted an important emerging issue....after all in my experience they are core to health visiting practice" (Research diary 13/3/06)

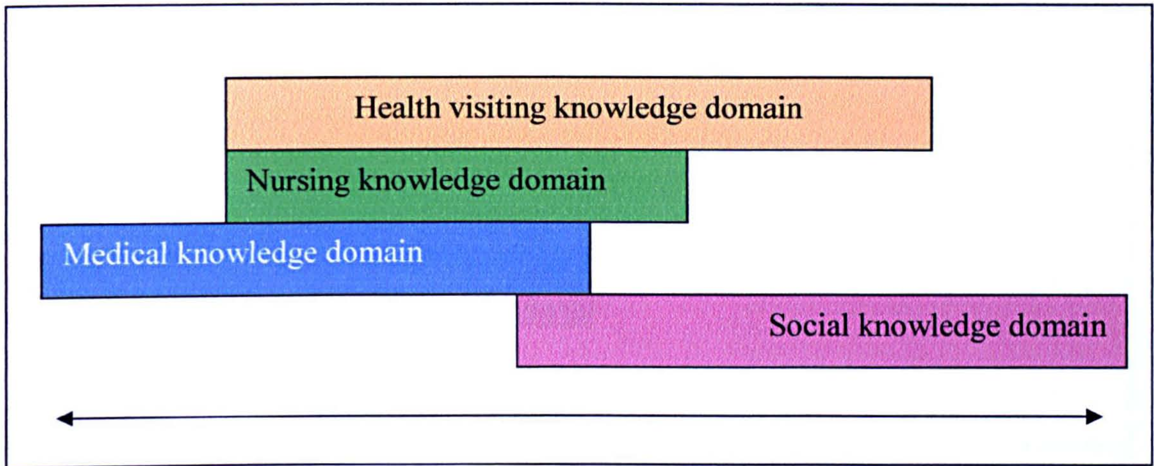
With this in mind I revisited the data to see if any of the health visitor participants' practice did **not** fit with the principles of health visiting. Having done this I was satisfied that the practice identified could largely be categorised using this framework. This supports the view of those providing national guidance for the profession (Cowley and Frost 2006).

Data from this study has indicated that the principles are a dominant structure for framing health visiting practice, from within the profession at least. They support the culture of health visiting. The recent health visiting role review (Lowe 2007) has been criticised for not incorporating these principles into its analysis (Cowley 2007). In failing to do so, the review team have potentially missed an opportunity to publicly raise the profile of the importance of the principles of health visiting in underpinning the collective professional role and identity of health visitors. As discussed by Foley (2005), closer alignment of professional and public identity can help avoid ambiguity in a collaborative working situation with clients and other professionals.

Knowledge Underpinning Health Visiting Practice

In addition to the principles of health visiting, the second area where it is important to understand the similarity and difference between health visiting and other roles is the nature of knowledge used to underpin their practice. Given the diversity of practice as presented, it is perhaps unsurprising that the knowledge used to underpin the continuum of health visitors' practice (DOH 2001a; Carr 2005) appears to come from a range of sources including medical, nursing and social. Health visiting overlaps in three domains of practice knowledge on a notional continuum, its use dependent on the context of its application in practice. Some attempt has been made to depict this complexity in figure six below:

Figure 6: The Position of Health visiting in a Suggested Knowledge Continuum

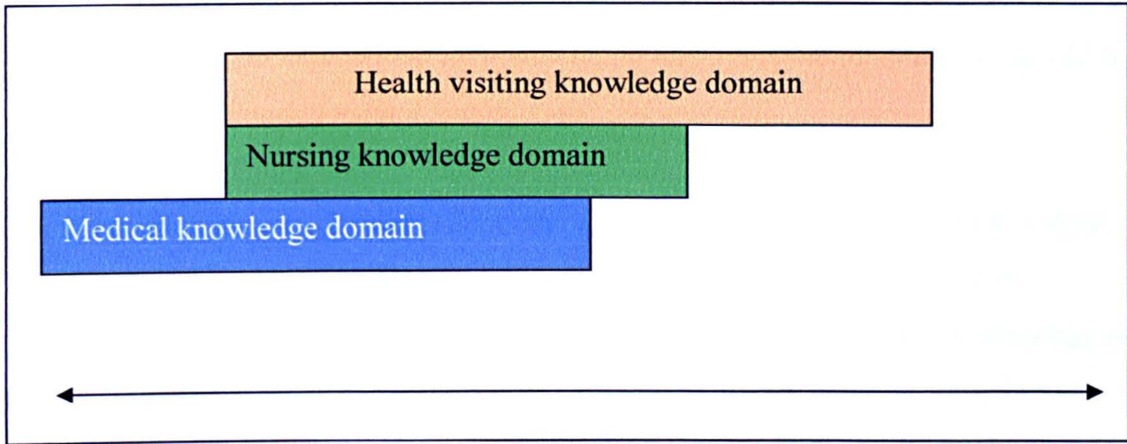


For health visiting, its overlapping, broad knowledge base adds complexity in the quest to understand its status as an independent profession, with its own identity. Cowley and Frost (2006) have suggested that the notion of an exclusive professional knowledge base is outdated. Indeed, discussion in the literature review noted the influence of global information systems on the ownership of knowledge and the effect of increased general public to information previously controlled by professions (Castells 1997). This information revolution might be said to have shifted the balance of power away from professionals somewhat and prompted the acknowledgement of service users in the development, delivery and evaluation of the services they receive (DOH 2004b). If health visitors are to maintain equilibrium of their unique position in the healthcare system, the work they do must be seen by others, professionals and service users, to be underpinned by credible knowledge.

Nursing/ medical knowledge domain

In this domain, health visiting knowledge has a clear overlap with that of nursing and medicine which reflects the historical development of the professions in their shared practice context (figure 7).

Figure 7: Health Visiting and Nursing Overlap in the Medical/Nursing Knowledge Domain



In their consideration of psychiatric nursing roles, Machin and Stevenson (1997) distinguish between a "theory of" the profession and a "theory for" the profession. The latter could be said to relate to knowledge taken from, or shared with, other disciplines and applied to practice. The former could refer to new knowledge resulting from its application in the new role context. Over time, different professional disciplines can build up an extensive body of knowledge that becomes both a theory "for" and "of" the profession. Compared to medicine, the emergence of nursing knowledge as a theory "of" and "for" the profession (Machin and Stevenson 1997) is a relatively recent phenomenon (Dingwall et al 1988). Given that health visitors are qualified nurses, any knowledge they bring to the practice situation will be a mix of nursing knowledge, medical knowledge and that gained during health visiting education and practice. However there will be some areas of knowledge the health visitor has, which medical colleagues and nurses would not have immediate access to, or indeed need to use, as theory for their practice.

In addition to formal knowledge development, individuals bring to any social interaction, all of their past experience and the meanings attached to it (Blumer 1969). This supports the view of Pritchard (2005) who suggested health visitors drew on their personal knowledge as women to enhance their practice. A focus on women's work is reflected in the following data extract:

....but as a practitioner I've often focussed on women, because it was, I worked with quite a large em, a caseload with a high number of single women, and I'm a believer in supporting women for their own mental health, which will in turn help them perhaps parent their child..... a large proportion of my job would be about addressing mental health issues (P6 2:58-64)

The way this work is expressed reflects the values and priorities of this health visitor. The literature has highlighted the importance of personal values as a source of professional knowledge in nursing (Ohlen and Segeston 1998) and change (Sullivan et al 2002). However, as discussed previously the argument that health visiting is undertaken by women for women, does not follow for those health visitors who are male. They may or may not have a different set of personal values to bring to the practice situation. This will be discussed further in the next chapter.

Separating out health visiting knowledge from nursing knowledge is problematic given the historical professional development of the participants. Participants in this study varied in the degree to which their nursing experience appeared to influence their identity and role. Again, the next chapter picks up this discussion. However, in this chapter's attempt to analyse the complexity of participants' professional role in action in its context, it is worth considering those practice examples that illustrate knowledge overlap with others in the application of different roles.

National public health priorities

On any health/social care intervention continuum, public health priorities (Wanless 2004) such as obesity, smoking cessation, hypertension are likely to be located more towards the medical/ epidemiological approach to public health than social and as such also acknowledged as legitimate areas of nursing practice (NMC 2004c):

........some of us has already been involved in doing hypertension and exercise and weight management , things like that (P3 20-23)

We are also now doing a group clinic (smoking cessation) (P2 45)

The knowledge needed to inform these interventions is informed by subject disciplines such as anatomy and physiology, biology, psychology and pharmacology. These knowledge areas are also evident in programmes leading to qualification as a nurse (QAA 2001a; NMC 2004c), doctor (GMC 2008) and other professionals that may be said to be allied to medicine such as pharmacy and physiotherapy (RPS 2008; QAA 2001b). The public health work being undertaken by some health visitors evidently draws on this knowledge, giving them some commonality with medical colleagues, nursing and other associated professions. In essence this knowledge affords health visiting the shared understanding needed for collaborative working in a health care domain of practice. The significance of this to collaborative public health working will be discussed in chapter eight.

In addition to the work highlighted above, there are other examples of work that could be said to portray knowledge that participants are likely to have developed in their health visiting role context, subsequent to their nursing role. However this work and its underpinning knowledge, is still located toward the medical end of the knowledge continuum, in the overlap (figure 7) between nursing, health visiting and medical. Examples include child development surveillance and screening:

> *Babies weighed.....developmental screening, family needs assessment, health promotion, dietary advice.....Discussion re medical advice for minor complaint and whether client should see GP or not. (P12 Ob1)*

> *That involves a six week check from the GP, em, a seven to nine month development check from health visitors, a one year review from the health visitor, a two year development check from the health visitor and a four year development check from the health visitor as well as three EPDS contacts. (P8 177-183)*

Child health and development screening is an aspect of health visiting practice evident in the work of most participants and has been legitimised as part of the health visiting role (Hall and Elliman 2002; Lowe 2007; DOH 2007a). However knowledge to

undertake this specific aspect of work is not exclusive to health visiting and forms part of the education of other professionals such as children's nurses (NMC 2004c) and doctors (GMC 2008). Child development knowledge also underpins the education of nursery nurses. As suggested earlier, nursery nurses are increasingly used to support health visiting work. Aspects of work such as advice on feeding, sleep and behaviour are cited in this study as undertaken by the nursery nurse:

> *I was trained a lot more in child development and screening which I don't do so much now. I have reduced my hours...... We have a nursery nurse who does sleep visits, behaviour visits. So I'm using her more for things like that (P2 197-210)*

As previously mentioned, Young-Murphy (2006) onsidered the emerging dynamic between the two roles concluding that for successful teamworking to occur, the complexities of the cultural and social context needed to be openly understood and managed. However acknowledging and valuing the knowledge overlap may provide the common ground for collaborative working.

In addition to family support work, health visiting work also included elements of measurement, prescribing, diagnosis and treatment of minor ailments. All of these are examples of activities that could be said to be allied to medical work:

> *Lots of questions asked as part of ongoing assessment and evaluation. Checked lady knew how to use bath seat and care call telephone. Reiterated information about recently prescribed medication for constipation. Advice re diet. Asked about social support. (P2 ob1)*

> *you know there's a lot of crisis work here, there's a lot of depression .....there's a lot of the prevention work around depression (P4 839-841)*

> *Primary birth visit – policy routine visit. First baby. Mother and father present. Issues discussed: Role of HV, breast feeding support and practical issues, coping strategies for managing sleepless nights and crying, baby weighed, colic. Ongoing support offered. Contraception. Contact with HV encouraged. Clinic*

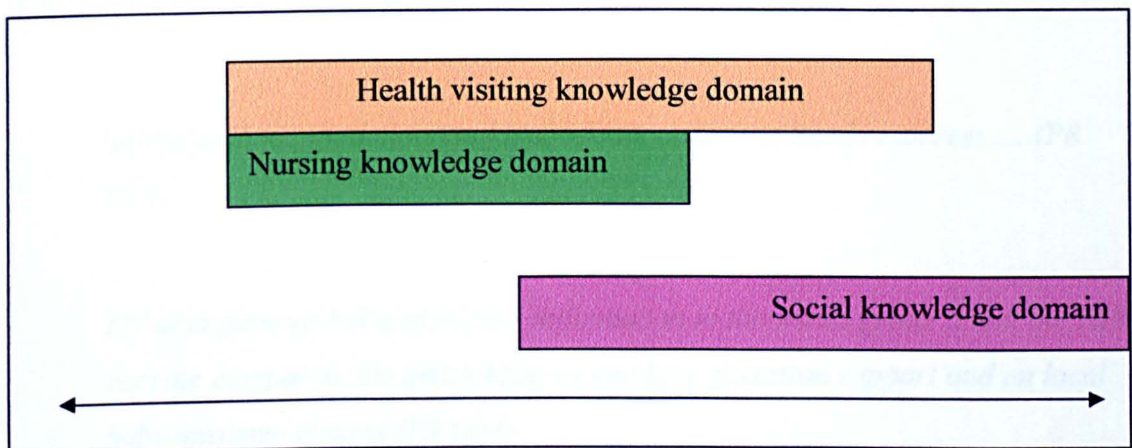
attendance discussed. Imms. Child health record. Post natal depression. (P3 ob1)

In the latter example there is a clear knowledge overlap with that of the midwife in the early post natal phase and the statutory requirement for a birth visit. The midwifery role has also recently widened its sphere of influence in relation to public health, especially in relation to women's health (NMC 2004d). Once again there is the potential for questions to be asked as to why two different professionals are involved in an area of practice, seemingly duplicating effort and resource. This reinforces the need for both professions to be able to understand and articulate their unique application of their shared knowledge.

Health/ Social Knowledge Domain

Health visiting practice in the social care domain other roles also overlaps with others such as social workers. The nursing knowledge of the health visitor is perhaps the factor that distinguishes them. This overlap is illustrated thus:

Figure 8: Health Visiting and Nursing Overlap in the Social Knowledge Domain



One participant identifies a perceived role overlap between the health visitor and the social worker in child protection work:

Although not recognised as the lead agency you tend to do all the lead work with child protection, we usually, we go over and identify you know, if there's a problem where the social worker will ring up, do you know the family? We spend time chasing round trying to find out what's going on, you know we have a background knowledge of this in health visiting (P16 330-337)

In this example, the health visitor is perceived to have unique knowledge of the families with whom they work. This is perhaps a reflection of the relationship building role of the health visitors, suggested by the literature as an important aspect of the role (De La Cuesta 1994; Chalmers 1992; Prichard 2005). Through this interactive and interpretative process in the local context, "family knowledge" becomes health visiting knowledge, on which others draw to inform their work. However, in the healthcare context, such personal knowledge is not perhaps valued a highly as medical knowledge, empirically derived from a systematic research process. Whilst the social situation of service users is relevant to the medical care of patients, the medical issues prompting engagement with medical services are likely to take priority, at least initially.

Health visitors often have local knowledge and facilitating access to local resources is some thing they engage in widely. Knowledge of available community resources and how to access them underpins the health visiting public health role with individuals (Home Office 1998; DOH 2001a):

Safety equipment advice given and info re accessing local resources..... (P8 Ob1)

HV also gave verbal and leaflet information to the whole group about the HIB vaccine campaign, the availability of smoking cessation support and on local baby massage classes (P4 Ob1)

However, this local knowledge will not be exclusive to health visiting. Many other roles such as social workers, community development workers and voluntary sector community based organisations, facilitate access to community resources through, for

example, information giving. Similarly community members themselves will have an insider perspective on community resources that differs from any professional perspective. However, health visiting might be said to be underpinned by a more in depth understanding of the link between health and social determinants (NMC 2004b).

This link is reflected in a range of practice examples: linking a cooking group with the healthy eating agenda (P15); developing a post-natal baby club for social support; and at the same time tackling the maternal mental health agenda (P4, P11). In addition through their membership on more socially linked groups, health visitors are able to contribute a primary health care, public health perspective to cross agency working to help other professionals and workers to see the social- health link:

> *We are working with local authorities, support workers, health development workers, I think that is excellent. It is good for our role and it is community based and that is what we are there to serve – the community. (P2 9-14)*

There is clearly an overlap between the health visiting role and other roles in the social care domain. However, perhaps the distinction between these other social roles and health visiting is the link to the health domain. Not only do health visitors potentially have knowledge of the community context and the family context, they can also contribute a health perspective, even to the extent of knowledge in the medical domain.

Theoretical Summary & Conclusion

The discussion in this chapter has considered the data category of "professional role in action". It has established that whilst the study participants carry out their role differently from one another there are some commonalities. For example they all work with individuals, and some do work with groups and populations, which has helped contextualise the department of health continuum for public health work in health visiting (DOH 2001a). There is also evidence of individual relationship building and partnership, which the literature review has indicated is a key feature of health visiting practice (Chalmers 1992; De la Cuesta 1994). The description of practice has identified

a range of practice contexts for health visiting such as: the home of individual clients; clinics; drop in sessions; and multi agency collaborative working settings. The data has also indicated that most of the practice of participants can be attributed to at least one of the principles of health visiting, suggested by the literature to be the underpinning framework for health visiting (Cowley and Frost 2006). Finally, the chapter has shown health visiting work draws on a range of different sources of knowledge in theory "for" the profession, across the continuum identified in figure six. Health visiting theory "of" the profession is therefore likely to be characterised by an integration of medical, social and nursing knowledge as well as the personal knowledge individuals bring to their practice.

This chapter's presentation of the participants' "professional role in action" begins to build a picture of what is potentially the distinguishable contribution of health visiting to their healthcare practice context. Their breadth of role and knowledge and the notable overlap with other professionals could be viewed as a weakness, stretching the role of the health visitor to the point they where they cannot claim expertise in any domain. Indeed, this risk was the main driver for the review of the health visiting role and the subsequent directive for health visitors to take the step to refocus on work with families with young children (Lowe 2007). However, this thesis proposes that in seeking to determine the professional identity of health visitors and their unique contribution to a changing healthcare system, the knowledge overlap as depicted in figure six should be viewed as a strength not a weakness. It is proposed that in some situations, health visitors have the ability to use their breadth of knowledge across the medical - social spectrum, contemporaneously in a family context, without referral for assessment or intervention from others. This is perhaps a defining feature of the health visiting professional role in action. The next chapter takes up the discussion of the implication of the latter for professional role identity of the study participants.

Chapter 7 - Professional Role Identity

"Half of the wrong conclusions at which mankind arrive are reached ... by mistaking general resemblance or imaginary similarity for real identity"
(Henry Palmerston – 1839 – English Politician)

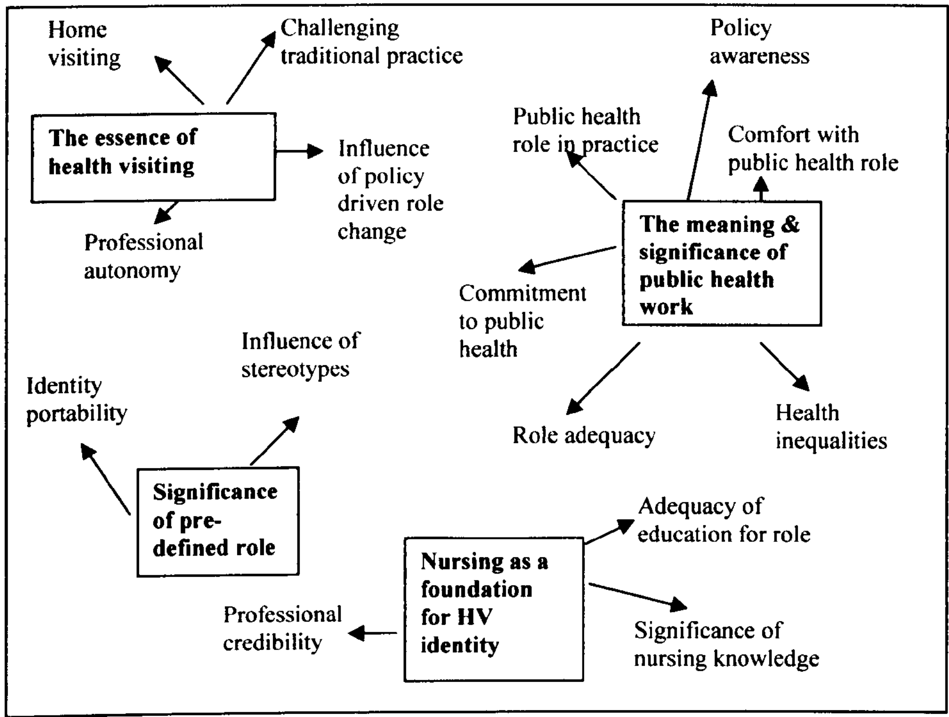
Introduction

This chapter will present and discuss the inter-related properties of the core data category labelled "professional role identity". Understanding the meanings participants attached to the practice experience considered in the previous chapter, is the first step in understanding their identity. My interpretation and discussion of relevant literature in chapter three and the articulation of an Integrated Interactionist Theoretical Framework for the study, has determined the perspective in this thesis, that practitioners' individual identities are formulated through a process of self-referent feedback on action. In addition, interaction with others in the practice environment, also influences the action and identity formation of individuals. The practice environment of health visitors in general is characterised by an increasing need for collaborative working and a positive engagement with change. The current culture of uncertainty in the NHS (Williams and Sibbald 1999) appears to be reflected in the data in this study.

The previous chapter has explored the diversity of the practice of the study participants. It puts forward the notion that it is possible to identify some basic characteristic of a health visiting role that differentiates it as a separate profession to nursing. Having a clear sense of identity and purpose is necessary to work effectively in a collaborative setting characterised by change. This chapter explores these issues further, by examining the value and significance placed on aspects of practice described in the previous chapter. It explores this in relation to professional identity in an attempt to ascertain from the study participants what it means to them to be a health visitors in their own practice context. A pictorial overview of the category is presented (figure 9). As in the previous chapter, this might be considered another part of a situational map of the participants experience (Clarke 2005). In soft systems methodology this might also

be termed a "rich picture" (Kogetsidis and McRoy 2008) relating to participants' identity:

Figure 9: Professional Role Identity – data category properties



The Essence of Health Visiting

Despite the emergence of a picture of inconsistencies in practice, especially in relation to public health work, it was possible to identify certain characteristics that appeared to be regarded as core to health visiting, contributing to some degree to a sense of collective identity.

Home visiting for relationship building

Home visiting work with individual clients has been established as the most common context for health visiting work (Craig and Adams 2007) and the recent role review (Lowe 2007; DOH 2007a). The home of clients was viewed by all participants as an essential location for work such as relationship building and assessment. One

participant described using home visiting to get a "truer" picture of the reality of life for clients and families:

I just don't think you see the true picture of people out of the home, perhaps that's a narrow way of working, I don't know, I just think that you can get more out of visiting people individually, I think you see the whole picture more. (P9 74-77)

Other participants described home visiting as a more effective context for health promotion work than some others, especially where there has been poor attendance when attempting a group approach to practice:

It was quite poor attendance at this healthy lifestyle group at the school, but people do listen to you when you're in the home (P4 460-466)

Our aims [health visitors] *are to raise the standards of health in the population and if it's done on an individual level because of whatever reasons that you're never going to get them out of the house or you know, you can't have four or five different interpreters at the group when you would outnumber the group, it's practicalities like that that you have to take into consideration (P12 216-218)*

Linking to the work of Sturt (1996) discussed earlier (P.65), and the use of self efficacy theory (Bandura 1976) for health promotion, the home context for health promotion may be effective because clients feel more empowered in their own home. Health visitors' expectations that this is the case might in turn lead to more positive outcomes. This links to the work of Chalmers (1992) and the notion that the health visitors in her study engaged in work based on their perception of their potential reward for doing so.

This introduces the notion of home visiting being the preferred location for health visitors' work and that individuals have a choice about where they practice. One participant suggested that rather than doing public health group work she placed a higher value on home visiting:

I'd rather be out visiting. Again, I suppose I felt that's what my priority was. (P6 367)

This links with the discussion in the literature on professional autonomy (Keenan 1999). The importance of autonomy to the identity of the participants is considered later in this chapter. One participant described a feeling that home visiting was being challenged by the emerging public heath drive for a more collaborative approach to practice with populations (Home Office 1998; DOH 2001a). This challenge was perceived as coming from professionals outside of the health visiting group:

Because that is one of the strengths of home visiting, which actually in the em, public health whole systems, actually the home visiting part of health visiting was rubbished which I think, well rubbished is a bit strong, but it came across as that, that it wasn't valued em, by a number of staff, that weren't the health visitors, but I think for health visitors that was, you know that was really difficult just sitting and listening to that. A number of health visitors challenged it ..... (P4 420-428)

What is evident from the above example is a sense of collective professional identity around the notion of home visiting as a core characteristic of health visiting. Presenting a collective perspective to others when their role is challenged echoes the experience of the American midwives (Foley 2005), where managing the impressions given to an "audience" (Goffman 1959) tended to bring the otherwise fragmented professional group together.

Health visiting work with groups and communities has been acknowledged as core practice for some time (CETHV 1977). However, historically, home visiting to work with individuals and families has been the prevailing model of practice (Baggot 2000). A systematic review of domiciliary health visiting (Elkan et al 2000) confirmed that there are potentially positive health outcomes from home visiting especially where the focus is on health promotion and bridging individuals with the community resources. As discussed, Putnam (2000) promotes the concept of bridging, as a concept having the potential to build community networks and enable otherwise disparate individuals to

bond in their social context. Engaging in bridging work with individuals is supported by the policy guidance for the public health role of health visitors (DOH 2001a).

Universalism

The "universal" nature of health visiting was something that was discussed in relation to home visiting and articulated as important:

> *I constantly would quote about health visiting I thought was important which presumably links into public health, this universal visiting, non-stigmatised and all that stuff, (P9 468)*

As discussed previously, study data and current professional discourse (Cowley and Frost 2006) suggest the notion of universalism needs further clarification. There is a need to establish its importance to the collective identity of health visitors. In addition, there is a need to examine the professional impact of new concepts such as "progressive universalism" (DOH 2007a) which appears to introduce an element of targeting resources. Introducing a new term to describe practice without considered exploration of its implications for the health visiting identity, may lead to confusion within the staff group. Shared language has been established as an important component of collective identity (Strauss 1959, 1997; Putnam 2000) and a starting point for management of collaborative, participative change (McDonald 2004). If the concept is not understood at the level of practice, there is potential for individuals to perceive that a core value of universalism is being threatened.

From the data it was evident that health visitors were experiencing some discomfort around the notion of targeting resources, especially in more affluent areas. One health visitor felt that her work was not valued by her health visiting colleagues and that it had created an almost "us and them" situation across the locality:

> *when I went on the public health course, six day course thing, and I was quite sort of depressed I think after a couple of days because I thought well what we're doing is not valued because I think that people* [other health visitors] *think that round here people don't need health visitors. (P9 130-134)*

This perceived division is echoed by another participant who works in the same organisation but in a more disadvantaged area:

> *I mean we've had people* [health visitors] *saying, I'm not staying in this area and working my bloody socks off and going over to softer ...., and they do, they have mass exodus (P12 192-194)*

This is an indication that some health visitors are assuming practice in the affluent area to be easier creating the identity issue as described above by participant nine. This situation is evidently divisive to the local collective identity of health visiting. Greater collective clarity on core values and role characteristics, along with greater recognition of the need for their contextualised application in practice whatever the setting, is perhaps key to maintaining role identity equilibrium in a changing professional practice context.

Introducing a process of targeting resources is a health visiting service change that needs effective facilitation to avoid a negative impact on the professional role identity of individual health visitors. Without effective facilitation of change at an individual level, and a collective adoption of new terms and processes as part of the language and practice of health visiting, there is the potential for policy generated concepts such as progressive universalism, to cause disaffection in the group to which it applies.

Professional autonomy

For some participants being autonomous was conveyed as an important aspect of their professional role and identity, both to their role and their personal satisfaction in that role:

> *It is very much an autonomous job in a way. You do what you can – it is needs led, so if there is something to do in your area you try and set up a group to tackle it, so it is very much how you feel towards a particular area and where your interests lie. (P2 286-289)*

Freedom of choice was viewed as an important characteristic of the health visiting profession. This links to the work of Ohlen and Segeston (1998) in suggesting self esteem and self image as important to personal identity as a foundation for professional identity. As suggested earlier, there was a perception that this much valued right to choose had been challenged by others to some degree:

> *We* [health visitors] *are practitioners in our own right and we have got to be accountable for what we do and I think we should be allowed to do things and develop. It makes it more interesting for you and allows you to do a better job (P3 39-42)*

There was also some evidence that health visitors resisted change where they perceived their autonomy was impeded by policy directives or other agendas:

> *Reports come out like Hall 4 but some health visitors are ignoring it and doing what they've always done anyway (P5 Ob1)*

One participant was clear about the difference between the levels of role autonomy between health visiting and nursing implying the latter to be less autonomous:

> *The experience of a health visitor is very different* [to nursing] *because you set out on your own, you don't have a hierarchy of medicine hanging over your head in public health (P16 203-207)*

Evidently there are some participants who perceive autonomy to choose the way in which they carry out their professional role, to be a core attribute of their health visiting role identity. The discussion of the literature has shown autonomy to be an important attribute of any occupation defined as a "profession" (Giddens 1989; MacDonald 1995).

However, justification for choices made often comes in the form of it being best for the clients, echoing the "other orientated" value of empowering others (Fagermoen 1997) rather than a self orientated value of autonomy:

they are the advocates of the patients and patients should come first and therefore you know, they're you know, providing high quality care and that isn't going to change and everything else is just peripheral. (P14 254-267)

Challenging traditional practice

Public health work as marginal

The importance of relationships to health visiting work has arisen in the discussion of both the literature and the data considered so far. In discussing a move to a different way of practicing with potentially reduced opportunity for relationship building, one health visitor said:

And I find, I'm just finding it really frustrating, the personal satisfaction from the job is the relationship with clients and the change that you effect through negotiation of need over a long period of time (P8 2:291-293)

The change of approach alluded to here is the introduction of a corporate caseload in which health visitors were expected to pool resources, share clients and work collaboratively with a public health focus. Corporate working is viewed here as compromising the opportunity to build necessary relationships which are the foundation for long term work. This was also a view reflected by another participant:

Well how do I identify health needs if I never see these clients, and at some point you've got to develop a relationship with those clients if they're going to access their health needs and do a robust family assessment (P14 248-250)

Health visitors have em, been quite restricted by caseload work and some of that does include public health work (P8 14-15),

What is interesting is the apparent impression from the participants that individually focussed caseload working, is restrictive of development of other ways of working. One participant uses the phrase "bogged down" by caseloads, an indication perhaps that the

professional autonomy discussed earlier (Keenan 1999), does not necessarily extend to individual autonomy to change the systems within which practice change occurs:

> *We are not changing things. I think that is why you need people who are not bogged down with the case-load. Teams of specialists maybe. (P4 118-119)*

There is also an indication that public health work is seen as something that is additional to caseload work, done where time permits outside of "normal" health visiting. One participant described an experience in which she was being made to feel guilty about doing some public health work perceived as out of ordinary:

> *I think there's a certain number of people think it's like an easy part of the job* [collaborative public health work] *and say I wish I could do it because it's easy and you can do it this way and we can't because our caseloads are heavier than yours....*
>
> *I have a particularly small caseload at the minute because they've changed in the practice and I was even considering changing jobs because of peoples' attitudes towards it, so I could do my public health work in a busier practice without feeling, well I don't feel guilty but I feel that some people just think we've got an easier life (P4 2:479-487)*

This perception that public health is something done if you have time, is reflected in earlier discussions (Craig 2002). It is also an example of the effect of feedback from others can have on the identity and behaviour of the individual practitioner (Burke 1980; Collier 2001). It further supports Collier's perspective, that though individuals might share similar roles and a consensus of role characteristics, as individuals they may not agree about the relative value of each component part. This is perhaps especially relevant in times of role change where the change process should facilitate a collective, cohesive service change, not one in which different individual role standards emerge.

In the above example it is the health visiting "role in use" for public health work in the local context that is contested. Whether or not the "others" in this case, actually feel

negatively about it is not the issue. What matters is the perception that they do. This interpretation of others' opinion, developed through social interaction with them, resulted in this health visitor feeling devalued within her peer group. This situation further develops an understanding that whilst professional autonomy might be something a profession might aspire to maintain, individuals may still feel disempowered within their professional group. This might be especially so where their personal values are perceived as differentiating them from the cultural norms of the professional group in the local context. She goes on to say:

> *There's a lot of em, it's made a lot of, oh what do I say, a bit of, a lot of friction between different colleagues em, with the ones that are doing public health work and the ones that say they haven't time to....... In my opinion I do really good work out there (public health work), but to others I'm lazy... (P4 2:538-542)*

It is suggested that where there is a mismatch between the meaning of an individual's identity and the meanings conferred by feedback on performance from others, as in this case, individuals may experience dissonance and a degree of dissatisfaction with the situation (Riley and Burke 1995). There is also the difficulty in demonstrating the efficacy of public health preventative work. As discussed earlier there is a need to address this at the level of service planning and securing resources (Campbell et al 1995). However there is perhaps also a need to do so at the level of practice in negotiating role legitimacy through convincing health visiting colleagues of the value of new aspects of practice. The participant goes on to say:

> *People* [other health visitors] *don't actually say what they really believe, you get it in bits that people say, don't tell anybody this, or blah, blah, blah,)....nothing's said when they know they're talking to someone who's got a small caseload....It's like it just gets you, it's a type of an insult (P4 2:597-624)*

Certainly this participant does seem to be experiencing the discomfort that Riley and Burke (1995) describe.

Public health work as mainstream

In contrast to the perception of public health work as marginal, some participants suggested that mainstream individual caseload work was the vehicle through which to carry out the public health role:

> *I don't know that you necessarily go out thinking am I going to discuss public health but it's the kind of thing that can just crop up and you just pick up on it. (P6 34-37)*

This supports the view that public health work could be enhanced through the health visitors capitalising on existing relationships (DOH 2001a). Another participant expressed a view that the local implementation of public health policy had resulted in health visitors working differently. In particular the changes had had most effect on the local implementation of the child development surveillance programme (Hall and Elliman 2002) through reduced routine contact:

> *Because I am not just dealing with under 5s, that fact that we are doing a lot of work with the elderly, so it is like the health visitor was 40 years ago. She was a public health nurse, cradle to grave, clients of all age groups. I do think it has developed. (P2 310-316)*

However another participant felt that the public health agenda focused too much on work with children and young families at the expense of others:

> *Because of the way we are doing it now I think we are focusing too much on children. (P4 110)*

The discussion in the previous chapter on the significance of the age of the client group endorsed the view that in the main, health visitors were working with young families (Lowe 2007).

One participant gave an insightful account of her individual and strategic work, indicating that despite the ongoing dilemma, the former remains her priority:

It's very difficult because sometimes you're literally struggling as to who you're client group, whether you visit them or do you go to that meeting that by going to that meeting you might be able to make some impact and actually make a difference for the client that is going to be coming into the system (P6 2:212-217).

This was a second interview with this participant who had changed job roles from being GP attached to work with a specific population group. At the first interview she said quite clearly she would prioritise home visiting, introducing an additional consideration of the impact of professional practice experience over time, on professional identity (Collier 2001).

The participants in this study have strong feelings about their work and are keen to defend what they believe to be the essence of health visiting. Significantly however, not all participants agree as to the relative importance of the different aspects of their professional role in action. In seeking to maintain equilibrium in their sense of self in role, other people are often used as a reference point for feedback on their identity and its value. Other health visitors have evidently provided a referent point for participants with both a negative and positive effect, depending on the outcome of the interaction.

The examples discussed, are perhaps indicative of the confusion across the health visiting group. Given the difference of opinion on both local and national changes, there is potentially a threat to the collective identity of the group. However, it may be that if the health visitors were enabled to discuss their collective core values, they would find that it was their "role in use" (Collier 2001) under debate. This will always be context specific and open to interpretation.

Experiencing the change process

Clearly there is a difference in whether or not the proposed role changes are perceived as valuable as core health visiting practice or whether they do indeed represent a change at all:

There are some health visitors who have been working in individual work for a lot longer, em, and whereas I've got very quickly involved in group work because I wanted to from the time that I qualified, I don't really feel like I've had a massive change in practice, but for some it will feel like that, and does feel like that em, and they are still much more reluctant to change,(P8 324-328)

This disagreement within the study sample echoes the lack of consensus across the professional group at a national level (Abbot et al 2004; Brocklehurst 2004; Carr et al 2003; Goodman-Brown and Appleton 2004; Pearson et al 1999; Smith 2004). This difference of opinion on the value of role development towards collaborative public health work has the potential to be divisive to the collective identity health visiting profession. Collier (2001) suggests that where different groups use the same role in different ways it is likely that this will result in the norms of the role, or the role "standard", will be reconfigured differently. For the participants in this study there are some characteristics of practice that most agree constitute the essence of health visiting. However, this analysis of participants' practice has indicated that there is no apparent single role standard in relation to public health work. There is also a lack of consensus on the relative value of different aspects of health visiting work.

An individual's attitude to change in general may also have an impact on their experience during it and subsequently on their identity (McDonald 2004; Higgs and Rowland 2005). Some participants in this study were feeling somewhat disempowered by the changes, especially in the local context of the whole systems pilot initiative (DOH 2001a) which, as discussed previously sought to develop the public health role of health visitors:

Everybody's feeling the same and everybody's being pulled in different directions (P8 225)

Others seemed more accepting of the inevitability of change:

There is change all the time, in every job, you just get used to something and there's a change. Health visiting will change even more. It won't stay as it is now, it will become even more broader. (P2 274-276)

Some participants were not clear whether the changes were particularly attributable to policy or whether the changes everyone was experiencing were simply part of normal practice development:

> *I'm not sure if it is the change in working which has made us look at it because it was actually started by a health visitor who was working in that area (P4 75-76)*

> *Health visitors are "up to here!" at the moment, they're sick of being told they should be doing when public health when they always have been. (P9 16-17).*

Thus there has been a varied response to policy development that is changing the professional practice context of the participants. The degree to which it is perceived that the policy changes have affected practice and practitioners is varied. Some participants are accepting of the change where others appear to be threatened by it. The exclamation that practitioners are "up to here!!" captures the mood of some participants well. There is evidently a climate of policy driven role change in which there is the potential for individuals to be unsure about their role and identity as health visitors.

This section has considered what emerged from the data as the essence of health visiting, the core elements of the role on which there is the most agreement. These include home visiting, building and sustaining relationships as the basis of individual working, autonomy to develop practice as the individual wishes and a caseload model of preventative healthcare practice. It has also considered things that may present a threat to this central professional role identity. What emerges is a picture of a lack of consensus across the professional group in the local context on whether or not public health work is to be accepted as the essence of health visiting. The threat to the stability of the professional role identity of health visitors from a lack of shared vision and purpose is evident. Symbolic interactionist theory suggests that for collective action to take place individuals within groups must attach shared meanings and engage in repeated social interactions with each other to reinforce those meanings. These then become collective norms (Blumer 1969). The next section explores the participants'

understanding of the concept of public health work and further discussion of their commitment to public health work in general.

The Meaning and Significance of New Public Health Work

Early observation of the health visitors' work in mainstream caseload focused roles indicated that there was no huge variation in the work they undertook. However, the sampling questionnaire described in chapter four, had asked the participants how much of their practice was public health and answers ranged from none at all to one hundred percent, indicating differences in the way in which certain aspects of practice were categorised.

Importance of Addressing Inequalities

In the data there was variation in the degree to which the priorities of addressing health inequalities (DOH 1997a; Acheson 1998) were acknowledged by participants. One participant suggested it to be fundamental to the work:

> *I mean the essence of PH work is about looking at not just the health of individuals but collectively at health. And looking at how you address on a wider scale the determinants of health. That includes addressing health inequalities (P5 5-8)*

For others, addressing health inequalities was a more implicit aspect of the work they were engaged in. The public health notion they described had a more target driven feel to it, framed around the Government key health priority areas (DOH 1999b):

> *I think it depends on the area where you're working and what are the major concerns for that area regarding mortality rates and em, we have certain targets from NICE and Central Government and we have local targets (P15 10-13)*

> *There are public health targets that everybody working in health visiting works to meet, like immunisation etc., and the screening here and testing. (P17 36-40)*

For the participants sharing this understanding of public health, there was an implicit alignment to a medical model of public health. One participant had a more explicit recognition of that perspective:

> *It's still very much medical whether you approve of that or not .....medicine is cultural issue where there's, you know, we'll tell you what's wrong and fix it for you. (P16 23-43)*

In policy, the priorities for public health work within an NHS context are defined by their epidemiology and the efficacy of preventative measures in reducing morbidity and mortality (DOH 1999c; DOH 2000b; Wanless 2004). Heart disease, cancer and sexual health, amongst others, are underpinned by medical knowledge as discussed in chapter six. In addition, such is the strength of medical discourse in the systems some individuals engaging in unhealthy social behaviours, have also been attributed labels with medical connotations, such as "alcoholic" and "drug addict".

The difference of priority given to addressing health inequalities is an important distinction when considering whether or not public health work is integral to all health visiting as a philosophy, or separate as a role task. Policy (DOH 2001a; Lowe 2007; DOH 2007a) implies public heath to be more to health visiting than a range of job tasks. As has been suggested a lack of role clarity can affect optimum role performance (Machin and Stevenson 1997).

Public health role in practice

The participant below clearly links her understanding of public health to the specific activities she was involved in:

> *We'd already started mothers groups.........some of us has already been involved in doing hypertension and exercise and weight management , things like that which is a bit more public health and doing it on groups rather than doing it on a one to one (P3 20-23)*

Another health visitor conveyed a sense that her perception of public health had changed over time and had perhaps been influenced by policy:

> *A while ago I would have considered it in a group or out in the community but I suppose……now I would suggest that it can be public health can be done on a one to one situation (P6 14-16)*

Another made specific reference to the public health resource pack (DOH 2001a), suggesting that there should be more of an appreciation of the individual work that contributed to public health:

> *The resource pack said we would be targeting the one to one work and the group work. I think they* [whole systems pilot initiative team] *are very lacking on the one to one work. (P4 44-46)*

Several other respondents had, however, picked up on the collaborative nature of new public health working:

> *I mean you can't do it in isolation, you'd have to have the support of the, you know, the public health people ..... to agree that that is an area that has to be addressed, in case you need to mobilise resources over and above what you have access to yourself (P17 25-31)*

> *Because I think it doesn't matter how much effort we do in deprived areas to try and get rid of the inequalities in health, I don't think we can do it on our own, and I think it's a much bigger picture (P9 11-21)*

A final dimension to understanding the public health role was evident in relation to the concept of service user and community involvement.

> *It's got to be a bottom up approach as opposed to a top down. And you can only get that with public consultation and it's something that the health service is*

desperately poor at, and I know there's a move now to em, to try and engage the public (P16 27-31)

Addressing the real needs of health of people rather than somebody else's opinion about the health needs of individual groups are (P17 12-13).

As discussed, there is a current policy emphasis on empowering the public to work collaboratively with the public sector to inform public services (DOH 2005a). In health visiting, empowering individuals to use their own health resources is not a new concept. Historically, the early women workers described in the introduction as having a public health role were women of standing from within the communities being targeted. They were recruited to "teach" their peers better hygiene and childcare (Dingwall et al 1988). This community development perception of the public health concept is somewhat removed from a model that is "professionally" driven where the resources for health improvement are seen as external to the individual people in need of them. However Smith (1994) suggests historical depictions of early health visitors may be over romanticised as altruistic, playing down their "professional" role in surveillance and control of infectious disease epidemics.

With diverse perspectives on the nature of public health, confusion in its translation into health visiting practice is unsurprising. This sustained diversity of meaning can only serve to weaken the collective identity of health visitors as a professional group. A weak collective identity, open to challenge and re interpretation in the course of interaction in practice, is a potential source of disagreement and disequilibrium across the staff group. Any collaborative working situation such as public health work (Acheson 1998), requires individuals to have a strong identity in order to articulate what they bring to the collaborative working situation. This will be explored further in chapter eight in a discussion of the impact of inter-professional working on the identity and experience of the participants.

Commitment to Public Health Work

Linked to the participants' understanding of public health work within health visiting is their general commitment to that type of work. Clearly the degree to which they perceive the public health work as a change to their practice affects their view. One health visitor was particularly enthusiastic about the role changes that had been initiated by the local Whole Systems Pilot:

> *Personally I think it is good, I'm really enjoying it, it has changed our role tremendously. I like the fact that we are working in collaboration with lots of other disciplines – not just the health visitor who goes and does their own work, head to the ground, doesn't liaise. I think it is much better that we are working with local authorities, support workers, health development workers, I think that is excellent. It is good for our role and it is community based and that is what we are there to serve – the community. (P2 9-14)*

However she did acknowledge later in the interview that some health visitors were not changing their practice in the way she had, but continuing in their usual individual model of practice with families of children under five and child health surveillance. This work, as discussed earlier, was thought to be part of the essence of health visiting and therefore perhaps being threatened by any proposed change:

> *There are some health visitors who aren't as keen on the whole systems approach as I am and are continuing to do checks because they think it is really important. (P2 283-284)*

Some participants express a commitment to public health work but only in relation to an area of practice in which they have a personal interest:

> *I think there is only so many things you can get involved in, so I've got an interest in smoking cessation anyway (P4 445)*

This participant identified with a more medical, target driven public health agenda hence the "fit" between smoking cessation and her personal values. This had evidently enhanced her commitment to this type of public health work. Another felt the local availability of resources had impacted on her ability to demonstrate commitment to the work, which she viewed as work not core to health visiting practice:

> *If you had appropriate resources you could spend more time doing that* [public health], *it's more worthwhile, rather than just your reactive crisis stuff or your bog standard health visiting (P12 52-55)*

Another participant talked about the lack of resources in terms of time and its impact on her practice, clearly expressing a view that where resources are tight "routine" work should takes priority:

> *I feel as if I'm not even doing my routine health visiting work, never mind moving on, I am doing some of it because it's in my, you know, weekly plans, so I am doing, taking my turn in the support group and I do my massage group, em, but in terms of preventative health of families it's very much going back seat, (P8 2:166-170)*

Earlier discussion has focused on what constitutes the professional role in action of health visitors, making the point that it is difficult to predict what is "routine" in health visiting (Cowley 1995). However, perhaps what might be considered routine or "stable" is the location of practice in clinics or in the home. As systems for practice, collectively understood by health visitors, each of these settings has a degree of stability, even in negotiating their changing professional practice context. The influence of these and other systems will be discussed in chapter nine.

Another participant expresses a similar view that she hasn't time for public health work and is concerned that those who do undertake such work will be valued more highly:

> *Health visitors doing lovely baby massage might end up being paid more than us doing crisis management and too busy to do anything else. (P12 Ob1).*

This comment was made in the light of a move, through the agenda for change workforce policy (DOH 2004b), to reward practitioners who engage in innovative, practice development work. Again, a lack of clarity could be potentially divisive for the collective group of health visitors in the local context:

> *I think those staff tend to be the more motivated, the more engaged, the more people who you know, people who would actively em, look to see what they're, the sort of guiding strategies are. If they're waiting for em, for other staff that isn't what they're about, they say, regardless of what policy says it's business as usual, head down and for them, nothing's changed for years (P14 254-263)*

There is emerging perception the changing professional practice context of the participants has evoked different responses, including variation in the level of commitment to such work. Level of commitment appears to be affected by previous experience of the health visitors and the degree to which public health work is viewed as "extra" work. Feedback from practice evidently influences an individual's perception.

Those health visitors who perceived public health to be marginal work, appeared to externalise the influences on their engagement in it citing resources, time and other caseload pressure as reasons for their lack of engagement. Another factor relating to the level of engagement in this work is the level to which participants felt adequately prepared for their role.

Adequacy for Public Health Role

As suggested previously, the drive for skills development was being promoted in the local area through the Whole Systems Pilot (DOH 2001c). However, there appeared to be an assumption that health visitors did not already have the skills for the work. In the local setting practice development "away days" for health visitors and school health advisors were held, in addition to optional public health skills training in a university

setting. One participant had a positive experience and felt in had enhanced her role, a view she assumed was the same as most of her colleagues:

> *We have had four training days now on the public health agenda and it has explained why we are doing it and what we are doing it for, we have been prepared for it and I would say that the majority of health visitors feel as I do, that it has really improved our role. (P2 19-23)*

Clearly the "away days" described, are viewed by her as an enhancement activity. However, this was different to the perspective of some others to who felt their autonomy was being challenged by the change process:

> *I can remember the away day, the first one that we had, there were two for all health visitors, and you had to go to one of them, and felt totally wound up by the time I came out... why, because I felt that we were being encouraged to go a certain direction. I felt there was a lot of the, an underlying message, although we were told that there wasn't any, that there wasn't an underlying message, but it still felt like that (P6 132-141)*

As a collaborative venture, public health work is likely to involve a wide range of others from health social care and education, in improving the health experiences of local communities. The absence of other professionals in the whole systems training approach is significant, given the impetus for interprofessional learning as the best vehicle for promoting collaborative working (DOH 2001b; Barr et al 2005). The change facilitation process is important to how health visitors are perceived within their local practice context and will be discussed more fully in subsequent chapters.

In addition to the away days, there was also a university based programme of study developed for those who were interested in understanding public health in more depth. Some participants were aware of the university programme but expressed a view that they were unable to fit this additional education into their busy work schedules:

> *If I had the time to go on study days...... I was asked to go but couldn't because I had too much child protection court commitments at that time.... there's some*

training on public health for health visitors at the University, so if I'd had the opportunity to go on that, I might be able to come up with a better answer, but really I don't know enough about it, my, the public health work I do is just very much geared in my day to day work with my clients (P6 98-103).

This fits with this participant's perception of public health development or enhancement, being an area of practice you got involved in if you had time. She does express the view that public health is part of what she does, though data relating to her practice portrays a role that is very much at the individual end of the public health continuum. Another participant who viewed public health as integral to the role felt the skills training was a way of refreshing her existing skills:

I'm not quite sure that the contents of the public health skills course em, but I think will, hopefully, I suppose it will be good in terms of a refresher, (P8 176-178)

Another participant also felt she already had the skills but did acknowledge that the training has changed the way in which she worked, her approach to practice around public health work:

I've at last, recently done my public health skills course...... parts of it were very interesting em, so we've changed the way in which we work, I mean that's been really positive I think, so I think that's enabled me in terms of time, not to have those sort of restrictions ... I think I had the though skills, I think it's just the change in my thinking (P10 269)

This example indicates that education programmes may have a role not only in increasing knowledge for practice but also in providing feedback on the legitimacy of a new area of practice. The "change in thinking" as described is more about altered perception and than new skills. Thus the education experience may have helped her to change whilst maintaining her identity equilibrium.

Adequacy of Professional Education for Public Health Role

Participants were asked to recall their basic health visiting preparation programme and its efficacy in equipping them with skills for public health work, regarded by some as core skills for the role. It might be expected that University preparation for professional status (Jackson 1970; MacDonald 1995) was regarded as a significant process through which to developing their role identity. However, the data in this study did not indicate that this was the case. Given the emerging picture of inconsistency across the group in terms of professional role and identity, the participants also varied in the degree to which they thought the theory and practice components of their professional education had equipped them for public health work.

When asked about the public health content of pre registration health visiting education one participant was quite scathing of the programme generally:

> *I don't think it equipped us for anything actually, personally, I came off that course a year later without a clue what health visiting was I'm afraid to say (P9 464-466).*

Other participants were also negative about the programme, suggesting that any skills for public health they had learned, were developed through their "role in action" once qualified:

> *I wasn't exposed to any group work as a student health visitor em, all of the group work skills and the em, public health training and things I've had has been since qualifying. (P8 144-146)*

> *I would say that when I trained, 13 years ago, we didn't receive that training. They were skills I've developed on the job (P5 114-115)*

These participants trained as health visitors over five years prior to the commencement of the study. In following up through theoretical sampling, the relevance of more recent health visitor education, another participant talked about the relevance of her practice based training:

So as far as the public health side things, from the university point of view, I take the message to some extent, em, but where I was placed, I was placed with a health visitor who did an awful lot, but she was moving on to an aspect I didn't like, smoking cessation, so for some of the aspects I didn't really gain very much on that, (P13 138-142)

This example links to earlier discussion of the influence of personal interest on role and autonomy in defining an individual's self legitimacy in role. Even as a student this participant was making a judgement on the practice areas on which she might focus once qualified.

Though participants acknowledged the relevance of theoretical knowledge to their work, it was its application in a health visiting context was given greater importance. It is unclear whether this was about priority given to skills for practice or "role in use" (Collier 2001) or whether primacy was being given to professional socialisation (Burke 1980) and bonding within their new group (Putnam 2000). This fits with the work of Melia (1987) which acknowledged the cultural gap between what was considered to be theoretical learning and the "real" learning that took place in a nurse education context. As in education for all nursing roles, fifty percent of time in health visitor education takes place in a practice setting. This is facilitated by a suitably qualified practitioner from the same part of the professional register. It was important to explore the influence of this.

One participant suggested that whilst more recent health visitor education had a greater reliance on the practice teacher than before:

I think as practice teachers you're expected to teach a lot of the other bread and butter stuff that we would've got on the course as students a long time ago, child development for example, em, but in some ways there is more straightforward to teaching. I think it's good that students are being trained more in a public health approach because that approach can be built upon and adapted and utilised in practice and developed. (P8 227-233)

The term "bread and butter health visiting" is one that reoccurs in the data, endorsing a view of work such as home visiting, child development screening, support for young families, as the core of health visiting. The next chapter discusses in more depth, the relevance of this where nursery nurses were undertaking some of this "core" work. However this presents a conundrum for those planning practice based learning. If student health visitors are to be taught by a health visitor community practice teacher (CPT) who has delegated such work to the nursery nurse in their team, what exactly will the student health visitor be exposed to experientially in their practice based learning? For one participant it is public health skills:

> *Students that are coming out now I'm seeing that through their clinical placements they are developing the skills in training.... (P5 115-116)*

However, this study clearly shows a lack of consensus amongst the health visitors as to the nature and value of public health work and its relevance to their professional role identity. Therefore standardising practice based education for the public health role is likely to be problematic.

The previously mentioned study by Pearson et al (2000) also reflected this issue. That study showed that CPTs were afforded a high level of credibility by their students. This being the case a negative attitude towards collaborative public health work would be likely to compromise the student's opportunity to gain experience in this area. More recent programmes (NMC 2004b) for entry to part three of the register, make public health more explicit. However, the data in this study shows that new practitioners may have limited opportunity to use their skills for public health where their colleagues do not share the same perspective and willingness to collaborate. One participant talked about how she was going to prepare a newly qualified staff member:

> *..and the thing is she will not have done any consolidation of health visiting, so you know, one could argue will that be a disadvantage .....she needs a good month out with other health visitors then come here and we've worked out another kind of month induction where she'll shadow myself, she needs to see the job in action. (P6 2:399-407)*

This shows clearly the place of role modelling in consolidating understanding of the health visitor role. As discussed in the literature review, Burke (1980) suggests that identity is developed through dialogue, partly with others and partly internalised. The development of their professional role identity is therefore likely to be influenced in a significant way by more experienced peers from with the professional group. The emerging lack of consistency in health visiting role and identity may be perpetuated through role modelling. Without a consistent role standard, students' may experience a differentiated acquisition of professional role identity (Burke 1980).

Degree of Policy Awareness

In considering whether they felt adequately prepared for the public health role, participants were asked about their awareness and understanding of the policy drivers for the change. What emerged was a difference in level of awareness between general health policy and policy that was perceived as having a direct influence at a local level. Few participants were well versed with specific policies. One participant had undertaken the previously discussed additional public health skills training at the university which had improved her understanding to some extent:

> *I possibly knew about them* [public health policies] *but not as well as I obviously do now because we've just done it last year, I'd forgotten about it all, but do you know what I mean? (P9 453-457)*

Another participant suggests her manager takes some responsibility in cascading policies to ground level staff, though this is conveyed as something to be read when time permits:

> *I mean I've got sort of liberating the talents and all those things on my desk and I'll have a flick through them, our manager, obviously now, is pretty good at sort of sending on information, so I wouldn't say I'm totally au fait with it all (P12 160-162)*

Others in roles perhaps more connected to policy directives such as Surestart, talked about policies as generating targets as drivers for their collaborative practice:

> *I think it depends on the area where you're working and what are the major concerns for that area regarding mortality rates and em, we have certain targets from NICE and Central Government and we have local targets (P15 10-13)*

However not everyone saw a target driven approach as a positive one:

> *People are looking very much target based on the medical model, and I can feel that creeping in to the health visitor role, (P16 238-245)*

This example suggests that this participants' view of her practice is not one underpinned by a medical knowledge domain. She indicates that from her perspective, a focus on disease orientated public health policies, such as coronary heart disease and cancer detection, treatment and prevention, is not one that fits with her perception of health visiting.

Policies linked more directly to practice seemed more of interest to the participants. The national guidance for a child development surveillance programme, known as "Hall Four" (Hall and Elliman 2002; Campbell 2004), was something that most participants were aware of. This was largely because it had invoked a change to the local child surveillance protocol. However the publication of this updated edition caused some confusion for participants that was evidenced through the course of this study.

The previous edition, Hall Three (Hall 1996), had recommended a reduction in universal visiting and more targeting of children at risk (Hall 1996). A reduction in universal screening would, in theory, free up the health visitors for collaborative public health work. In the early part of the study this reduction in developmental screening was of concern and impacted on the commitment to public health work:

> *I am a bit uneasy about them* [the changes]. *I think that it is a backwards step. If the checks aren't needed then they aren't needed but I think that we are not as involved with families as we used to be……. I don't think we should do screening*

for the sake of it but we should have some contact and may be call it something different. If you are visiting in the home you can assess the development anyway and some of the more serious developmental problems that you come across, like autism (P4 28-53)

Hall four (Hall and Elliman 2002) acknowledged a need for balance between universal screening and targeting services. It suggested that reducing screening significantly may present a greater risk to public health than anticipated. Over the course of this study, local PCT interpretation of Hall 4 resulted in a reintroduction of the regular checks, largely undertaken by the health visitors or delegated to others such as nursery nurses. However some health visitors had developed new work areas following Hall 3 and were feeling the pressure of their reintroduction:

And we just don't know how we're going to do it, we've actually em, mobilised the nursery nurse em, to em, to do group sessions where we've given individual appointments in group sessions and we each take turns just to quote her with facts to cover ourselves (P8 177-182)

The child development screening programme is better described as a protocol, in that it sets the parameters of practice in the local setting, within which every practitioner is expected to work. Other examples of policy encapsulated in protocols will be discussed in chapter nine.

Degree of comfort with public health work

The degree of comfort practitioners had in undertaking public health work also demonstrated the extent to which they possessed role adequacy (Machin and Stevenson 1997). For example, earlier discussion of approach to practice demonstrated that whilst some health visitors did do group work, work was, in the main done with individuals. Group work was also commonly associated with public health work however one health visitor was clearly unhappy working in a group situation, feeling she did not have the skills:

I just think I'm not, I think that's just my personality, em, and I think others are very good at it, so I think we've all got different skills and I think we should all, as a locality, look at who's doing these things and share the skills (P4 705-719)

For another it was less about skill than confidence, which they linked to experience:

I think that effective public health work you have to have quite good, very good interpersonal skills and a certain level of experience and a confidence in your role ....I think you need that life experience (P12 402-405)

This confidence was also conveyed as important in convincing others of its value:

I think I'm more confident in what I'm doing and I feel what I'm doing is the right way to work. I'm enthusiastic about it [public health work] *and that makes you want to share it with people because you believe in it (P3 17).*

Developing professional role identity and professional role confidence through experiential learning fits with the work of Collier (2001). However Collier also suggests that the way a role is executed is the basis for group consensus on identity. With the variation in a public health practice approach for health visitors it is difficult to see how a collective identity for public health practice will emerge without consideration of a change facilitation strategy to address the emerging diversity of practice.

Significance of Organisational Role

As already mentioned, participant six had changed roles over the course of the study from a mainstream, individually focused role to a more specialist role involving more strategic public health work. The significance of this change was considered by the participant:

I'm the specialist health visitor for homeless and transient families......
this job differs from em, my previous health visiting job because I visit anybody irrespective of whether they have children, so I visit couples, em, single people,

people who have school age children, as well as people who might have pre-school children (P6 2:15-19)

The previously considered concepts of universalism and home visiting are clearly visible. The transferability of these core values and associated skills might be said to contribute to equilibrium in her identity, despite her role change. However, her more specialist role does not specifically focus on families with preschool children which is at odds with the current role review recommendations (Lowe 2007). She also goes on to say:

Half of this job, which I haven't actually said, is strategic, so that's very different from my last job, I mean I sat on some committees, but this is kind of strategic work as well as client based (P6 2:140-142)

The implication in this example is that strategic work is not part of mainstream health visiting but is given legitimacy in her "specialist" role.

Participant five had three facets to her role: caseload holding health visitor; clinical nurse lead (CNL); and health visitor representative on the PCT professional executive committee (PEC). Despite the complexity of her pre determined organisational role she had a clear understanding of how each part of the role integrated to align with the public health agenda, also suggesting a degree of equilibrium in her identity:

So I see my role as a health visitor to actually be doing the job getting out there, and it might be that some of your work is on a one to one but I'm aware of where that fits on the continuum of PH, I'm aware of how my one to one work feeds into that continuum. As a CNL I see my role as somebody whose providing leadership who can support people to get together in groups to look at what are the PH issues in your locality and how are we responding to those and that's working across boundaries, across disciplines,. Then as a PEC nurse, I think all of the roles have those elements in it I mean a health visiting looks broadly as well (P5 101-109).

For the participants discussed above, a clear job description depicting the parameters of their practice supported the clarity with which they perceived their role and its fit with their own expectations and those of others.

Participants three and nine both had been given a less well defined, time limited leadership role as change activists for the duration of the Whole Systems Pilot. However their experience in the role differed. Participant three described part of her role as providing a health visiting perspective in multi-disciplinary, cross organisation group looking at policies across the PCT, again strategic and combined with her usual health visiting caseload role. This health visitor did not express any difficulties with this and was able to give positive examples of the result of her increased public health role:

> *I've really made a difference. I was able to make the case that* [a specific locality] …… *should be included in any initiatives as it's often missed as an area in need. My pushing got it included. So now it has some resources and is starting to develop its own community groups (P3 Ob1).*

However although she talked about attending public health training days, she said little about influencing other health visitors in the locality to change. The other change activist was less positive about the benefits of the role:

> *I've been seconded to the Change Activist for two days a week but I didn't get any backfill really, actually, so I was trying to sort of do this practice in one day a week, which is a bit ridiculous and occasionally I, well for a short period of time, for a few weeks, I did get half a days backfill from a very experienced health visitor and she did some primary visits for me in that period of time and she did the clinics because it seemed, it seemed the easiest thing to give her, em, at the time, but what it did was give me a gap then in knowledge about those families (P9 349-357)*

Here the health visitor talks about the detrimental effect on her relationship with the families in her caseload, linking back to the primary importance of relationships to the role.

Another participant, recently qualified, described a change to her contractual arrangements as the only way to enable her to work in sexual health services, work which she defined as public health work:

> *The other thing that I did before is contraception, I thought it would be part of my health visiting role ……….don't understand why you can't ….I decided not to lose that skill so that's why I was offered a position for four half days, so it's half a day out of my health visiting and with sexual health services …so I've got two separate contracts with PCT. (P13 342-349)*

This participant appears to have experienced less autonomy to choose her approach to practice than she expected. She also talked negatively about her experience in joining the health visiting team as a newly qualified health visitor. She did not perceive that her colleagues gave her any credit for her experience prior to health visitor education:

> *While I was still there.. and they sat down and complained that they were losing an experienced health visitor and they were gaining a inexperienced health visitor on less hours. And I just felt that they don't want me, they hadn't asked me what I can do. (P13 321-325)*

This experience would indicate that despite health visiting being a specialist nursing role, there is a perception from those in the role that it is different from nursing. It suggests that post qualifying experience as a health visitor is what equips the individual for the role not nursing. This supports the perspective of health visiting having professional status of its own, at least in this particular team. The relationship of health visiting identity to nursing is a key area of discussion later in this chapter. There were several other participants occupying what might be called atypical roles for health visitors. What was evident was the "portability" of the health visiting identity to different roles.

Identity portability

One participant worked in Surestart setting as a health co-ordinator. When asked if her role changed from being a health visitor she said:

> *Well I don't think it can move though can it, if there's a family struggling and they come, you know ……………I've got the crisis, I mean what can you do you can't just say you need to go someone else (P15 456-459)*

She also talked about the advantages of having been a caseload holding health visitor in the same locality prior to this role and the benefit of having already developed relationships with families in the area:

> *I think as a health visitor you're a good networker anyway and used to working in the, you know, maybe not in the one office but you know, with social worker, with the schools, with the childcare, with housing, so you know, em, and that's what, how it works in Sure Start really….. for the clients I think you know, if they've got that confidence and then you can, I mean how we sort of engage with the very heart of each (P15 253-271)*

Despite this participant still having a health visiting identity in her Surestart health co-ordinator role, she felt that her peers had a lack of understanding about her role:

> *I don't think they* [other health visitors] *see the side of sort of the performance management , the budget holding, the em links with the more strategic work (P15 341-343)*

Another participant working in an atypical role with transient families also suggested that there was a lack of role awareness amongst her peers which was sometimes addressed by them witnessing first hand the context of her practice:

> *And in fact some of the health visitors that you know do get to go and visit in the bed and breakfasts. I think it gives them good insight (P6 2:486-887)*

Two other participants were in atypical organisational roles, linked to the PCT but employed in an acute trust as specialist nurses. Both were registered health visitors and one of them was also doing bank work as a health visitor:

> *I don't have complete control and there have been specific difficulties in being a public health nurse employed by an Acute Trust ……there is a complete lack of understanding of public health role (P16 123-144)*

Again there is a lack of understanding of her role expressed, which evidently impacts on her own view of the valued placed on her work. Despite this, she still had a clear professional role identity as a health visitor, presumably given legitimacy by her part time role in mainstream health visiting:

> *I do feel myself as a health visitor as opposed to a nurse as a specialist practitioner so even though my job title is officially specialist nurse, I always put /health visitor at the end of any communication because em, my role is public health and I think it's good for people to realise I am a health visitor and it may perhaps make even the Acute Trust think, well this might be something different. (P16 189-197)*

This example indicates an awareness of the impact of her identity on others. She was also able to articulate why the public health role was important, an essential skill in an acute working environment where other professionals may not understand the unique nature of health visiting:

> *If you're addressing people's physical health needs as opposed to their emotional family concerns em, physical needs will in a hierarchy will come first and addressing the truly old-fashioned notion of health visiting, you know, if you're addressing the physical needs you're downstream resuscitating those who've fallen in. If you're a health visitor you aren't, you're upstream looking for the reason why they fell in the first place and I always think that will she will get lost unless she has a specific role to do that. (P16 497-508)*

The other specialist nurse had similar views in regard to the employing organisation's attitude to preventative work and its influence on their role but didn't have the same perspective on the health visiting nature of his work. At the beginning of the interview he was asked whether he felt his role was health visiting to which he replied:

No………..I don't do a lot of home visits (P17 152)

This clearly endorses the perspective that home visiting is core to health visiting. Having had time to reflect during the interview he later said:

I guess I do use my health visiting skills but I don't think of myself, if somebody was, if you at the start said simply do you think of yourself as a health visitor, well I said, no ……..I mean for me one of the em, key parts of health visiting was the early involvement of the babies and seeing them through etc., which I don't do ….I do occasionally review health assessments for babies but that might be the only time I actually see that child, you know, so, but I think my health visiting background helps (P17 745-7)

For one participant, the stereotypical view of her organisational role by others appeared to cause her to question her professional identity. She suggested that her work on the health visiting bank, supporting the service on a sessional basis, meant she was not perceived as a "real" health visitor:

People saw me as a little bit set aside and perhaps not a real health visitor, working on the bank ……..some of the more perhaps difficult characters amongst my colleagues have been a bit more accepting of me once they'd actually worked with me, (P16 580-583)

Evidently through social interaction she has become increasingly accepted as part of the group. These examples raise the importance of the influence of practitioners' individual characteristics on their self perception. They also indicate a perceived anticipation of how other people view them in their role in the course of their social interaction. As discussed, the theoretical framework for this study acknowledges that individuals bring to any interaction their prior experiences (Blumer 1969).

In addition to organisational role, participant seventeen was included in the study sample because he was male. This is unusual for the health visiting professional group (Craig and Adams 2007) and may have been of relevance to identity development in that role. As mentioned previously, his perception is particularly relevant to the significance of the work of Pritchard (2005) who suggested health visiting to be based on women working with women. This participant talked of the influence of the stereotypical views of others on his self perception and self esteem:

> *I mean she moved on from the whole disgust issue... and she used the word "disgusting", the idea of men in midwifery because she was a health visitor and a midwife......... And banging on about how she couldn't personally see a role, unless it was to work more with the men in the family, and that's what I objected to..... But professionally I never saw myself as being any different. (P17 389-515)*

Whilst he did not prior to that experience see himself as different from his health visiting female colleagues, knowing that this one person did not value him in the same way may have affected his subsequent identity in relation to his professional role legitimacy. He went on to suggest he had modified his identity as a male health visitor to be more accepted by his peers:

> *Well I used to say when I was in health visiting I've been one of the girls for years, I mean I didn't see myself as doing anything different and I would have objected if I'd felt I was being steered into doing something different. (P17 444-447)*

This seemed to be a clear acknowledgement that in essence the health visiting identity is historically gender orientated toward female occupation (Dingwall et al 1988). This example of his experience occurred more than twenty years ago and one would hope this has changed due to the influence of legislation on equality in the workplace. However the recent work of Pritchard (2005) may present a continued challenge to men entering the profession and seeking to legitimise their professional role identity. The historical influence of gender on the professional roles across the healthcare system is

well established. In relation to health visiting the ongoing changes in their professional practice context, this is a debate requiring further systematic analysis and is perhaps for another piece of work. However, it is potentially of significance in this discussion that both nursing and health visiting do share a predominantly female oriented history. In addition, the notion of identity portability is of relevance not only to changing roles, but also in a developmental sense. Given that health visitors are nurses first, it is useful to explore the portability of the nursing identity to a professional role identity as a health visitor and its influence on practice.

Nursing as a Foundation for Health Visiting Role Identity

Professional credibility

Several of the participants felt that their nursing background enhanced their professional credibility as health visitors through a positive public identity. Participant nine expressed this as follows:

> *I would say to the parent craft classes, you know, that health visitors are nurses, fully qualified nurses because I think that gives them some power, some credibility, I think if you've been a nurse you're automatically given that credibility, I think really, ...(P9 598-601)*

> *And that gives the client a bit more confidence in you, I mean I'm not saying that it, you know, in the future that would be of any tremendously bad thing to lose that nursing side of things but for me personally I've found it really useful (P9 452-455)*

Whether this was about enhancing credibility from a client perspective or enhancing her internal feeling of credibility and role confidence is unclear. Participant five, in her leadership role had talked about losing her caseload in an organisational restructure but maintaining clinical credibility. When asked what she understood that to be it was framed in nursing terms:

In my mind I see clinical governance, advancing nursing practice as the key issues. So I would hope I would be looking at things a bit like you're doing, not necessarily going in as an HV doing any clinic, but looking at how you could advance nursing practice, evidence base, how we're demonstrating what we do. (P5 91-92)

This can perhaps be explained by the fact that the leadership aspect of her role was one of responsibility for all of the nurses working in primary care in that locality, not just health visitors. However framing her clinical credibility in the nursing sphere of practice indicates both a certain degree of primacy for the nursing perspective. It may also give an indication of her need to internally identify with nursing and externally be seen to do so.

Significance of nursing knowledge

As discussed in the previous chapter, the knowledge used to underpin health visiting work potentially spans a knowledge continuum from medicine to social care practice. The ability to use this breadth of knowledge contemporaneously in a range of practice settings is potentially what is unique about the health visiting contribution to health care. However, earlier discussions have also indicated that there is no role standard in health visiting and that some health visitors place more emphasis on nursing and medical end of the knowledge spectrum than others, to underpin their public health work. For some participants, being a nurse enhances their work through the transferability of skills and experience:

Em, it's the skills you learn as a nurse and your understanding of health and illhealth, em, that, and your contact sort of people in your training and the experiences you gain in your training that I find it hard to imagine coming into doing public health without having that sort of groundwork (P10 429-433)

It's the link with health, it's not just em, it's not just a development job, that I do think this, I think you need the base line and the nursing is a good base line for what we do (P4 788-789)

Others express the benefits of having a nursing background to be the shared understanding it gives when working with others in a primary healthcare setting. However, in this particular example, health visiting is allied specifically to mental health nursing, perhaps implying more of an overlap in that sphere of practice:

> *It's just like, I don't know, when you talk to someone in the surgery you understand what they're talking about ..... it's not important in one way, but you, it's, I don't know, I think it, I still think you should be a nurse really........I mean really if you want to look at any nurses probably your mental health nurse would have been a better background for health visiting (P4 817-833)*

This perhaps reflects the legitimacy given to areas of work such as post natal depression and family support. In such work there is a clear overlap between health visiting and mental health nursing role in use. There is also overlap with other socially orientated roles such as occupational therapist working in mental health or a social worker.

Another participant suggested it was the communication skills and the confidence in decision making developed as a nurse that enhanced her health visiting role:

> *I mean I really feel my nursing experience gave me a great foundation for health visiting, even though it was ITU, I mean there's lots of other skills obviously I knew I was using, but I think it's about em, having that confidence in decision making em, that the need for close communication at all different levels of staff which again, you know, and obviously there's the rapport that you learn to develop with your nursing role (P12 444-452)*

As discussed in the literature review, along with the changes to the professional register (NMC 2004a) a direct entry route to health visiting was considered and rejected, a decision challenged as not representing the views of the majority of health visitors (Cowley and Frost 2006). This was explored with participants. Clearly those who strongly identified with the benefit of being a nurse were against this educational route:

> *I got quite horrified to hear that, yeah, (P10 420)*

I don't even think a newly qualified nurse could come into health visiting, you need so much experience and expertise don't you to deal with the families in them situations (P15 644-652)

I'm really quite against that because I don't see, I mean I'm not a midwife, a direct entry midwife, and looking in from the outside isn't quite to the direct entry there does seem to be some gaps which perhaps if they had a nursing background em, could be perhaps em, you know those gaps may be wouldn't occur. (P16 184-188)

One participant did not reject the idea completely, though acknowledging the health visiting programme would need to change to ensure core skills she had learned from nursing were incorporated:

I personally think you can do health visiting directly, I think you would need a much, much longer, you would need a longer course and you, one of the added advantages of being I think, had been a nurse first is the number of issues that are raised in terms of that draw upon your, you know, whether you're a nurse or whether you're a midwife background in health visiting, that is not currently covered in the health visiting course (P14 551-556)

Perhaps the tension in this debate for health visitors is captured by the following insightful response from a participant who considered themselves to be almost as the end of their career:

I think there's a kind of a tension with this because [health visitors are] *kind of proud to be nurses but didn't necessarily want to be grouped as nurses, they wanted to be grouped as health visitors (P17 240-242)*

This implies a more personal reason for wanting to retain a nursing identity and keep it public. This perhaps links with the work of Ohlen and Segeston (1998) who, as discussed, conclude that self image and self esteem as part of a personal identity are the foundation for a professional identity and professional role function.

Rapport and Wainright (2006 p110) present the work of Flaming (2006), which considers the link between personal and professional identity, quoting a nurse as saying "I don't have to act the role of a nurse, it just feels right.......it's just who I am". One participant in this study said:

> *I'm a health visitor and an agenda builder (P16 7-10)*

She seemed to be associating herself closely with her role as she didn't say, "when I do my job as a health visitor I'm an agenda builder". This also fits with other aspects of her work that were done in her own time, like writing a strategy paper for the local council. This congruence between activity in her own time and her work role, indicates that the autonomous, proactive, nature of a strategic public health role fitted with her personal predisposition to that way of being and the "personhood" (Dombeck 1997) she brought to her role identity.

Another participant appeared to be wrestling with the notion of having moved on from her nursing identity yet wanting to maintain the credibility associated with that role:

> *I would say* [to clients] *I'm a health visitor and if they said, what's that, I'd say I'm a nurse that's done extra training, but I always say I'm a nurse and I'm not. I'm a nurse first, although I've lost those skills, I've lost the clinical skills (P4 809-811)*

There is significance in saying "I'm a nurse" when in fact her occupational role is as a health visitor. She would not however, by reference to her role, be able to say "I work as a nurse", as she recognises she no longer has what might be termed core nursing skills. However, she still clearly has the personal identity that went with her initial professional socialisation.

Influence of role title change

In keeping with the expressed view of nursing as important to the role, the change of role title on the NMC register (NMC 2004a) to specialist community public health nurse (SCPHN) appeared to be of little concern to one participant:

> *I think it's sort of on a day to day basis removed from people who will still call themselves health visitors ...... it hasn't really made a major difference (P8 353-359)*

This example suggests that this practitioner's identity was resilient enough to withstand the external challenge of a name change, despite the potential change it made to their public identity or image (Strauss 1958, 1997; Foley 2005). However, for another health visitor participant working in a management role, the changes were perceived to have had more of a negative impact:

> *NMC, UKCC and the government who is the lead on this, has sent out a profound message to health visiting about how they're valued and they can dress that up any way they like in terms of the policy context etc., I do think we were sold down the river (P14 553-557)*

The decreased visibility for health visitors, caused by the title change, may have precipitated a greater need for this participant to explain and defend the health visiting healthcare contribution, in the context of her interprofessional strategic work.

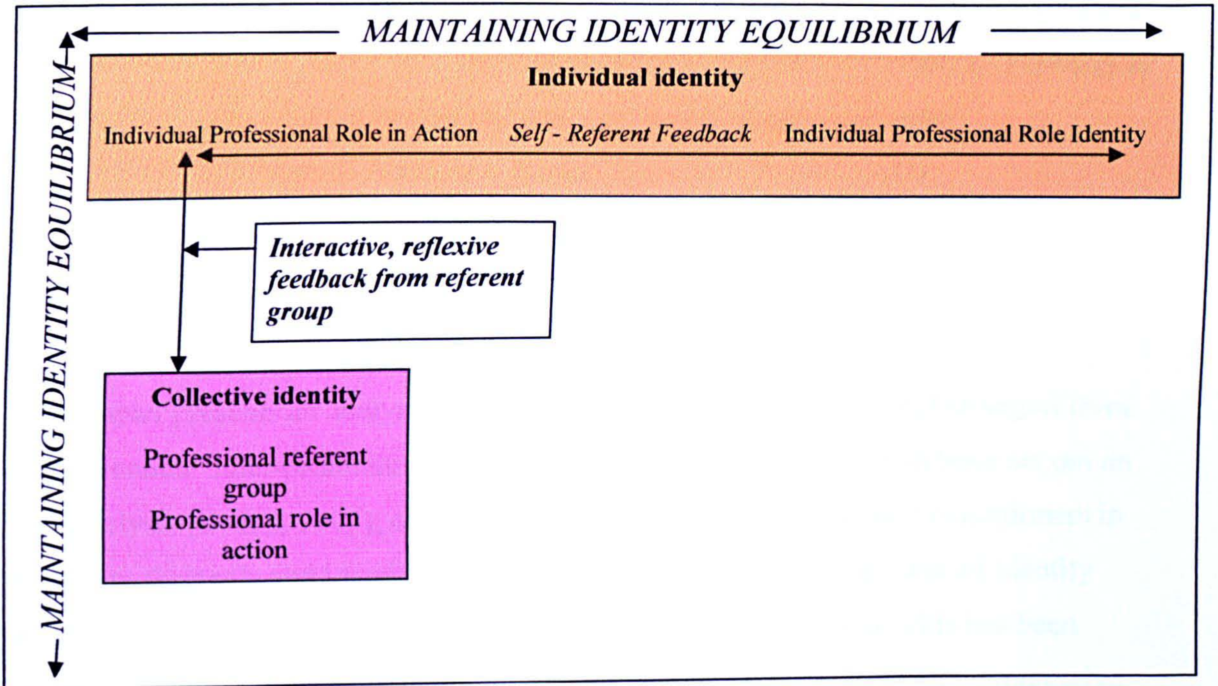
Theoretical summary and conclusion

The data shows clearly that there are some elements of the professional role identity that are considered by the participants to be the essence of health visiting, core to the role: home visiting; relationships as a foundation for future work; a preventative philosophy; and a degree of professional autonomy. As the basis of a collective identity and role

standard, health visitors can use these a referent point for continued legitimisation of their approach to practice and verification of their individual professional role identity. However, there are other aspects of practice and identity upon which there is an apparent lack of professional group consensus.

Collaborative public health work has evidently presented a challenge to the health visitors in this study. There is clearly a difference in opinion as to the relative value of this way of working when compared with the individualised home visiting approach to practice. The result of this is a conflicting role standard causing disequilibrium within the health visiting group. In seeking to legitimise their own identity, through a self referent feedback mechanism, individuals need to choose which approach perspective to take and defend it in the face of challenge from others who differ. For example, some areas of socially driven, collaborative public health work might not fit with an individuals' health visiting identity where they still have a strong identification with nursing and a medical perspective on public health. Engaging with work they do not feel fits with their identity will require individuals to modify it or change their practice to fit, in order to avoid personal disequilibrium and reduced functioning in their role. The conceptual model presented in chapter five suggests there are a range of factors influencing the interaction and experiences of health visits with their changing professional practice context. Figure ten reflects the interplay between an individual's identity and that of the collective health visiting group. It is the first stage in building a picture of the interactive social processes involved in the process of identity legitimation amongst participants, and the maintenance of identity equilibrium.
The next chapter build this further by exploring the influence of others on the identity perceptions of the study participants, in an interprofessional practice context.

Figure 10: Maintaining Identity Equilibrium – the individual dimension



Chapter 8 – Inter-professional Working

"Since you are an integral part of a social system, let every act of yours contribute to the harmonisation of social life. Any action which is not related directly or remotely to this social aim disturbs your life, and destroys your unity"

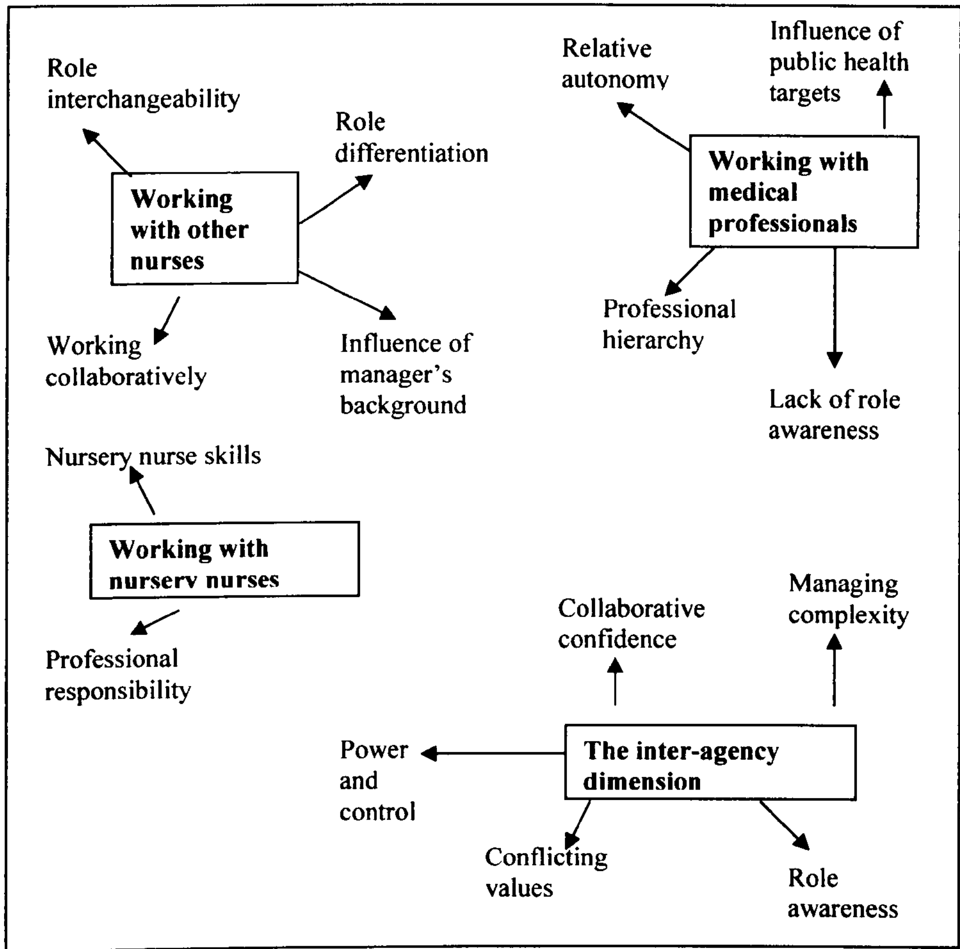
(Marcus Aurelius – Roman Emperor - 161-180 AD)

Introduction

This chapter presents an analysis of the data from the third category that emerged from the data called "inter-professional working". The previous two chapters have set out an intra-analysis (Bednar 2007), of the perceived experience of individual practitioners in relation to their role and identity. Whilst grounded in the data, the picture of identity presented, is based on my own interpretation in the research process. This has been inevitably influenced by the social interaction experienced in the constant comparative process and ongoing engagement with contextual material of relevance. The choice of label for this category, interprofessional working (IPW), evolved from an initial label, "interaction with others". The decision to use "IPW" was influenced by my own professional identity development and my recognition of its significance in increasingly integrated services.

Social interaction is an important feature of identity formation (Strauss 1978). Indeed Riley and Burke (1995) suggest that social interaction is more of a challenge to identity than individual action. This chapter thus presents what Lazega termed a "relational" analysis (Miller and Dingwall 1992). It is an exploration of the influence of inter-subjectivities, factors and interactions external to the participants, which impacted on their individual professional role identity. Inter-subjectivity can be described as the relationship of self to others that is achieved through interaction and dialogue (Kensella 2002). Given that the participants' changing professional practice context is increasingly integrated and collaborative, it is important to understand the influence of others on identity. Figure eleven depicts the properties of this data category:

Figure 11: Interprofessional Working – data category properties



Research on inter-professional collaboration shows that a strong professional identity and the ability to articulate to others what is unique about their professional perspective is a key factor that affects the success of inter-professional working and the degree of comfort a practitioner feels in that situation (Kenny 2002). This is echoed by the identity theory work of Riley and Burke (1995 p.64) who suggest that:

> *"Sustaining and verifying one's identity in a group requires not only behaviour on the part of the actor that confirms his or her identity, but also that the behaviour is interpreted and accepted by others, and that the behaviour of those others confirm the actor's identity"*

Data from the participants suggested they worked in diverse settings and with a range of different professionals. This varied in the degree to which their work was truly

interprofessional (Barr et al 2005) however most practice involved other professionals, even if this was through referral to other agencies. In articulating the rationale for their practice approach participants made reference to their working relationships with others. These data examples will now be discussed to establish how others affected their professional role identity in negotiating their changing professional practice context.

Working with Other Nurses

Role interchangeability

Data has shown that some health visitors still have a degree of nursing identity. Through interprofessional working there is the potential for them to practice collectively with other nurses in a way that reaffirms that identity and the legitimacy of their "belonging" to the wider nursing profession. "Role interchangeability" and evidence of role negotiation in a specific context is clearly described here by one participant:

> *We have a weekly GP meeting on a Monday and the district nurses are there. I just don't think they have time to even think about smoking cessation, ... so yes I will go and visit someone who has just come out of hospital having had an MI and has been commenced on NRT or needs to be started on NRT, and then we take that further..... (P2 78-89)*

Discharge from hospital, focus on disease management and prescribing of medication locate this practice in the nursing/ medical domain. However, given the focus on preventing further deterioration in cardiac health and in the promotion of a healthy lifestyle, the work is also in the preventative paradigm that has been discussed as core to health visiting. The fact that the health visitor in this practice has responsibility for this work, seemingly endorsed by other nursing colleagues, legitimises it as health visiting work. However it is unclear whether this legitimacy comes from a shared collective nursing identity or a perception that this work fits with the individual's professional role identity.

Role overlap is of increasing significance in the complex UK health care system and understanding. This is relevant to interprofessional education (Barr et al 2005). In areas such as assessment, a range of professional roles may overlap. In an interprofessional collaborative working this is viewed as a strength with each individual contributing their particular professional perspective on the task. Where this works successfully, the outcome of the collaboration is better than that possible from combined independent practice of individuals. In other words collaborative advantage is achieved (Huxham 1996).

In contrast, the term "role interchangeability" could be used to describe a situation in which different individuals could undertake a specific task with the same output. In other words there is an aspect of genericism to the work that negates the need for a unique professional contribution. Participant two above describes role interchangeability not collaborative working. However, in this case it perhaps less about genericism per se and more about core nursing skills. These skills would be those that both groups would be perceived to share, having gone through standard initial preparation for the nursing profession. Williams and Sibbald's (1999) study suggested there was an uneasiness amongst participant nurses working in primary care who suspected a policy move towards a generic primary care worker. However, policy now clearly supports the maintenance of individual professional roles to gain collaborative advantage for the benefit of service users (DOH 2001b; DfES 2003; DOH 2005a).

Another participant suggested her smoking cessation public health work could also be done by the practice nurse. However, she also acknowledged the limitations of that role interchangeability, in terms of the inability of the practice nurse to prescribe nicotine replacement therapy:

> *I do more of the cessation now than the rest of them because of the prescribing. It is easier for me to do it than for our practice nurse. So I do the bulk of it, where once we used to be a bit more equal in doing it. (P4 217-220)*

This degree of role interchangeability and overlap again occurs in the shared nursing domain, yet is legitimised as preventative health visiting work. Since this data was collected, the previously limited prescribing role of health visitors and district nurses

has been extended to include other nursing roles and other non medical professionals (DOH 2008c). This could potentially present a perceived challenge to the practice domain of health visitors. It is therefore increasingly important for health visitors to be able to articulate the added value they can bring to practice situations as justification for why commissioners should continue to pay for their more expensive specialist services. This is another example where resource availability may have an influence on professional role identity.

Work with older people was also an area where roles seemed interchangeable. A previous example showed a GP practice where elderly assessment visits were shared between the heath visitors, practice nurse and district nurse according to the context of their practice. Another health visitor described a similar situation in which it appeared arbitrary who took the referral for assessment:

> *Either a district or myself will get a referral just to see if there's anything, you know, support etc.. (P10 380-382)*

Assessment is one area of practice that has been acknowledged as a core skill for all professionals. The emergence of the Common Assessment Framework (DfES 2003) for children and the Single Assessment Process (DOH 2007d) process for older people, are examples of new systems being put in place to help facilitate collaborative working, manage role overlap and avoid duplication of effort. However ongoing evaluation of their implementation indicates difficulties due to lack of role understanding, use of different terminology and conflicting priorities (Brandon et al 2006). However this study indicates a positive working relationship between the nurses and health visitors working in primary care. This may reflect a shared identity, language and cultural norms that enable them to bond in a sense of professional belonging (Putnam 2000), which by default, differentiates them from other groups.

Role differentiation

Despite the potential for a shared nursing identity as discussed, there was evidence of some participants attempting to differentiate themselves from nurses they worked with.

One participant identified limitations to the input of other nurses when compared to health visitors. These limitations may stem from a lack of role adequacy or from organisational constraints. The example acknowledges perceived similarity and difference between the practice of nurses and health visitors in relation to scope of public health practice in the family home context:

> *A lot of the district nurses who've done, you know, the recent training, they would argue that they can provide that level of em, public health that health visitors do as well and we're generic. However you know, the person who goes in and addresses a specific problem, do they really have a specialist skill to address other family concerns? (P16 492-497)*

Despite some differences, collaborative working between the disciplines of nursing may be less problematic than with other professions for shared identity reasons discussed earlier. One would expect that such closely related professional groups would have a clear understanding of each other's role standards (Collier 2001) and there is some evidence of this, especially in relation to "traditional" practice. However, data also indicates there is the potential for the role standard for health visiting to become fragmented by diminished role clarity around new public health working. There is therefore a need for a renegotiation of roles and a redefinition of the legitimacy of the health visiting identity and its relationship to nursing.

Working collaboratively

The participants give examples of working collaboratively with those nurses focused on the health of school populations. School nurses have undergone a similar role title change to health visitors and are also eligible for registration on part three of the register. Data has indicated that the role title change (NMC 2004a) to specialist community public health nurse (SCPHN) did not appear to be of significance to some participants. In one of the PCTs where data collection took place, the school nurse role was renamed "public health nurse", whilst the role title of health visitor remained unchanged. However, school nurse, school health advisor and public health nurse were titles used interchangeably by participants, perhaps reflecting a lack of concern with

names within the nursing and health visiting practice domain. However, as public indicators of role identity (Strauss 1959, 1997; Foley 2005) in an interprofessional context, other professionals do use role titles to differentiate across the professions. To avoid confusion individuals need to clarify their public identity in the course of their contextualised individual interactions. Alternatively a collaborative role change process could facilitate an awareness raising process across the whole system, of the changes and their significance to interprofessional working. Left to individuals to manage in their practice context different role identities may emerge.

Some examples of collaborative public health working with school health advisors are described positively:

> *And I am working now more with public health nurses than any other group before. For my first two years as a health visitor I liaised with them every year when I was handing over children who were starting school but I didn't really get very involved with them and now we are hoping to set up a group in a school to try and tackle smoking and obesity, so we will be working much more closely with them. (P2 257-262).*

> *I mean it's a golden award for smoking in schools ………… the public health em, nurse taking the lead on that, there's teachers, em, myself and my colleagues (P4 401-404)*

What is interesting about the latter example is that the school health advisor is leading and co-ordinating this multi agency group. How this fits with the policy depiction of health visitors leading public health teams is not clear. Perhaps it is the school context of this work gives the school health advisor primacy over others, in relation to ownership and identity. Again context is a useful indicator of identity and important to understanding the social processes in which individuals engage (Miller and Dingwall 1992). This will be explored further in chapter nine which considers the influence of practice systems on professional role identity.

Influence of professional background of managers

Chapter seven explored some influences of management on participants' professional role identity. One health visitor participant in a leadership role worked with both nurses and health visitors, to help them develop practice:

> *As a CNL (Clinical Nurse Lead) I see my role as somebody whose providing leadership who can support people to get together in groups to look at what are the PH issues in your locality and how are we responding to those and that's working across boundaries, across disciplines* [nursing] *(P5 22-25),.*

It was not the remit of this study to seek the perceptions of others nurses about having a health visitor in a leadership role. However, data did emerge from the health visitor participants, who had nurses, not health visitors, as managers. Participant sixteen gave an example in which she felt the public health contribution of health visiting was not valued by senior nursing management in her organisation:

> *The new em, director of the Acute Trust* [nurse by background], *I heard him speak a couple of weeks ago, and he rattled off all sorts of public health targets that weren't being addressed and things that we needed to do and I do believe he was, he comes from an Acute Trust background and a couple of health visitors in the audience who were looking open-mouthed at things he thought he was coming out with which were innovative, which needed to be addressed, which health visitors have been doing for years, but aren't being allowed to do because of the targets in the nature of their work. Em, obviously it didn't go unexpressed and a couple of health visitors in the group of maybe two hundred people that were there said excuse me but health visitors do what you're saying, they have been doing, they're not able to do it now because of staff not being replaced. (P16 297-310)*

However the same health visitor spoke highly of her immediate line manager who came from a community nursing background, though still not health visiting:

Only good aspect in this is.... I happen to have a direct line manager who has a background in district nursing......so she has an understanding of my role and the other community health workers (P16 153-160)

This indicates from her perspective, a sense of shared identity between two different nursing disciplines from a community background. This suggests there may be continuum of degrees of "shared identity", identity overlap as well as role overlap. Their collective experience of the context of work in a primary care setting facilitated an understanding of the health visiting role in action and a perception by the participant that her role was valued. This participant goes on to differentiate herself from her other nursing colleagues who work in a hospital setting. This is framed in terms of her perception of their continued hierarchical working relationship with medical colleagues, implying that that is not the case for her:

Hospital based people tend still em, have a hand maid mentality, I'm sure a lot of them that disagree and they disagree with you outraged by you saying that, but from what I can see from looking in having had a health visitor public health community background, (P16 200-210)

This stereotypical perspective implies a point at which the practice domain of medicine became less relevant to the participant and put a greater perceived distance between her and her nursing colleagues. This links to the work of Foley (2005) and the differentiation between traditionally educated midwives and those who were prepared as nurses first, the latter considered to be more closely allied to medicine. This participant appears to feel marginalised as a health visitor working in acute Trust. However, her identity as a health visitor when working in a part time health visiting practice role in the PCT appears strong, perhaps reflecting congruence between her identity and her professional role in action:

I'm completely aware of where I stand in health visiting [as opposed to her specialist public health nurse role]. *(P16 237)*

From the literature (Dingwall et al 1988) and data examples to date, there is clearly the potential for medical professionals to have an influence on the professional role identity of health visitors. For the participants this was discussed mainly in relation to their interaction with GPs in the primary care context.

Working with Medical Professionals

Relative autonomy

Professional autonomy was a key area for discussion relating to interprofessional working with medical professionals. This was affected by their relationship with the particular GP they worked with. Several participants were GP attached i.e. located within the practice building and clearly visible as the named health visitor for the practice. Most participants were employed by the PCT not the GP, yet data suggests that the GPs took a leadership role, giving them some control over the health visitors' role in action:

> *With our practice the drive came from the GPs – would we set up a smoking cessation clinic because they were getting a lot of referrals (P2 42-44)*

> *I used to do the health checks on the over 75s but when the contract changed and the GPs stopped doing that, I don't anymore P10 (378-379)*

One participant took referrals from the GP and felt obliged to prioritise that work. A distinction was also made between the work "owned" by the health visitor and that directed by the GP:

> *Yes I do tend to do them as soon as possible. I suppose out of a sense of "obligation" - "it must be worse for people based within the GP practice building. I'd never get any of my own work done for referrals from the GP" If HVs worked in teams and weren't attached to GPs there perhaps would be less of an obligation. (P2 Ob1)*

The latter example uses the word obligation in such a way as to suggest the health visitors had no choice but to comply with the GP's request. This relationship is at odds with the notion that all professionals have a level of autonomy (MacDonald 1995). It does, however, support the assertion that nursing has traditionally considered to be below medicine in the health profession hierarchy (Giddens 1989; Turner 1995). There is also the suggestion that the context of practice had an influence on the degree of autonomy the health visitor had. The GP was perceived to have less control when the health visitor was not based on the premises.

This is supported by another participant who was linked to a GP practice but not located in the building and expressed a view that the GPs she worked with did not try to direct her practice:

> *I think I am lucky with my GPs because they never ask me what I'm doing, they just let me get on with it. If I suddenly wasn't available to something which I would normally do because I was too busy, then they might question it. I am lucky. I know lots of health visitors have problems with their GPs and they probably wouldn't even let them do a baby club. (P4 229-233)*

However she describes her situational autonomy as "lucky", suggesting that if the doctor was unhappy with her work, that autonomy could be rescinded. This perception gives the impression that the autonomy she has in her practice has been indirectly sanctioned by the doctor. This does not fit with a model of the health visitor being an independent autonomous practitioner but it does fit with a perception of medicine being a gatekeeper to the nursing profession, delegating responsibility for "their" patients. Another participant was insistent she was autonomous:

> *I decide what's the priority (P6 420)*

However, she then suggested that she was autonomous unless the GP insisted she see someone, again implying a degree of delegated autonomy:

Unless the GP asks me to see somebody urgently (P6 420)

What is not clear from this example is what would be urgent enough for her to do that. The urgency expressed in the example may however, be indicative of a shared sense of priority in crisis management. Responding to the request would thus legitimise the heath visitor's compliance with the request by reframing it as part of her own identity and practice priorities. This participant overall expressed her working relationship with GPs positively:

I'm fortunate working in this practice: it's a small practice so it's easy access to the GPs and given the, our caseload which is needy and requires social problems, complex family issues, I think it is important to have easy access to GPs and maintain very good communication links and keep those kind of channels of communication open all the time and I know that, you know, we work well in the GPs (P6 179-183)

The word "fortunate" is linked the previous discussion of participant four being "lucky" to have a good working relationship with the GPs she worked with. Perhaps both of these health visitors work well with their GPs because equilibrium of mutual understanding of identity exists in terms of informal hierarchy. Whilst in this example GPs do not direct the health visitors' work, when necessary the health visitor will assume a lower status and allow the GP more control. However, when the GPs try and influence practice in a direction not considered legitimate by the health visitors in that practice there was a deliberate non compliance displayed:

They just wrote it on the back of the door, you know, on the whiteboard, didn't discuss it with myself and my colleague, so maybe they think that's what we would like to do undetected, I'm not remotely interested in diabetes and that is because, well one I'm not, and two I don't have the knowledge and I don't like to be involved in things unless I have the knowledge. And I'm not suggesting they would make us do a clinic unless we'd had training but I would rather do something else, (P6 493-500)

In this example the GP was perhaps mistakenly assuming interchangeability between the nurse and the health visitor.

Professional hierarchy

The dynamic in the example above also relates to earlier discussion of the relative positions of doctors and nurses in the hierarchy of professions (Giddens 1989; Turner 1995). The perception here is that the GP wanted the health visitor to deliver a service she felt was incongruent with her role identity or personal interest. Drawing on her perceived professional autonomy she refused. Other participants also expressed the importance of freedom to practice without direction from the GP, who had no formal control over their work. A useful comparison is provided by some data from participant one, who was a practice nurse, in which she suggests she feels disempowered by the fact the GP is the gatekeeper to her service:

> *"All referrals have to go through him" (GP). (P1 Ob1)*

> *"I've tried to bring it someone's attention but no one listens to me"* [meaning GP] *(P1 Ob1)*

Whilst she perceives her interprofessional working relationship with the GP to be problematic, the role she occupies is atypical of her peer group, being employed by the PCT not the GP. There is however, an indication that being set apart from her professional peer group causes some degree of discomfort:

> *I say lots to him I wouldn't have done if he was my employer……..the PCT don't know what to do with me being the only PN employed by them" (P1 Ob1*

She describes the situation for other practice nurses as them being disempowered but accepting of it:

> *I think that's the biggest thing, challenging their employers they're not confident at doing that. I mean a lot of them have been PNs for a long time. They've only*

worked one way and they're quite happy working that way. And the GPs are happy with then doing that (P1 165-167)

Given that this practice nurse had previously been in a GP employed position, there is apparently some feeling of an internally re-negotiated professional role identity caused by the displacement of changing jobs. However as the GP she works with perceives her to under his control the reframed professional identity has not been validated as part of her public identity, which is perhaps contributing the degree of discomfort she is feeling:

He's not letting me use my skills to their best advantage. I recently walked out of a meeting when he started, told him I was going to leave. (P1 Ob1)

Whilst this is a nursing example, it does fit with Riley and Burkes's (1995) identity theory work which suggests social interaction to be of more challenge to identity than individual action. It also reinforces the continued existence of a professional status hierarchy between medical professional and nurse, at least in this case. Given that health visitors are technically specialist nurses, some doctors may still perceive them to be nurses. Even for those health visitors who said the GP left them alone there was still a feeling that it was because the GP chose to and should circumstances change then they may choose to try and exert more control:

He did realise that I was allowed to do five percent outside the practice! Because of that he was quite happy for me to see patients that weren't our patients.. (P4 237-238)

In this case the GP seems to have sought external verification of the health visitors' remit to work in a collaborative public health way outside of his GP practice population. Some practitioners attempted to show some insight into why the GPs they had worked with did not seem to be encouraging of them doing public health work that was not easily attributed to having positive outcomes for patients on their list:

With the most progressive forward thinking GPs it's difficult for them to be really altruistic because of the nature of the way they're paid. With them being

independent contractors they don't look on it as a geographical population (P5 146-148)

I think a lot of the health visitors are up for that [collaborative public health work], *the difficulty comes particularly when they're starting to bring in GP practice based commissioning, em, and the need of the PCT to engage the GPs in this, but unfortunately at the moment it's about trying to em, address all of those issues that keep the GPs engaged and there's no easy way to do (P14 133-151)*

The latter example implies that there may be an increased level of complexity in the practice context dynamic with the introduction of GP based commissioning.

Lack of role awareness

Given the diversity within the health visiting group in relation to professional role identity it is difficult to see where this clarity in collective identity will come from. One participant expressed a view that there is already a general lack of role awareness amongst GPs about the health visiting role:

Some GPs, don't really understand what health visitors do here .... I think they assume that you know what you're doing which of course you do, and their targets are OK, immunisation wise, you know, we get our 100% targets, so they're quite happy with that and if they have any individual issues coming in to the surgery em, they know they can just like refer them off to me, em, so, and they don't have any problems, the clinics run smoothly and em, they don't get many questions about feeding and all that stuff because I would deal with it all (P9 274-282)

However, she did feel valued in her role which is perhaps indicative of the participant's comfort with the more invisible home visiting practice context she felt was core to her professional role in action:

Try and take them [health visitors] *off them* [GPs] *and they'll have a fit, so they Must really hold the value of the health visitors. (P9 267-269)*

That practice attached health visitors are valued by GPs was also expressed by a participant in a management role:

> *As they started to try and move staff around and address target needs and that was met with significant resistance from the GPs and that unfortunately wasn't supported by our senior, higher management, (P14 161-164)*

Clearly the GPs are seen to have a degree of organisational power. However, the influence of that on an individual health visitor's identity is affected by their role clarity, perceived professional autonomy and the degree to which they identify positively with a nursing role position in their work context.

One health visitor talked about her education work with medical practitioners on the management of nutrition through preventative public health work and the contribution of health visitors. She describes trying to change negative attitudes about the contribution of other professionals to the management of nutrition related problems such as obesity and failure to thrive:

> *I mean there's some* [GP & medical students] *that you cannot in the short space of time that you have them, do an awful lot about changing their attitude…… (P12 350-351)*

However, based on her own professional experience Participant twelve may have erroneously formulated the opinion that doctors are unconvinced of the value of interprofessional working with health visitors. This being the case she may be entering into this work in an unnecessarily defensive and challenging frame of mind. This fits with the notion of role taking as a process within social interaction discussed previously (Mead 1934; Blumer 1969).

Attitudes to others whether correct or assumed, are an important consideration in interprofessional learning and working and there is an increasing understanding of their impact on collaboration (Meads and Ashcroft 2005). As discussed previously, the emergence of inter-professional learning in pre registration professional education is a

means of trying to minimise the development of negative attitudes and inaccurate role perceptions, both of which can inhibit effective inter-professional practice and result in system failure to the detriment of service users (DOH 2001b, Laming 2003).

Influence of public health targets

One health visitor, felt that there had been a change in the IPW relationship she had with her GP, because of the targets GPs have to meet:

> *I think they're all jumping on the bandwagon because GP have targets to meet anyone is wanting to help meet the targets (P3 120-121)*

The introduction of explicit GP targets related to key public health priorities (DOH 1999c; DOH 2000b), highlighted areas of work where health visitors could tangibly demonstrate their contribution. Being able to demonstrate the health visiting role more publicly, perhaps led to a greater understanding within the team and a subsequent appreciation of the health visitors' input. Other examples above support this where other participants have suggested GPs are happy with them health if their targets are met. Provided that this target work is perceived as legitimate health visiting professional practice there is likely to be some degree of congruence between the health visitors own role identity and their public identity. However, the earlier example of participant six refusing to help with work around diabetes management suggests that in that particular local context, the GP had misinterpreted the relevance of that work to the identity of the health visitor. The alternative choice for the health visitor would have been to do the work and reframe her identity to legitimise it. Participant three made an observation that times are changing in relation to the health visitor-doctor relationship:

> *At one time people would say yes doctor no doctor but I think now people will say why have you done that and why have I got to do that and what difference will it make? (P3 78-80)*

The discussion thus far in this chapter has been focused on the influence of medical professionals and other nurses on the identity of health visitors. Despite the differences

discussed, the shared health paradigm gives them all some form of a shared identity. Not everyone with whom the participants interacted shared the health focus explicitly.

Working with Nursery Nurses

As discussed in chapter six, some participants worked with nursery nurses who have knowledge and skills particularly related to an early years context of practice, but in the social care domain. The role of nursery nurses as part of health visiting teams has emerged from the value for money agenda and the need for health visitors to focus on more collaborative public health work (DOH 2000a; DOH 2001a; Young-Murphy 2006). In addition, the children's workforce agenda (DfES 2003) is driving the development of early years' professional status for all practitioners working with children, including nursery nurses.

The process of professionalisation of this group includes plans now being implemented, for degree level university education, professional regulation and a code of conduct (DfES 2005). All of these characteristics fall within those expected of professional status (Giddens 1989; MacDonald 1995). However, the nursery nurse has already been integrated into health visiting teams as an assistant to the health visiting role. This suggests that despite increasing professionalisation, they may find it difficult to establish professional autonomy in that context. Again this is an example where a potential role title change may not necessarily impact on the role in action in the practice environment. It is important to acknowledge that the external status of individuals can have an influence in group and team process (Cast et al 1999). Therefore clarity relating to the organisational status of group members is important when creating teams that are interprofessional. As the professionalisation of early years workers continues to evolve, the influence of this on the health visitor - nursery nurse working relationship and relative status will be worthy of further investigation.

Professional responsibility

Evidence of the work of health visiting team nursery nurses suggests nursery nurses are delegated task focused work by the health visitor, who retains professional

responsibility for the families in their care (Young-Murphy 2006) This hierarchy based model is traditionally used in uniprofessional nursing teams. The health visitors in this study, having previously worked in this type of nursing hierarchical system will perhaps be more familiar with this concept of a team than one that is based on equal power sharing. The success of the latter relies on the successful negotiation of role boundaries between professionals of equal standing. The work of the nursery nurse appears focused at the level of individual indicating an overlap in roles in that dimension of practice. For the participants in this study who discussed this issue, the nursery nurse was valued highly:

> *We've got a nursery nurse who's excellent who shares within the team, and it means that all clients access those services and she's got fantastic em, resources and em, huge amount of input to the work that we do, she's got weaning group, practical weaning groups set up, em, she does all the organisation and preparation for the massage classes, em, she is really, really good from a practical point of view and offers support to all our clients on (P8 300-305)*

It is important to note that there is still a perceived ownership of the clients by the health visitor which presumably links to the health visitor's caseload responsibility. Whilst their support is highly valued, Young-Murphy's study indicates that the health visitor - nursery nurse working relationship is not without difficulty in the day to day context of work, with issues arising including control, responsibility, role clarity, and trust.

Nursery nurse skills

Another health visitor, talked about the nursery nurse she worked with in a baby club setting, clearly valuing the skills she brings to the group, for example role modelling play skills:

> *.. it goes without saying and she's (nursery nurse) fairly good at encouraging mothers who get some doubts, ...that are a bit you know, scared to play with the children, you know, she'll get down on the floor and she doesn't say, do this, do*

that, she just does it by showing them, em, and that, it works quite well (P4 691-695)

The language used in the latter example conveys a difference between the approach of the nursery nurse and the health visitor, as if the model of practice for the latter would be about advice and guidance rather than demonstration. The parameters of nursery nurse practice are well expressed by an observation undertaken in a baby clinic setting:

Mum asked NN about baby being off his food and a bit off colour. Told will need to speak to health visitor. (P2 Ob1)

Whilst there is an obvious role over lap between the nursery nurse and health visitor, it appears that this is not replicated in the nursing, medical dimension of a health visitors' role. Not everyone was positive about the development of skill mix in health visiting, described in unfavourable terms by one participant:

A "nightmare situation" (P17)

However a recently published policy document (DOH 2007a) affirms that health visitors should have roles as child health team leaders. In addition to the effect of this on health visitor identity, clarity in the nursery nurse role boundaries in this context is essential in maintaining equilibrium in their own collective identity. The need to clarify role boundaries was an identified outcome of Young-Murphy's study which identified "Connate" theory as a useful model for this. Connate theory was used in an interprofessional context by Rushmer (2005) to describe a model to help explain the degree of overlap in role and identity between different professionals. Similarly Machin and Graham (2008) describe a model for interprofessional working in the children's sector. This emphasises the need to acknowledge the necessary existence of role overlap, balanced with recognition of the unique contribution each practitioner in the collaborative working situation.

The Inter-agency Dimension

Managing complexity

The policy agenda for working together across agencies for public health is also discussed by the participants. However they also acknowledge its collaborative complexity and the need for effective co ordination:

> *I think the whole systems ethos is good and I think for many people that's how they practice anyway, working in partnership...... they worked across organisational boundaries; they developed sort of social allies with the workforce and with local sort of key leaders within the community (P14 183-188)*

> *Public health work isn't just led by health visitors now because there was so many, like you say, other factors and other agencies, they'd need to work together like em, social services, housing, education in order to address needs a bit more, but to make this thing work and trying to co-ordinate and facilitate that on the scale that you know, it needs to be is quite a task for the time that people have .. (P8 432-441)*

At the level of mainstream practice there is a perception that there is some distance to go in joining up services effectively:

> *It's you know, a lot of the higher social service children's services and what have you, em it's very interesting but I don't think the joined up working is there yet (P15 471-494)*

The emerging literature on this issue supports the view that there are complexities which need to be managed to facilitate successful collaborative working and that the interface between Children's Centre staff and health visitors is an area where collaborative working cannot be assumed (Machin and Graham 2008).

Power and control

Some participants suggested a power imbalance existed between health visitors and others involved in IPW, who were felt to be more in control of the process:

> *It seems to me certain people have a lot of influence* [in cross agency working] *and we've* [health visitors] *have got loads of information that nobody asks us about (P3 183-185)*

> *For some reason the health visitors have allowed themselves to be kind of ridden over really, em, not everywhere, but in a lot of places the voice of health and public health hasn't been heard. Education has taken over.....(P16 470-477)*

These examples convey a sense of disempowerment, perhaps linked to a lack of understanding of the health visiting contribution to cross agency working context. For example, that their in depth knowledge of local networks and established relationships with community members could enhance community development public health work. One participant expresses a view that in her experience, collaborative working to facilitate children's service reorganisation has been led by agencies other than health, resulting in a lack of health emphasis. This has been exacerbated by a lack of representation from health visiting and others who could provide that perspective:

> *It's quite interesting I go to a lot of these meetings and I think where are health care - school children's services or local authority they're presented, and I have let the powers that be know this, that you know there's things going on that you* [health managers] *need to be aware of and we need to you know, get our perceptions in there* [health visitors] *but it seems like, certainly with children's centres, it's just running away without health, even though they've got the health targets ....(P15 471-476)*

This raises an interesting issue about the source of policy. Whilst Every Child Matters (DfES 2003) has cross departmental implications and agreement at a national level it was generated from the Department for Education and Skills. This may be partly responsible for both a lack of ownership from the health sector and the lack of health

priority given by others sectors. In a collaborative change environment, successful engagement as a precursor to effective participation is essential to its success (McDonald 2004; Lines 2004). Systems for managing change evident in the data will be explored in more detail in the final findings chapter.

Role awareness

Role awareness is well documented as important to the success of inter-professional working (Meads and Ashcroft 2005). A study by Ellefsan (2002) compared the experience of collaboration of Scottish and Norwegian health visitors suggesting both groups experienced "collaborative strain" from lack of recognition of the value of their role to their respective healthcare systems. Previous discussion in this thesis has indicated that even within the health visiting staff group, a lack of awareness of a role standard can be problematic causing difficulties in working relationships. In an IPW setting some participants did not feel their role was well understood and getting their perspective recognised was something that they felt needed to be asserted:

> *What I'm finding increasingly difficult is with cross-organisational discussions, is the perception of other organisations about health for social care, em, you know, I'm meeting with them on a regular basis in terms of the em, every child matters agenda and the older peoples' agenda and they've still got this fixed opinion that health is operating out of the medical model of health ……. don't seem to be able to value or understand our [health visitors'] contribution in terms of the social em, aspects of you know, public health or health, you know (P14 72-85)*

Another participant described her experience in trying to advocate for her clients in finding suitable housing. She suggested the local authority which makes housing decisions was unlikely to share her health visiting view on factors that should be taken into account:

> *One of the problems is around, although I'm sure the local authority wouldn't see it this way, is around housing and staff particularly in relation to not going there, em, they try and see the families as well as looking at those families who*

are considered to be at risk in terms of child protection and vulnerable adults, it's looking at suitable accessible housing which isn't going to compound their additional problems em, that they've already got. (P14 61-67)

There is an implication here that this participant anticipated a conflicting perspective with those working in housing. Whilst this can only be assumption, it might be the result of previous negative inter-professional working experiences. This again links to the notion of role taking (Blumer 1969) and to the notion of the influence of expected outcome on input (Vroom 1964). Clearly having this negative anticipation will affect her behaviour in those interactions and her interpretation of how she is perceived by others. Another participant described an IPW context in which she felt the need to defend the nursing perspective and the value of its contribution to collaborative working:

I mean the meeting I had just before here, was around funded nursing care and continuing care assessment and up until just recently from the older persons' team in social care they couldn't see how a nurse, any nurse, could do a comprehensive holistic assessment, they felt that nursing was about assessing the medical needs of an individual and didn't touch on the emotional, the psychological, the social needs and how that would impact on them, particularly in the context of the community, em, and how that differed significantly from what perhaps they thought em, some hospital nurses did and obviously I personally I would challenge that any nurse is trained in that way, I certainly wasn't and that was a long time ago. (P14 86-95)

However this participant goes on to acknowledge that professional stereotypes are one of the causes of misunderstanding that impacts negatively on the experience of inter-professional working:

But I think how we're perceived also depends on a) as written in the profile, but also the sort of fixed cultural stereotypes, the social stereotypes about what the various disciplines and professions did and I think personally from my point of view that is a real barrier to try and change and make progress on (P14 95-99)

Unhelpful stereotypes, as a barrier to IPW, have already been identified as one of the drivers for interprofessional education (Carpenter 1997) and discussed in relation to participants' professional role identity. The participant in this example talks about having to defend nursing, in an interprofessional group, not "health visiting". This may have been because the discussion was about services for older people and less relevant to the health visiting role. It may also have been that the public identity of nurses is easier to defend as it is more visible, requiring less explanation than health visiting. Alternatively it may be that the participant felt more confident in her own nursing identity which was more resistant to challenge than her health visitor identity. Another participant agreed that stereotypes were sometimes a barrier to successful collaborative working. However this time it was his own stereotypical view of social work that he acknowledged, describing a situation in which his perception was challenged and changed due to increased role awareness established through interaction:

> *We had no real understanding of what their job was, no real understanding, and I think that was em, that was unfortunate because given the kind of close links you had to develop, and quite rightly so, with social services, particularly in areas of great deprivation, it kind of almost provided barriers that were unnecessarily, if you had a bit more information about how each other worked and I don't know if it was better when they worked, when they did part of their training together, I really don't know because I hadn't experienced that. I did think we were all a bit naïve and a bit sheltered. (P17 290-298)*

Conflicting values

Another comment made by the same participant was about the difference in social work and health visiting values and practice approach, which he suggested might be a source of misunderstanding. He describes a situation in which the health visitors were unhappy with the allocation of the social work service based on need, when their service was universal. The latter he suggested was defended by the health visitors as the right way to do things, which fits with the earlier discussion of universality being an underpinning philosophy of health visiting and core to their identity:

We were all filled with righteous indignation how these people could possibly ignore the needs you know, I mean that was perhaps a fault on the health visiting service because it was seen as a universal, we were the ones for everybody (P17 308-311)

This health visitor trained over thirty years ago around the time when health visitors changed employment from a local authority function to a specialist nursing service. His recollection of how he and his colleagues felt towards the social workers at the time would have been affected by education, experience and interaction with others in the context of that time. Whilst registered on part three of the NMC register his most recent caseload holding health visiting post was over fifteen years prior to being interviewed. At that time healthcare policy was characterised by an individual approach to public health and health promotion (DOH 1991). Whilst professionals did work together for the benefit of their patients, clients and service users, the organisations and cultures they worked in were not as integrated and as open as they increasingly are in the current context. When recalling his very early health visiting socialisation, which was in the late 1970s, he acknowledged a tension between health visitors and social workers:

I guess there was always a bit of rivalry between, professional rivalry between health visitors and social workers, and I think they'd just stopped being trained together when I started to train. (P17 267-284).

The change in employment context of health visitors (Dingwall et al 1988) and their move from local authority work to the NHS is likely to have necessitated a process of redefining and legitimising of their professional role identities in its new position in the healthcare system. This will have had a ripple effect to other professions with whom they worked closely, both in health and social care. An overlap in client group with social workers, who were still employed by local authorities and a shared community practice context may have triggered a degree of defensiveness from both sets of professionals as a result of new organisational commitments. Whilst this happened over thirty years ago, the same might be said to be still occurring with the emergence of new roles linked to traditional health visiting work, such as the nursery nurse or Children's Centre family support worker.

Collaborative confidence

As discussed earlier, the pre qualification development of collaborative working skills through interprofessional education provides an opportunity for individuals to develop the confidence to be able to articulate their own contribution to IPW. Dombeck (1997) considers the notion of professional personhood, an individuals' perception of themselves in relation to what is expected of them as professionals. This link between identity and role in action has also been established earlier in this thesis. Dombeck (1997) further suggests building collaborative relationships is difficult where they have role and identity insecurities and a lack of confidence. Role confidence has already been discussed as an essential component of adequacy for the public health role (Machin and Stevenson 1997). One participant suggested that confidence is not only important in maintaining a stable professional role identity it is also an important component in legitimising the public identity of health visitors in a collaborative working context:

> *And if we're* [health visitors] *not confident with it within health then you know, how can we expect to be working with other people in a public health, you know, sort of forum without, you know, if we haven't got the skills ourselves then other agencies aren't going to respect our input.. (P8 456-458)*

Another suggests health visitors increasingly need to defend their mode of practice, its efficacy and its relative value:

> *I think the spirit of health visiting has been lost ....because of constantly working defensively or with em, the legal aspects of practice..... looking over your shoulder, you know, they're* [other professionals] *trying to take over our roles well, we work defensively, as opposed to em, supportively. (P16 514-518)*

The suggestion that the "spirit" of health visiting has been lost is perhaps a reference to a perceived demise of a collective identity, leaving individuals feeling vulnerable in the system in which they work. Re establishing a sense of collective identity in their local context might go some way towards strengthening the resilience of health visitors during time of transition and change. This is especially important in an

interprofessional, interactive situation. Raising the awareness of others of the contribution of health visitors is an important pre requisite for successful collaboration where interprofessional synergy and collaborative advantage is the aim. "Synergy" in this case refers to the added value to be gained from the process of different professionals effectively working dynamically to pool their resources and commitment. Effective interprofessional synergy should result in a better outcome for service users.

Theoretical Summary and Conclusion

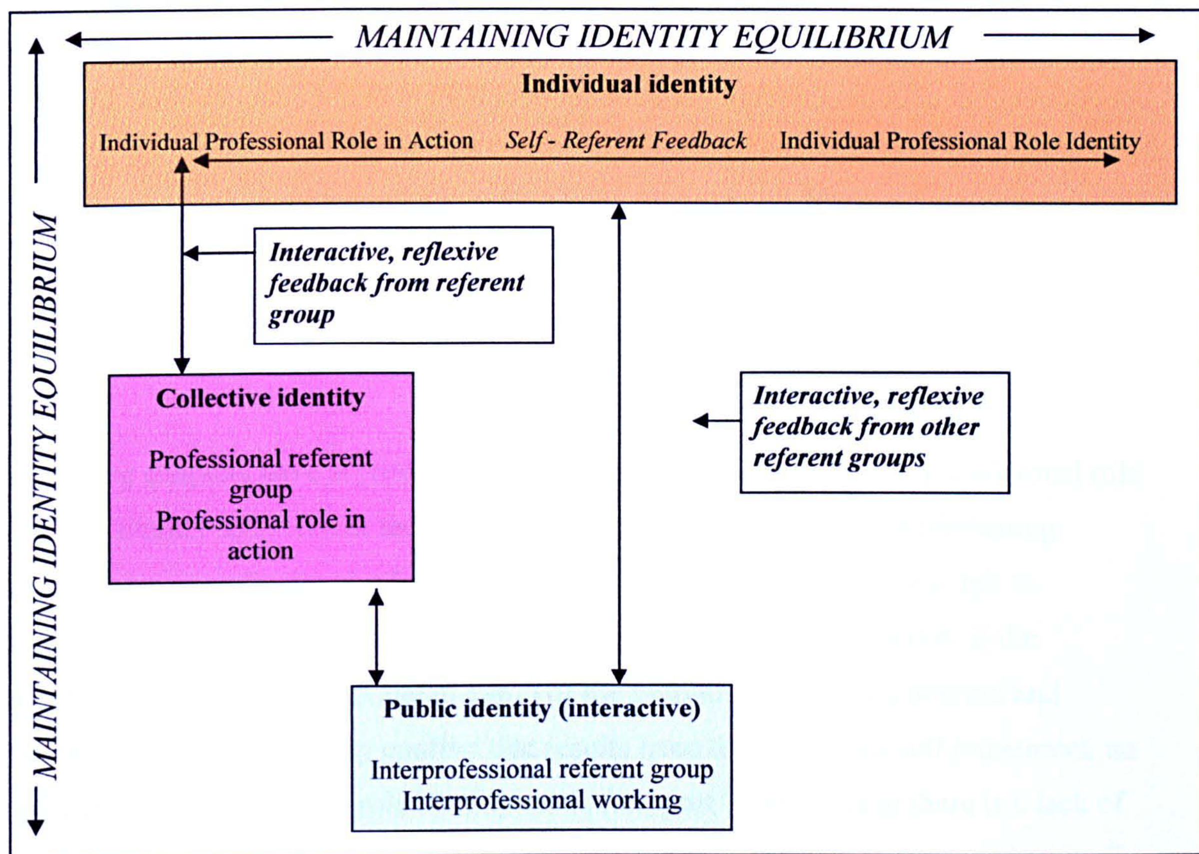
This chapter has presented the category Inter-professional Working (IPW). It has shown that relationships with other professionals are significant in the health visitors' continuous reaffirmation of their own professional role identity and its legitimacy. It has demonstrated links between the degree to which health visitors have a nursing identity and their working relationships with others from the medical and nursing knowledge domain. It has also explored the degree of comfort with which health visitors work across professional and organisational boundaries and the influence of this on their practice and identity.

Chapters six and seven have put forward the theory that the professional role identity of the participants was inextricably linked to their professional practice experience. In keeping with the interactionist theoretical framework of this study, it is suggested a self referent feedback mechanism shapes and re shapes identity, through interpretation of feedback that occurs during social interaction. A negative practice experience that is perceived to devalue the contribution of the health visitor in an interprofessional situation is likely to result in a feeling of professional displacement (Rapport and Wainright 2006). This in turn may impact on the self judgement of the health visitors feeling of self worth. How this is managed, whether that be internally by the individual health visitor or externally by those facilitating collaborative working, will influence the degree to which the feelings of displacement are successfully incorporated into the individuals' identity as a positive change. The management of this change will also affect the degree of psychological disequilibrium triggered by the negative interaction, which potentially could result in role crisis.

Where the collective professional role identity of the health visitor group is unclear, individuals are left vulnerable in IPW situation. Having no cohesive referent group against which to judge their own role standard health visitors leave themselves open to challenge from the wider interprofessional team. One response might be the alteration of the individual's role in action to re establish equilibrium in the local context and contribute towards interprofessional synergy in the local delivery of services. Reframing their own identity through "self referent" feedback (Collier 2001) can then be used to legitimise this change and re-establish internal equilibrium. However, where an individual has a strong resistant identity that is in conflict with expectations from the interprofessional team, this is likely to produce disequilibrium within the team and an antagonistic working environment in which collaborative working will struggle to be successful.

For the individual in this situation, their behaviour might become defensive or they may take strategies to avoid the change and continue to practice in their usual way, legitimising this as a way of protecting their identity against the challenge from others. This type of behaviour in an IPW context might then result in a public identity, impression or image through which they are perceived as uncooperative and incompliant. This might be exacerbated in an IPW situation where professional hierarchies exist, formal or informal, and the external influences are perceived to be in a more dominant position than the health visitor. The complex interplay between individual identity, collective identity and an interprofessional context, where public identity is of relevance is depicted in figure 12:

Figure 12: Maintaining Identity Equilibrium – the interprofessional dimension



Data from the participants in this study suggests that change toward a public health way of working, as an external trigger, has produced both types of response. There is evidently a lack of collective identity across the team in relation to public health working, which has resulted in a diversity of practice response. This lack of consistency within the health visitor group means that their public identity is also inconsistent. Where other professionals are unsure of the "role standard" of health visitors, this is likely to affect their role expectations, leading to confusion and potential conflict. To add to this complexity data from participants has also indicated that there are several systems which influence how practitioners carry out their role in action. It has shown that these systems are sometimes in competition with each other, and that even within more stable practice systems, the focus of their priorities have changed over the course of this study. This adds an additional level of complexity to an already confused picture of the experience of the health visitors in this study, in negotiating their changing professional practice context. The next chapter builds upon up this discussion.

Chapter 9 – Local Practice Micro-systems

"Observe how system into system runs,
What other planets circle other suns"
(Alexander Pope – 1733 - An Essay on Man)

Introduction

Preceding chapters have argued that a process of external feedback on professional role and the internal self referent feedback (Burke 1980) are important in maintaining equilibrium in professional role identity. Where feedback is negative enough to significantly challenge existing identity, it is suggested that there is a risk to the psychological equilibrium (Caplan 1961) of the individuals. Without internal and external management of any conflict that results from the process of self judgement, an individual may experience role identity crisis (Rapport 1996). Where there is a lack of agreement between professionals in the same group as to the core nature and intent of the role, there is a risk of identity displacement. As discussed previously, Collier (2001 p220) suggests

"how a role is acted out is the starting point for group consensus".

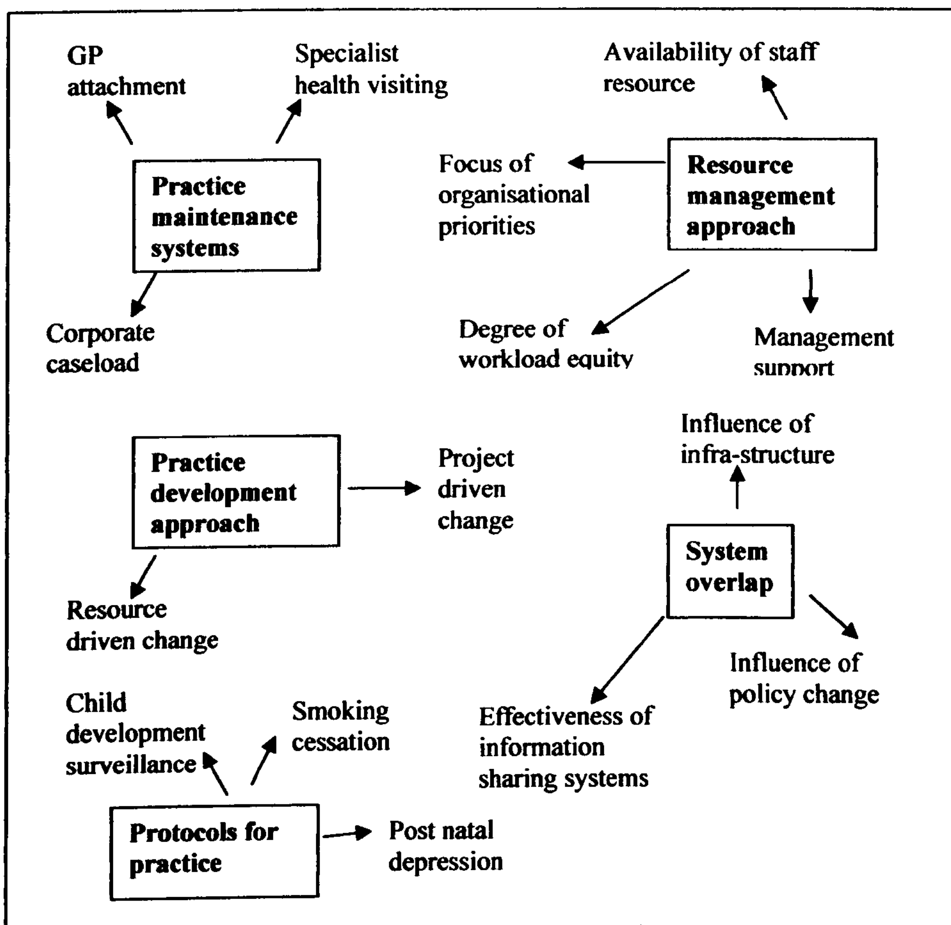
In addition he suggests that where the same role is used in different ways the role standard, against which individuals assess their role identity, will be reconfigured differently. This appears to be the case for the health visitors in this study who evidently work in a different ways and have individual perspectives on the place of public health in health visiting that are at times contradictory. Despite this diversity, all appear to align their professional role identity with health visiting and there are at least some areas of consensus. Giving these a higher profile may help to maintain some form of collective identity equilibrium across the health visiting group.

The discussion of findings so far has largely considered the data collected at an individual level. It has explored its meaning for the participants and their practice. In

addition, a relational discussion has been undertaken, of the influence of social interaction with others on the professional role identity of the individual in their practice context. It is suggested that any micro level analysis of interaction cannot discount the influence of the social structures in which the interaction takes place and the reflexivity between interaction and context (Cast et al 1999).

This chapter focuses on participants' experience in the system and its influence on their professional role identity. It concludes by adding final components to the process model developed in previous chapters to illustrate the dynamic relationship between factors influencing the process of maintaining identity equilibrium (figure 4). The following picture represents a situational overview of the data category Practice Micro-systems.

Figure 13: Practice Micro-Systems – category properties



Practice Maintenance Systems

GP attachment

As indicated in chapter six, the main context of practice described by the study participants is as individual "attached" health visitors within a GP practice or a corporate health visiting team "aligned" to GP practices. Both systems for practice are part of a primary healthcare team that is focused on work with one or more GP practice populations. Those health visitors working individually within GP practice primary healthcare teams (PHCT) generally perceived this model as a supportive system, a view which is well captured by the following quote:

> *So for me that is why I want to be GP based, 'cause of the GP links, it's also, because clients come to see GPs and the practice nurse, not just to see me it's easier to maintain contact with them, 'cause you see them in passing, you see them opportunistically, em, and I suppose the bottom line is that it would perhaps give me better job satisfaction because I feel it's more holistic in a way and I can communicate with other members of the team like the practice nurses, em, counsellors, psychologists, you know these are all people that work here and if I'm referring clients to the counselling psychologist again, it's much easier, you know the day that they're in, you know that they're around, you know that you can catch them and when you're always pressured in your job, those things are important for making extra time. (P6 189-201)*

This participant clearly describes an effective communication system within the PHCT in which she feels a valued. It also depicts as a working environment conducive to supporting individualised, GP population focused, caseload working. Whilst this been the prevailing model of practice for some time, with other models of practice at the margins of the system (Craig 2002), this model has recently been challenged through the emergence of corporate caseload working.

Corporate caseload

The recent survey of health visiting suggested that around fifty percent of health visitors are now working in teams sharing corporate caseloads (Craig and Adams 2007), which represents change from the traditional model of individual caseload working. In this study there was disagreement on the value of the corporate approach, as a system to support health visiting practice. This has implications for those managing transition from one way of working to another. The corporate caseload approach was viewed by some participants as a way of ensuring a fairer, more supportive approach to sharing workload:

> *We all tend to share that a lot more evenly. And against the child protection it means you do lots of joint working or em, I mean when I first came here the health visitors were very inexperienced, just recently qualified and they found it really useful just co-working to do sort of team supervision and things (P12 302-305)*

However for other participants, the corporate caseload was described as having many disadvantages. One participant had worked in both types of practice systems and favoured the individual caseload. One of the key reasons given for this was the perceived impact on the potential to develop effective relationships with clients, which as has been discussed, was viewed as one of the core elements of the health visiting identity:

> *To my mind I feel that the advantages of corporate working are for the staff but the disadvantages I feel are for the client, from having worked in both ways, but it may be that that's my perception having come from a long time working in em, GP attachments in a caseload that I know extremely well and had very good relationships with clients, in fact I'd done a lot of proactive work, I don't feel I'm effective here (P8 2:139-145)*

Milligan (2003) studied the effect of spatial displacement on identity. Whilst her study was not conducted in healthcare setting, it had some resonance in seeking to understand

the changing position of the participants. Participant eight was still located near the GPs in her new corporate caseload practice context. However, in terms of physical space it represented a shift from being the only health visitor in a GP surgery with her own office. This may have caused a degree of identity displacement (Milligan 2003) and be part of the reason why the corporate caseload is viewed more negatively than the familiar context left behind. Milligan (2003) concludes that change of physical space needs to be actively managed in order to help individuals successfully make the transition from the old identity to the new. This discussion will be returned to in subsequent chapters.

Other participants discussed the corporate caseload suggesting it could affect communication generally and the continuity of their relationships with clients, thereby reducing client confidence in accessing them when needs arise:

> *I really think in the long term I don't think we'd get a great deal of satisfaction from it, it's in and out of cases and I don't think you would, could build a relationship up with someone. You've got to tell them the basis of the relationship at the beginning, but they're going to know you're going to be passing back into the pool after six or nine months and that's going to feel they can't come back to you, no matter what they say, and I've been in my caseload quite a few years now.....you just get more and more involved with all the different families and people come to you more and seek you out, and I just think you'd lose that (P4 572-581)*

> *Communication is a massive issue and I feel that I'm struggling to maintain continuity of a kind and I'm struggling to maintain effective communication a lot of the time (P8 2:110-112)*

Interestingly in the examples above, participant eight was working with a corporate caseload and speaking from experience. Feedback both internal and external on her role enabled her to reflect on the experience and consider its fit with her identity. Participant four had not worked in a corporate way but clearly felt strongly on the issue. Potentially she was making a judgement about the efficacy of this model based on the public

identity of her colleagues, whom she had either observed working in this way or heard talk about it. She was then interpreting the potential impact of such a change on her values and identity. As there is a move toward corporate working nationally (Craig and Adams 2007) there is potential for it to be regarded as significant threat to the health visiting identity. The corporate team is located as a sub set of other practice systems involving other professionals. The previous chapter has shown that interprofessional working (IPW) can influence individual practitioners' self perception.

Despite the perceived risk to identity that the change to corporate working has engendered, it was suggested that health visitors working in a corporate way locally, were trying to minimise the impact of the change on the client relationships:

> *For others who have always you know, valued the continuity and the relationship which is fundamental to health visiting, em, regardless of what some people think, em, they have managed to facilitate that continuity and very effectively negotiated the allocation of active families based on their own experience and therefore despite the corporate caseload have maintained that effective service. (P14 484-489)*

Whilst the corporate caseload appears to have some particular defining characteristics, it seems to be open to variation in the development of its internal processes. Without consistent management across the PCT this clearly has the potential for the creation of different "role standards" which, it has been argued, can split the staff group and to create differences in professional identity (Collier 2001). One participant conveys a problematic reduction of role clarity and a feeling that the system is not as facilitative as it should be:

> *It's supposed to be according to the number of hours that you work, your capacity and also things like holidays, so if you go on holiday the week after, ideally you're not supposed to be on a case that needs work because you wouldn't then be able to plan it for the week later, so we do allow for ideally we're looking at the capacity and workload of team managers. I personally at the moment don't feel that's working very well in the team, em, for various reasons (P8 2:89-96)*

The working system described above is evidently characterised by rigid micro systems of referral and active or inactive caseloads. Such a system be said to challenge the professional autonomy of those professional involved in it. There is also an added complexity of an overlap with GP attachment as a practice system. Earlier discussion of interprofessional working has established that the health visitors appeared to defer to the priorities of GPs they worked with. This interactive phenomenon, it has been suggested, is potentially the result of previous nursing experience and identity, in which doctors had a perceived higher status in the healthcare system. The overlap between the health visitor led corporate caseload team and the primary healthcare team led by the GP caused problems for participant eight:

> *We're all aligned to one of the surgeries so the GPs have a link with the main health visitor, and I'm linked to the practice here, so I'm actually based in an office which is over by the surgery, so I'm based with the district nurses who just work in one practice and I'm based with the nursery nurse who works with the whole team. Unfortunately we don't have one office which is a huge disadvantage so most corporate teams which have one office in which the team is based, we actually have two keypads between us so you're constantly between offices so the active case load level is housed in our office and the inactive case load is housed in the office of three other health visitors plus the public health nurses ....so all the rest of the building appears to be PCT premises but it's joined on to GP premises, it's quite complicated. But it does make communication more difficult...because we've two message books to check. Two answer phones to check, with doors locked in between. (P8 2:23-44)*

This is a detailed description of what is clearly a very complex system within which the health visitor is expected to maintain a high standard of practice and be professionally accountable. Where there is confusion and reduced role clarity there is the potential for the individuals to feel dissonance about their role in action when reflected on in relation to their identity and core values:

Communication is a massive issue, massive issue and I feel that I'm struggling to maintain continuity of a kind and I'm struggling to maintain effective communication and a lot of time .....the organisation takes a massive amount of time and because we're in two different offices and people working different days huge amount of time. I've spent communicating relevant information to the relevant person, and they each cover all the clinics so the clinics go on the relative so you do take up people's times at every clinic every week and then you've got to communicate all of that and I feel as if I'm a headless chicken and I'm completely em, I'm really, really stressed about it. (P8 2:110-120)

I've recently had meetings and discussions with the GPs as well, they're thoroughly dissatisfied (P8 2:139-147)

This participant was clearly feeling very uncomfortable in her practice environment through not being able to carry out her role in the way she would prefer. In essence her professional autonomy was perceived as having been compromised. This has been exacerbated by the negative feedback from the GPs in the local practice context. It is likely that the GPs are more used to interacting with health visitors an individual model of caseload working. However, there is a possibility that where rigid practice systems are set up, such as that described by participant eight, all professionals interacting within them, may potentially feel disempowered. These negative feelings may cause them to re examine their professional role identity in terms of professional autonomy and accountability. There may also be the tendency for individual to abdicate responsibility blaming any issues on "the system". Without collecting data from the GPs in this situation any discussion of their perspective can of course only be conjecture.

In creating new practice systems policy makers need to be aware of the impact on both individuals and systems. This supports the "transformative" change management work of Karp (2005) discussed in the literature review. He suggests that the most effective way to manage change in a complex system is to engage the individual, by acknowledging their past experience, values, attitudes. Furthermore it has been suggested that a change process that does not allow for the emergence of unpredictable

individual responses and levels of engagement is likely to be ineffective, especially in complex systems (McDonald 2004; Higgs and Rowland 2005).

In this study there is a perception from someone involved in leading change, that despite a corporate practice system being introduced, some practitioners have resisted major alteration in their role:

> *They still appear to be thinking as an individual health visitor with their own individual caseloads, it's just they happen to be working or sharing an office with a group of people and they're the end, and that to me there the resemblance to a corporate caseload or a team ends. (P14 476-480)*

There is no evidence in the data that participants were aware of being engaged in an explicit change management approach to introduce them to this new practice system. Of course there may well have been a strategy just not one that was visible. Disequilibrium through lack of "fit" with the existing role identity may have been a consequence of the change that was unanticipated at organisational level. Interestingly there is a perception that some individuals have used the corporate system as a way of reducing their work:

> *If we're looking at sort of some of the evidence around some of the corporate caseload and listening to the experience of health visitors who've been health visitors for many years they've seen this come round, you know they used to work in teams, although it wasn't called corporate caseloads. I think some people have used it as a way of getting out of the work, and this almost mental compartmentalisation of active/inactive caseloads is not without its problems .....the fact that mentally they're busy looking at, you know after a certain period em, not necessarily based on robust assessment which was my original understanding that somebody would be determined inactive, em, people are put into a drawer as inactive and basically forgotten about unless that individual then presents themselves with a problem. (P14 447-461)*

Corporate caseload working is presented by participants as a reactive service. In the previous practice system individuals may have had more autonomy to be proactive,

without recourse to other team members for the use of their time. However in this example, the behaviour of some individuals is perceived to be the root cause of inefficiency not interaction with the system. This view was expressed by Participant fourteen who was in a leadership role and also a health visitor. It is likely to have been affected by her professional identity, with value placed on continuity of responsibility for families and the importance of health needs assessment driving their work. She also indicates a degree of personal discomfort with some aspects of the "inactive" caseload concept which as has been discussed, may be perceived as challenging the notion of a universal service. She may also feel some dissonance and frustration in her leadership role about the way in which her health visiting colleagues have engaged with the change.

Despite the difference between an individual model of practice of some participants (P2, 3, 4, 6, 8, 9, 10, 11) and corporate caseload working of others (P8, 12, 13), both systems for practice might be said to be mainstream and sit within the general system of the primary healthcare team. The communication and interaction processes within the two models are notably different but the same actors are present within the system. Interaction on a daily basis around shared clients reinforces reciprocally each other's identities, through a process of interactive feedback that is both external and internal. An attempt has been made to illustrate where both types of mainstream health visiting are located within other systems (figure 14). Participant eight appears twice due to her change of job roles over the course of the study. This form of map has echoes of that proposed by Clarke (2005) as a "social world arena map" in which the subject of study is visually located with other relevant contextual elements of the situation. To fully represent the position of the participants in this way, the previous maps of the data categories (figures 7, 9, 11 and 13) which Clarke would call "messy situational maps", would need to be inserted into this picture. This picture is a simplified version to illustrate the location of the participants in the system.

Figure 14: Mainstream HV Roles in Context

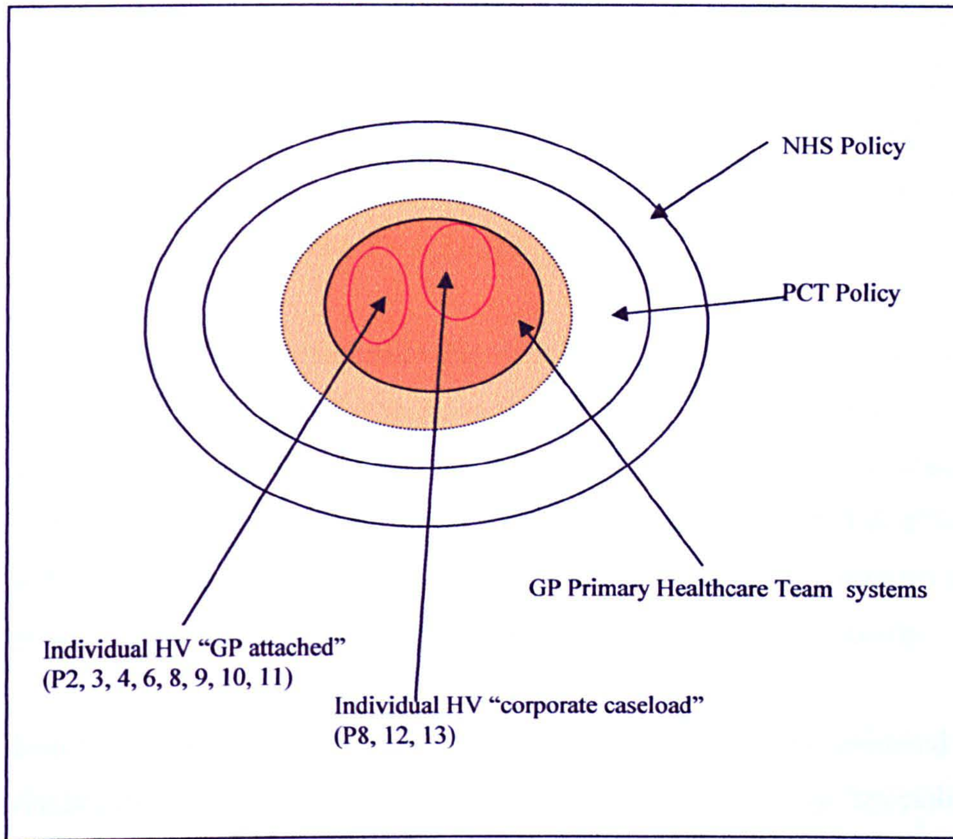


Figure fourteen also illustrates levels of system in which policy can be re interpreted, from national policy development through to individuals working in practice. These systems support some of the situational conditions which affect the interpretation and interaction of the participants in negotiating their changing professional practice context.

"Specialist" Health Visiting

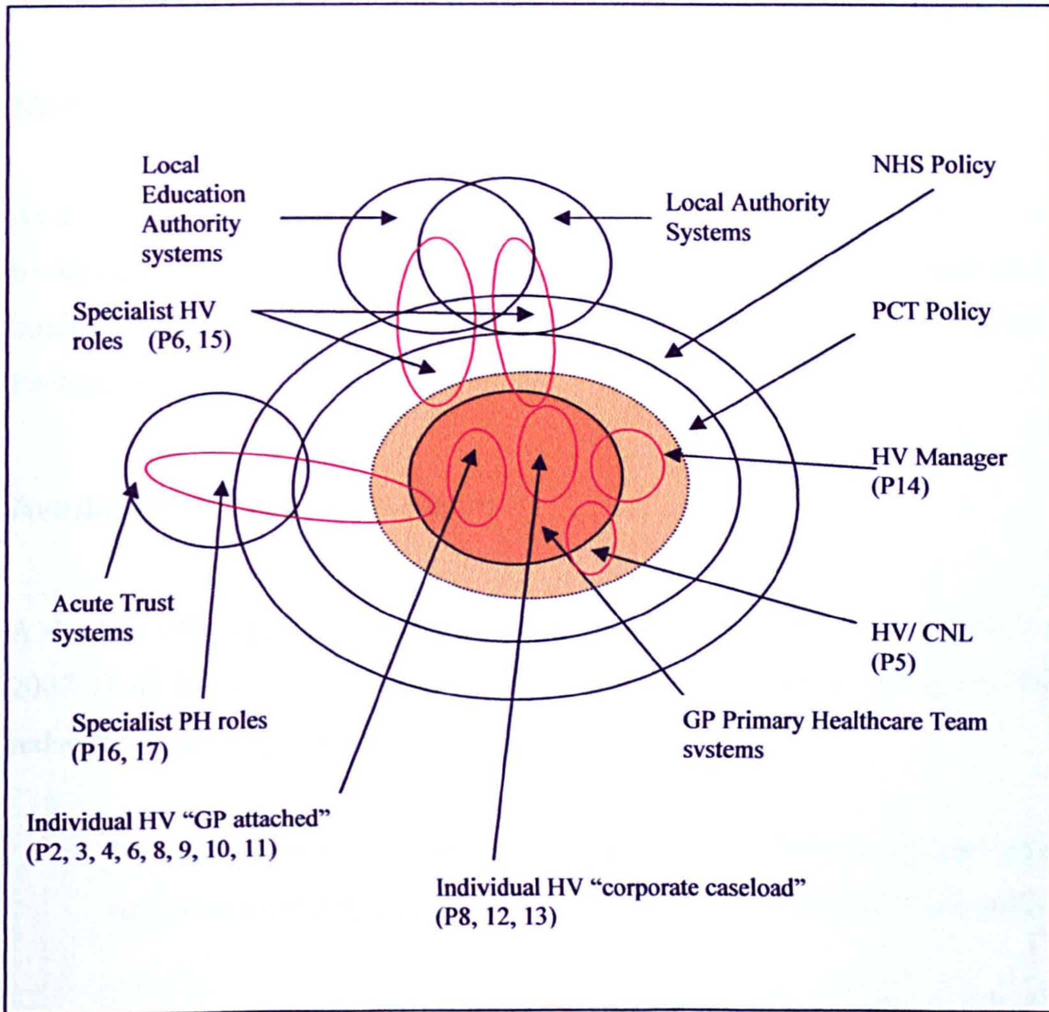
As indicated in previous discussions, some health visiting participants had "specialist" roles and atypical models of practice. For example one participant (P6) worked in a role supporting homeless and transient families not GP attached. Whilst she had previously been in a mainstream post, the nature of this role meant she worked more closely with the voluntary and education sectors, social care agencies, community based health teams:

*If I thought I liaised a lot in my last job, this is, there's much more liaison because I will be working with people who are from within ******but they are possibly coming from any of the four localities as opposed to being based in one locality in my last job. I also visit people who have been placed from out of the area so I'm liaising predominantly with housing, em, community mental health teams, GPs, er, social workers, school nurses on occasions and obviously on a health visitor's list (P6 2:85-90).*

Two other participants had roles that were partly (P5) or wholly (P14) in the health visiting leadership/ management domain in the PCT system. They each shared a historical context with the mainstream health visiting model of individual caseloads. Participant five, as has already been mentioned, had a small practice attached caseload and was a clinical nurse lead (CNL) in her locality. Participant fourteen was the manager responsible for, amongst others, the health visitor staff group.

Two other health visitor participants also worked in roles not considered to health visiting roles per se, being employed by the NHS acute Trust in "specialist" public health roles. One role (P16) relied on referral into the service from GP practice attached staff and could result in collaborative working. The other (P17) relied on collaborative working with both health and social services. The systems for practice, the parameters of policy, and priorities are different in these specialist roles to those of mainstream health visiting roles. In addition, the participant who worked in Surestart (P15) is difficult to place in the system given the interprofessional, multi agency nature of her work. She was employed by the PCT to address health inequalities through public health work, but did not have "health visitor" as her title and she managed a team of people who were employed by the local authority, giving her a complex set of organisational priorities. Figure fifteen is an attempt to depict, albeit in a simplified way, the location of these roles in the wider healthcare system and the overlap with other systems. Participant six appears twice also due to her role in change during the study:

Figure 15: Specialist HV/ Public Health Roles in context



The picture illustrates in a simplified way, the distance in the system between specialist and mainstream health visitor roles. It also attempts to show, through the coloured area, that the link between all health visitor participants is identification with a shared health visiting practice domain. If individuals in these disparate roles are to maintain a collective identity, there needs to be opportunity for them to interact with each other. However, the network of practice systems in which the study health visitors work is complex. This makes it difficult to determine a common reference point for health visitors. As has been discussed this reference point is necessary to facilitate ongoing peer group feedback on their health visiting collective identity. Where this feedback opportunity is minimal then the risk of the development of disparate health visiting professional role identities is increased. Some local systems supporting participants'

roles are formal, organisational systems. One such system described is the local approach to resource management and which is perceived to influence their capacity to change their practice.

Resource Management Approach

As discussed previously, public health work was perceived by some to be extra work to be developed and engaged in where time permits. This being the case there is an implication that this work requires staffing resources above that needed for the maintenance of normal practice systems.

Availability of Staff Resource

A shortage of health visiting staff is a national issue (Craig and Adams 2007; Lowe 2007; DOH 2007a). The health visitors in this study were clearly feeling the effect of reduced health visitor numbers in their locality:

> *The reality is that we're actually struggling, em, to fill any of the health visitor vacancies even if they're doing the normal caseload work (P8 465-467)*

> *The big issues in health visiting at the moment in the locality where I work because there's a huge shortage, people are leaving, (P16 239-241)*

In particular, where there was a shortage of staff in the form of vacant posts, this was perceived to have impacted on their ability to develop other work in relation to public health:

> *My idea is to put more health visitors in and attack this need for public health initiatives, it's not going to happen but I think that's the way forward if the government wants all these changes then it should be putting the money in there (P4 588-592)*

The notion of public health work being outside of mainstream health visiting work and something that should be done by specialist is reflected in the following quote:

> *If there were more health workers without a caseload what we could then do in the background of it all, is get a good project, have to time to work out what is really needed, then come together as a group to facilitate it. I think it would work better like that (P4 66-69)*

The inference from this is that additional resource is needed, not a reorganisation of the existing workforce. Interestingly this participant did engage in public health work in a focused way around smoking cessation, within her mainstream role. As considered previously, she defended this as a legitimate part of her work in the face of negative feedback from other colleagues, who considered they had not time to do public health. The notion that such work could be done better with more staff with defined, legitimate roles for public health, implies that she is perhaps attempting to find and negotiate common ground with her colleagues.

In human resource planning, increasing the number of mainstream health visitors into a workforce without a cohesive collective identity may not be an effective model to increase collaborative public health work. Consideration should be given to a participative change facilitation that enables health visitors to determine the best use of any new resource to maintain identity equilibrium in their local working environment. This approach would give existing staff the opportunity to discuss and agree shared health visiting values as a foundation for a more stable collective identity. Establishing shared values in the change process (Sullivan et al 2002), taking account of current professional practice context, will enable individuals to work towards re establishing a collective sense of identity. A team that feels like a team is clearly more likely to be effective in collaborative working for public health. However, this process of change requires skilled lateral leadership to be effective (Dopson and Waddington 1996; Kuhl, Schnelle and Tillman 2005).

Focus of Organisational Priorities

In theory, well defined employment structures and clear organisational priorities for the service, should provide a more stable interactive working environment (Riley and Burke 1995). However discussion has shown that the health care system is a complex interplay between: social care and education; individuals' interactions; professional identities; and the local systems which contextualise their individual role in action. For example some participants perceived their employment status as inhibiting their autonomy, sense of belonging and the development of public health work:

> *There's pressure on me from the Acute Trust as well, they want something in the last couple of weeks .... because they're not addressing the government targets, they're getting slightly twitched, are we doing anything, what is going on in the Acute Trust? Well actually nothing's going on in the Acute Trust, and yes do have a.....strategy written but done in my own time. They didn't pay me for it as much as I feel quite passionate about the work I'm doing......... I clearly can't continue to work and not be paid for it. But you know, it's quite acceptable, people think it's OK for me to do that. (P16 357-367)*

> *I think we are a good practice but they still see the staff employed by the Trust as simply attached staff which is frustrating at times... if you're late getting back from your visit there's a bell on the back door....they won't give us a key because we're not **their*** [my emphasis] *staff (P3 198-201)*

For one participant a range of employment arrangements within her team was noted to add complexity to, though not inhibit, her collaborative developmental work:

> *I mean some of us are employed by PCTs, some by ****healthcare, some by the council, Barnardo's etc so it's quite interesting you know, just the different terms and conditions, holidays, things like that, but it's certainly for the clients seems to work (P15 238-242)*

Differences in employment conditions such as salary have been noted to be a barrier to successful inter-professional working. However the interprofessional working experience of participant fifteen implies that the cross agency nature of Surestart minimises the impact of other, external employment systems. This may be the result of a local internal system that sustains a collective goal and agreed local organisational priorities.

For other participants working in different contexts, the priorities of the organisation, conveyed through interaction with their managers, had a negative impact on their perceptions of the capacity for public health work in the PCT:

> *It's still very difficult to be able to re-focus when you're tied to caseload work and there are two posts now ...., well there's one post that's essentially community development and another post which is part time community development and part time caseload, so they're the only posts that have actually got it specified within em, job description (P8 179-184).*

The latter participant described two emerging new roles that were created in an effort to "pump prime" public health work across the PCT. This has echoes of the model suggested by participant four as the best use of resources. However in a second interview two years later, the changed priorities of the organisation were clearly evident in that the public health visitors had been redeployed into caseloads where there was a staff shortage:

> *We had a situation recently where there was five short in another area, there were health visitors that were pulled out in that area, the ones doing the public health work (P8 471-474)*

This was also discussed by another participant in a second interview:

> *And because of the shortage of health visitors I think from the management's point of view, although they say, well we were the pilot for the em, whole systems approach, but I think their priority is making sure they have got staff in the practices and for example, there is one health visitor had a small caseload*

and half development role in an area that really needed some workers in there and shortage of staff, well there's two of them actually, pulled out of the development work and put in caseloads and so I think that still happens (P4 2:518-529)

There is an indication here that organisational priorities change over time. The employment of two health visitors for public health work occurred around the time of the Whole Systems Pilot work (DOH 2001c) when the organisation perhaps gave it priority. Two years later, and no longer part of the Whole Systems initiative, caseload work, focused on GP practice populations, had evidently been prioritised instead. However, the organisation could justify this action if they were of the opinion that public health should be mainstream practice and not specialist or separate. This is reflected by participant fourteen who in her management role suggested public health to be core business, giving an historical perspective on the development of public health in health visiting:

Some people who can still remember working and were part of a very pro-active workforce when they were employed by a local authority and public health was their core business, so what they see is just em, an almost re-affirmation of public health values which the old health visiting service was based on and for some were sort of led away from when they came out of local authority and were placed with em, GP populations and they were, there seems to be sort of two different thoughts really, for some of the newly qualified health visitors, they see public health as obviously in terms of explicit in what they do and that this is new, em, where you've got the older ones, who as I say, who changed in the past were working as part of local authorities or who have just been a health visitor a long time and basically can't see what all the fuss is about, public health has always been their business. (P14 108-122)

This perception from someone in a management role has important implications for those she manages, which includes both GP attached health visitors and some in more specialist roles. For those who share the same view, any public health work undertaken by them is likely to be legitimised as part of their professional role identity. Such legitimacy has been established as important to optimum role performance (Machin and

Stevenson 1997). Those who express a need for more resources to do the "additional work" will need to enter into negotiation at a local level to gain organisational support and legitimise their perspective. The outcome will be influenced by the availability of resource. It will also rest on the success of an individual's negotiation and which party is prepared to re revaluate their perspective.

Degree of Workload Equity

A more equitable caseload, in terms of numbers of families and complexity of need, would, it was suggested, result in making more time for collaborative public health working:

> *That is an issue that does need to be looked at with, that we're all going to be looking at in terms of the weighting of caseloads etc, maybe looking at more corporate caseload work, which would free up more time em, and to create more equity amongst health visitors so that all health visitors are able to develop initiatives and have an equal amount of time (P8 334-339)*

However, Participant four suggests that were she to get more families on her caseload to make it more equitable, her capacity for public health work would be reduced. This supports the view that in times of pressure on resources, individual caseload work is prioritised over public health work:

> *I just wonder what's going to happen when you look at everybody's caseloads, whether shifting it too much might mean you've got less time for the public health work (P4 536-538)*

This echoes my own experience described in the introduction where colleagues had given negative feedback about my development of a community development, public health focused role.

Management Support

Another issue that emerged from the data as relevant was the level of perceived role support from management. In theory having a health visitor as a manager this should give an added strength to the position of health visiting as a profession, in negotiating its standing within the local healthcare system (Giddens 1989). However, this perspective might be said to be built on a premise of a sense of collective identity from within the professional group, shared at both the level of practitioner and manager. Discussion thus far has indicated this not to be the case amongst the study participants, especially in relation to their public health role. Management support for a role has been discussed as an essential pre requisite for optimum role clarity and performance, along with perceived role legitimacy and adequacy for the role (Machin and Stevenson 1997).

Some participants perceived their management to be supportive of public health developments, perhaps as a result of a shared value placed on public health work:

> *It's encouraged by management* [health needs analysis], *encouraged by the projects like this project* [Whole System's Pilot] *that we're taking part in at the minute. It's very much seen as good practice (P8 254-259)*

If the manager had different values she may not have been as supportive. Another participant discusses management as being increasingly distant from practice decision making, with a subsequent perception of increased individual autonomy:

> *I remember when we all started doing hypertension clinics they* [management] *were saying no you can't because there won't be any cover when you're on holiday now you can virtually do what you like (P3 52-55)*

Others perceive this distant management style as unsupportive though they are perceived as available should there be a problem:

> *The hands off management. We see them ....once a month, we have a professional forum em, where we're updated on issues but that's for all health visitors across the whole locality so if there's something there you could bring it*

to the team, but otherwise you would see a manager if there was a problem (P8 203-209).

One health visitor who felt autonomous in her role felt this had been compromised recently by management, a fact she was unhappy about:

> *Because we were told to, put our names down for a working group* [public health – Whole Systems Pilot*], that was the expectation that we all had to do that, but I don't like being told what to do (P6 152-153)*

Another expressed her opinion of health visiting management with a touch of sarcasm:

> *They* [HV management] *leave you alone. And praise you. They are very good at praising us all (P4 183)*

Clearly there are implications for health visiting managers in understanding an individual's perceptions of their efficacy. Arguably this is especially important if a collective health visiting identity is to be supported by organisational hierarchies. A shared value base and sense of priorities between health visitors and their managers will be an important source of feedback. Through this process equilibrium in their reciprocal identities can be maintained and their role legitimised. This is especially important in strategic working with colleagues in other services and agencies where individuals at any level may be seen to represent the views of their professional peer group.

Another health visitor in an atypical role expressed a view that her managers did not understand the differences between her role and mainstream health visiting and thus devalued it:

> *But the point I'm getting at is that I was raising the issue that to visit fifty families that are all in crisis was intensely stressful and needed more manpower for the want of a better word. One of the senior nurse managers* [a qualified health visitor but responsible for both staff groups] *actually said ……this is what other health visitors do, visit the people in crisis, well I would argue they would not have fifty families that they're expected to do this. That would be very*

unusual and I felt that I was very taken aback by this person's response (P6 2: 434-437).

The difference in perspective of managers from the same professional group as her was evidently a surprise. That said she had herself previously indicated her specialist role to be very different from her GP based role. This suggests her public identity (Foley 2005) in that role was not as well established and its "role standard" is not well understood. It appeared important to her to legitimise it within the scope of health visiting, and as such, maintain its congruence with her professional role identity. She described taking some managers out with her into practice to enhance their understanding of her role:

I have a director of nursing that has come out with me and I have two line managers that have come out with me, em, and I think that's really valuable for them to do that so they can actually see, understand the concept of it. (P6 2:477-481)

Taking action to address this issue is perhaps an example of "project identity" (Castells 1997). Given that her managers may not have been in practice roles for some time, the experiential feedback on her role offered them an opportunity to reframe their perceptions in relation to their own role identity. This may subsequently have led to a change in their management approach and more positive future interactions with participant six. The example might also be considered an attempt at influencing policy (CETHV 1977) through changing management's impression of her role (Goffman 1959; Foley 2005).

In a discussion relating to the redeployment of the health visitors out of public health roles into case load work one participant felt health visitors in general were not valued within the system:

I think health visitors were the most disposable item, which is quite interesting, ...(P8 478)

For this participant there is also a feeling that in a climate of scarce resources, management have unrealistic expectations of practitioners' ability to manage their work

and meet their professional obligations to the families for whom they have responsibility:

> *I feel that yes the management is more hands off, so we're being what the policies are but without actually being given the support to em, to prioritise or implement the workload on a day to day basis, we're being left to manage by ourselves and they would argue that we were being paid at, you know, a management level to self-manage and manage within practice, but very, very difficult to manage if you haven't got enough resources or enough time to implement what's being expected (P8 2:239-246)*

> *You do feel isolated sometimes and where there are staffing problems and things you are on your knees before you get help (P3 297-298)*

> *But the bottom line is your caseload and if you're not here who's going to do it (P6 319-320)*

Whilst the pressure on human resources is a national issue for the UK healthcare system, decision making is devolved to individuals at a local level. This will be influenced by the multiplicity of priorities and the negotiations of individuals in an inherently complex system. This has echoes of the work of Strauss' negotiated order theory (Strauss 1984) in which the ongoing process of negotiation with others is seen as a core social process that links individuals and their interactions to the social structures and systems in which they are contextualised. Previous discussion has made reference to the importance of the approach to change management in taking account of this negotiation process and in engaging individuals in the change process.

Practice Development Approach

Whilst no explicit framework for managing change and contextualising negotiations was evident in the data, participants had clearly experienced practice development systems and processes.

Project Driven Change

Throughout the data, references have been made to the national pilot in which both PCTs were involved (DOH 2001c). It is evident that this time limited initiative did lead to some changes in health visiting practice in the local context of the participants. These changes legitimised the professional role identity of some participants, where they fitted with their perspective on their role. For others the project caused disequilibrium in their professional identity, causing them to question the legitimacy of their professional role in action, especially in relation to their public identity. As previously discussed this confusion was in part to do with a lack of common understanding of the concept of public health and how that should inform practice. However it may also have been as a result of the process of the whole systems change initiative, which aimed to develop the public health role of nurses in the PCT, with a particular focus on health visitors and school health advisors.

For example there was a view that the short time scale of the initiative resulted in a rushed approach to developments that may have evolved differently given more time:

> *We might have thought something out over a long period and tried something, whereas now we have these away days, we have to be quick, what are we going to do for the next 12 months and I don't think that one day is long enough. So sometimes …………………the money might have been better somewhere else, may used on a different project (P4 165-169)*

Another participant had had a positive experience generated through improved collaborative working:

> *I mean I work quite closely with others, and because of the change activists stuff, the three localities we, the three of us* [HV change activists], *and we got together and we shared lots of things, so there's lots of sharing and that's, back to that previous question, I think now I would imagine that the health visitors appreciate that our work is different but not necessarily an easy option. And we,*

I hope have a better understanding of some of the difficulties that they have, (P9 379-386)

Similarly another clearly felt very involved in the process:

It was locality based and we had to get together and decide what we felt we'd achieved – health initiatives in our areas which needed addressing. So it was done through consultation (P2 31-33)

For another participant the Whole Systems Pilot was interpreted more negatively, perceived as a vehicle for wider implementation of a corporate caseload which she vehemently opposed. She suggested that she joined a working party to challenge the introduction of corporate caseloads which she was against, thereby defending her professional role and identity in an individual GP based practice context:

Because I feel so strongly about being GP based and not being forced, probably not the right word, but you know, being forced to go to work with a corporate case load, because I felt strongly about that, I went to that working party about geographical/corporate case load. Because I thought, well how come I moaned about something, I've got to be on this meeting, even though there were other ones that I would have perhaps enjoyed more or got more out of, or been interested in more, em, I could only commit myself to one. (P6 154-161)

She suggested that there was no consensus within the group on the value of corporate working which worked in her favour with current practice systems remaining unchanged:

there was no real outcome ....not a consensus, it just almost came to a natural conclusion, so there wasn't one, if that makes sense ...... I would not want to have the corporate caseload, I would rather be GP based. (P6 167 - 176).

In essence, equilibrium in the system was maintained. Another participant gave a view as to the sustainability of project initiated change. In her opinion, the focus of the Whole

Systems initiative on generating project based activity, contributed to the perception that public health work is outside normal mainstream work:

> *Whole systems came in and yes whilst it looked fine and there was some funding the actual fundamental changes em, weren't sustainable and I, this is a very personal view and not a popular view, that I actually think that whole systems pilot significantly contributed towards some staff and therefore some managers perceiving that public health was a project because the way in which that whole systems was run was very project specific, rather than actually embracing and embedding practice in public health in day to day practice and making any real sustainable changes (P14 192-201)*

Though this pilot it was aimed at whole systems change, there was no data evidence that it targeted staff in the whole system, only nurses and health visitors. Had the role change initiative been effective, those involved would need to have each negotiated the legitimacy of their new professional role activity with other members of the interprofessional team with whom they work. The previous chapter has discussed issues such as power and control and professional hierarchies which could all impact on an individual's efficacy in embedding their new approach to practice. In turn this could result in different modifications of the role standard, further reducing the potential for a cohesive collective identity and adding to the confusion.

Another project aimed at initiating cross professional change called "Time Out". The goal was to generate shared local priorities and collaborative working amongst all working in GP based primary care settings. However, the initiatives were not compulsory for health visitors and not necessarily prioritised, depending on the personal interest of the individual:

> *Time out, it's a new initiative ... all the GP practices close.... and we all go off to (a local hotel), have a very nice lunch ..... and I'm not being sarky....but you know, one could argue could that cost go to something else.....they have is various sessions like, I went to one on, it was about mental health but the first*

one I had was on the elderly.....and I didn't go because I thought I've only got one elderly client and I could be doing four visits.....(P6 344-354)

Resource Driven Change

As has been discussed, there was a perception amongst some participants that changes such as corporate caseload working were simply a means of saving money and not necessarily service improvement. This is well captured by the following quote:

> *It just makes you wonder what they're doing because they use the money in that area to develop the corporate caseload, which is only just starting off and people don't actually say what they really believe, you get it in bits that people say, don't tell anybody this .....in that area it doesn't seem to be able to keep the staff, there're loads of people leaving and I've heard from what people've said why they left but I've been told not to say anything, I know at the moment there's two people looking for jobs out of that area and then I found that there's another one not happy there, someone has moved from another area thinking it would be brilliant, corporate caseload because she had a very heavy caseload in another district and it's been proved it frying pan into the fire, so, but when you hear them talk, the ones that are developing it and the ones that are, the odd person will just say brilliant.........it's not an easy option (P4 595-610)*

Leaving a job may be viewed as a way of limiting the effect of role identity disequilibrium. It may also be an indication that context influences this process. Remaining a heath visitor but moving to a different organisation is evidently also perceived to be a solution to a stressful work situation. The perception that colleagues were not always truthful about their views in some arenas fits with the work of Goffman (1959) and Foley (2005) and the notion of "impression management". Another health visitor described a situation in which there was a public health strategy, but her employers were unwilling to give her the necessary resources to implement it:

> *Now every couple of days somebody from Acute Trust will ring me up and ask me about the obesity strategy, em, what I need them to say is " here's some money, you can either increase your own hours to full time and implement and*

co-ordinate the policy that you've written or would you like to, you know, have another colleague come in and work sort of opposite you" .... because the scope is there (P16 442-448).

Notably there was a lack of "mainstream" resources. This is in contrast to the project related funds associated with, for example, the Whole Systems Pilot. In the latter case change was also resource driven from a ring fenced, time limited budget. However the sustainability of any projects and role change is questionable without ongoing mainstream funding. This situation may leave those individuals who had responded to the change feeling identity disequilibrium.

System Overlap

The primary healthcare team, whilst multi-professional, is essentially a healthcare system focused around medical need, overlapping with others in the context of specific patient need. Participants have evidently had a range of different experiences in working across boundaries. Where new systems such as Surestart (Home Office 1998) are created to support the integrated working and bridge the potential conflict between organisational priorities, interprofessional working appears to be successful. Infrastructure that is coherent with current policy directives is therefore an important system to support collaborative practice.

Influence of Infra-structure

Long standing multi agency groups may be said to have developed sustainable infrastructure that can withstand a change in its members. Several participants are members of such groups that focus on housing, domestic violence, fostering and as the following participant suggests child accident prevention:

I'm involved in the multi-agency child accident prevention ... group, em, which has been going for quite a number of years, so that's a multi-agency strategy group looking at developing initiative on a regular basis em.......... that's been quite a longstanding project (P8 113-118)

A supportive infra structure is an essential pre requisite for successful inter-professional working (Freeth et al 2005). However, multi agency groups are not organisations in themselves. Practitioners remain accountable to their employing organisation, which is likely to provide the primary reference point for their professional role identity. More dominant mainstream practice systems will inevitably take priority over task group systems at times of pressure of time and resources. Indeed within systems, the data has shown that work considered to be most closely aligned with the individual practitioner's professional identity will be focused on when there are time pressures.

Surestart as an infrastructure

The Surestart (Home office 1998) initiative and more recently the development of Children's Centres (DfES 2003) are examples of a Government attempt to develop mainstream integrated working across organisational boundaries for the benefit of service users. Participant fifteen described public health work examples to give an indication of the type of development work this organisational system sustains. Such work includes initiatives around fire safety, first aid and stress management:

> *I just put some of the groups that I thought come into the public health domain...got excellent referral systems now with the fire service to do em, to go into risk assessment of houses ...we get into the child safety workshops and the fire brigade come and do a session.....You know it's just sort of that partnership working ....I've put these together to show you that that's the sort of groups that are ongoing, mainstream (P15 195-229)*

Surestart also enhanced the work of other health visitors who were not directly in that team, through for example, provision of a support worker and other supportive resources:

> *Surestart funds church hall. Support from a sure start worker.... The club will become part of the children's centre initiative (P11 Ob 1)*

Contact at Surestart centre to look at engaging fathers in the locality services. Also discussion trying to facilitate access for families outside the Surestart area. (P5 Ob 1)

However, not everyone had a positive view of the Surestart initiative which as has been discussed, was initially a targeted activity:

It bugs me that Surestart can, you know, your postcode's not right, so the services aren't there to support, em, you know, and as I say, you know, not huge numbers compared to other areas, but just as needy families, it's tough on them, because they're not getting the opportunity. (P10 708-712)

Funded on the basis of socio-economic need, an aim of Surestart was to address health and social inequalities in communities which had little access to resources. Public health work was therefore given organisational legitimacy. Individuals in those teams had the political power (Payne 2000) and autonomy to practice in a way that differed from mainstream practice. However, targeting services on the basis of population demographics created an issue for some health visitors who, as has been discussed, view as strength their commitment to a universal service. For some health visitors in this study, working in more affluent areas, it was a particular issue:

We have no resources, whereas in the more deprived areas they've got lots of other resources to tap into. (P9 124-126)............ We haven't got Surestart here, em, it is said that there's no child protection in this area, of course there is (P9 238-239)

Whilst the participant who works within the infrastructure of Surestart and not in mainstream health visiting, she gives an example of where practice overlaps:

I had to go to a quarterly meeting last week because I had a funded place in the child care but the health visitor couldn't attend and it required one going to support and what have you, so I went representing the health visitor in that

instance but I usually go with what Surestart can offer this family em (P15415-420)

Despite working within a different practice system, this participant still identified with the health visiting role to the point where it could be interchangeable with her own role if necessary.

A model of practice used in other areas was also described that combined Surestart resources with mainstream provision with all health visitors working in an integrated team. She suggests this infrastructure supported health visitors with smaller caseloads using Surestart resources to work collaboratively for public health:

> *And I think a lot of Sure Start where they have health visiting teams and they have a smaller caseload I think they've probably cracked it, em, (P15 316-318)*

In this example public health is clearly viewed by the organisation as mainstream health visiting practice. It is interesting to note that the introduction of Surestart as a national policy initiative had not resulted in the development of a standard organisational model which had been developed at a local level in context. This shares similarity with the policy initiative for changes to the health visitor role which have been open to individual interpretation and implementation. However, as referent points for those in the system trying to negotiate their professional role identity, the low level of consistency in these policy driven developments is problematic.

Influence of Policy Change

Some participants, especially those with leadership and management roles in their organisations, had an awareness of broader health policy and an opinion about its impact on their practice. However, for some, national policy guidance had been vague and unhelpful:

> *"Public health role is woolly in policy but yet we're told it's not an option" (P5 Ob 1)*

One participant had a view that some practitioners were willing to respond to policy whilst others ignored it and carried on in their usual way of working:

> *I think those staff tend to be the more motivated, the more engaged, the more people who you know, people who would actively em, look to see what they're, the sort of guiding strategies are. If they're waiting for em, for other staff that isn't what they're about, they say, regardless of what policy strategies or what Department of Health changes happen, what performance indicators change, what the strategic health authority do, it's business as usual, head down and for them, nothing's changed for years (P14 253-259)*

This is perhaps an indication of the readiness for change of some staff. However it may also be an illustration that practitioners have reviewed the policy and interpreted it as irrelevant to their daily practice and identity.

For example one participant who did not readily identify with the medical practice domain, viewed diseased focused public health policy as limited in its efforts to tackle inequality:

> *But the changing the general public health policies I think that we're too, I think we're still medically modelled, I think we're still kind of in the medical model, you know, still looking at em, diseases (P9 442-444)*

Some participants were able to link national policy with local PCT policy and to the agenda of reducing health inequalities. That they were able to articulate this link may have been because all of these participants had some sort of leadership role in their area, and as part of their role, the implementation of change locally:

> *I mean there's national priorities that we have. And we have local frameworks for both of them. The NHS plan the NSFs and things like that and then there's national priorities. We also have a local delivery plan linked to those. (P5 13-15)*

One national report which seemed to have relevance for several participants in mainstream practice was the Hall Four report (Hall and Elliman 2002). Given the prevailing practice focus of child health in a family context it is perhaps unsurprising that this policy was one which many health visitors identified. This report superseded Hall Three (Hall 1996) over the course of this study a change was perceived by some participants as having had an impact on their practice through changed employer expectations:

> *Well the theory was that we'd reduce the visits with the Hall report but in fact what we've done here is increase them, but at different times and, but we're not really visiting between, we're not routinely visiting between six months is the last visit routine visit to two years, and then that's going to leave a huge gap (P9 328-333)*

Not everyone was negative about the change in child development core screening. One participant clearly viewed the previous universal system of working as superfluous:

> *A lot of the screening we were doing was totally pointless. We were going out to see children who we knew were perfectly alright because they were coming to clinic, and then we had to do this developmental check and we knew there was nothing wrong anyway. The mother didn't have any concerns. It just seemed to be a total waste of time (P2 209-214)*

Another participant suggested not all health visitors were responding to policy change in the same way:

> *Reports come out like Hall 4 but some health visitors are ignoring it and doing what they've always done anyway (P5 Ob 1)*

This implies that the health visitors were exercising their professional autonomy, which has been discussed as a core element of the health visiting professional role identity. However another participant suggested that health visitors were complying with the changes but were in the main unhappy about it. This seems to contradict the notion of professional autonomy and choice:

Discussion on local interpretation of Hall report which requires a reduced number of "core visits". HV is compliant but is also reluctant to let go of extra visits she feels are valuable. Feels routine visits are important to identify problems and needs. (P9 Ob1)

For one participant the policy change had caused role confusion:

You know as regards to their developmental assessment and things like that, and the Hall report, you know, a year or so ago was saying one thing and kind of why it changed everything and now they're saying you've got to go back to doing these assessments, I haven't got a handle on that (P6 266-269)

The "they" referred to may be the organisation or it may be the paediatricians who took responsibility for child development surveillance in the locality. Indeed Hall 4 was published and endorsed via a medical route (Campbell 2004). In a hierarchical sense, those health visitors with a nursing identity may be more likely to comply with the policy without the sense of disequilibrium generated through feeling disempowered.

Any top down policy driven approach to change, may run the risk of individuals within it feeling disempowered (McDonald 2004; Higgs and Rowland 2005). This powerlessness may cause the individuals to disengage and resist any changes they perceive as a threat to their identity (Karp 2005). However, where policy driven change fits with an individual's own core values, then they are perhaps more likely to embrace the changes and respond positively with no risk to the equilibrium of their identity. Policy implementation may be perceived as less likely to invoke a resistant identity (Castells 1997) where the core identity characteristics of the target group are acknowledged in the process. Furthermore framing policy change in the language of the target group will enhance its perceived fit with the discourse of the professional group. As discussed earlier, shared language and terminology and its exchange, is one way individuals in a group identify and bond with each other (Putnam 2000). Any policy driven change process needs to engage individuals in order to negotiate a group

consensus on their current position in the system before engaging with the proposed change.

Effectiveness of Information Sharing Systems

Effective information sharing is acknowledged as an essential aspect of an infrastructure for in an increasingly integrated public sector workforce (DfES 2003). The primary aim of this development is an avoidance of tragedies such as the death of Victoria Climbie (Laming 2003). However, in the process of providing information and interpreting it, there is also an aspect of professional judgement that can affect professional role identity. Erroneous assumptions can be generated from the language an individual uses making cross agency referrals, impacting on their public identity and subsequent collaborative working. Therefore what is conveyed is not only factual information it also gives clues about the individual professional role identity of the referrer.

Traditional, formalised, cross professional and cross agency referral mechanisms were mentioned several times by participants, as part of the system supporting their health visiting practice. Interaction in these processes can influence the professional identity of health visitors, through feedback from the recipients of the referrals and their subsequent actions. Interaction and information sharing with service users can also influence the professional role identity of the health visitors. Again, the additional information the professional gives about their role will affect the perceptions of their clients and perhaps impact on their subsequent use of their service.

From the data collected and discussed previously, it is evident that some working contexts involve information sharing within GP practice teams and group settings on a more informal basis:

> *I'm fortunate working in this practice: it's a small practice so it's easy access to the GPs ....I think it is important to have easy access to GPs and maintain very good communication links and keep those kind of channels of communication open all the time and I know that, you know, we work well in the GPs (P6 179-183)*

They're [GPs] *quite happy with that and if they have any individual issues coming in to the surgery em, they know they can just like refer them off to me, (P9 277-278).*

Also represents this local group at the health development network. This involves health, LA, HAZ, PALS, police, carers and transport. Role in that is to provide a HV perspective (P3 Ob 1)

From the discussion on corporate caseload working there is also evidence of the creation of formalised information systems that facilitate both client referral and workload allocation. However this is described as problematic:

I'm struggling to maintain effective communication and a lot of time, I don't think the workload's different but the organisation takes a massive amount of time and because we're in two different offices and people working different days huge amount of time I've spent communicating relevant information to the relevant person, and they each cover all the clinics so the clinics go on the relative health visitor so you do take up people's times at every clinic every week and then you've got to communicate all of that (P8 2:111-116).

Clearly the margin for error is likely to be increased in an unnecessarily complex information sharing system. Some participants, especially those in more atypical organisational roles, described practice systems that were used to facilitate information sharing and cross agency referral to access services and support:

All of the requests for the health assessments come through our office, em, we produce what's called a health action plan for each child and that goes to social services after the health assessment's carried out (P17 16-18)

The health visitor will put a little input herself and if she hasn't seen any em, recovery from doing it herself, then she'll ask us to er, come in and support her in primary Care and also ask for our dietetics services to go out (P16 71-73)

From one participant there is a recognition that cross agency information sharing can also be problematic due to conflicting priorities and a lack of understanding of the impact of inefficient information sharing:

> *...particularly for the initial health assessments it means that these children are not being seen until we get the consent because quite rightly the doctors will not do em, a health assessment, I mean it's technically a medical, what we call a health assessment, without the appropriate consent. (P17 117-126)*

Child protection was an area of work that all of the health visitor participants were involved in to some degree. Clearly an effective information sharing process is essential to the protection of children in a complex system. There are statutory guidelines to support this work including the establishment of care teams with clearly identifiable accountability for work areas. One health visitor was observed on a visit described as obligatory as part of her well defined contribution to a locally convened child protection care team:

> *A child protection visit – young mother, father with a history of violence – aim of visit: Compliance with care team requirements "Weekly support" "Monitoring of situation" "see how they're coping with their new baby" (P2 Ob1).*

The reason for the visit was the collection of information about the family's ongoing situation which would be reported back and shared with the interprofessional cross agency care team. In this context, effective systems for information sharing are of vital importance to child safety.

The participant who worked within Surestart was the only participant to mention the recently published Common Assessment Framework (CAF) (DFeS 2003):

> *Well I think the em ...bringing in all the CAFs around and that it's going lie heavily upon the first line worker which a lot of the time is going to be the health visitor (P15 498-507)*

As a national framework, the CAF is intended to facilitate inter-professional working in an increasingly integrated children's workforce. As discussed earlier it has been piloted and is now being implemented as a solution to poor information sharing. However its integration into the professional role of the health visitor is likely to be dependent on its perceived legitimacy as mainstream health visiting activity. The evaluation to date has indicated its implementation to be problematic (Brandon et al 2006). Whilst there is a programme of shared "training" to use the CAF, it is not clear that the process used to implement this national strategy, will take the individual perceptions of professionals into account. How changes are managed will undoubtedly impact on their compatibility with the professional role identities of individuals and groups.

In order to fully engage staff across organisational systems to engage in new shared processes, there needs to be a process of change facilitation that is more than simply "training", as in the case of the CAF implementation process. There is a need to engage all stakeholders in a process of change that matches the new initiative to the existing professional role identity of individuals and professional groups. Failing to do this may result in no single applied role standard within the staff group causing collaborative confusion.

Information systems evidently vary according to the needs of the service and its users. However the control of the information flow in the system will be affected by the decision making of the professional within it and their understanding of their role and responsibility in relation to it. The greater the degree of mandate around this sort of system the more the autonomy of the professionals within it will be reduced. In the case of child protection as discussed there is a very tightly controlled information system and a statutory requirement for information sharing. Individuals would need to absorb this challenge to their autonomy and through self referent feedback, reframe their identity to incorporate it as a legitimate aspect of their professional role identity. They would then judge their role in action by reference to the system in which they are working and their degree of professionalism and its effectiveness within the given parameters.

Protocols for Practice

Child Development Surveillance

As discussed earlier, there appeared to be some confusion about child development surveillance in terms of the timing and nature of screening. Each time there was a policy change, the local protocol for child health surveillance was altered. None of the health visitors expressed a view that in general, responsibility for child health development assessment was not appropriate to their role. This suggests some degree of a continued sense of legitimacy, developed through self referent feedback on their practice, feedback from other people and endorsement of their role in policy (Lowe 2007). However, the relative value of this work was viewed differently, especially in relation to developing new public health work. Opinions on this protocol varied as follows: it as an area of work not essential to health visiting and delegated by some to nursery nurses (P3, P8); it is an essential mechanism for getting access to families to develop crucial relationships (P9); it is a time constraint against developing public health work (P2); and it is an essential aspect of health visiting practice which is at risk from the public health agenda and from increasingly targeted services (P4).

As discussed earlier, if the policy changes and an individual's identity are congruent, and local developed protocols reinforce that perspective, then individuals are less likely to experience identity disequilibrium in their compliance. For others, where there is dissonance due to conflicting views, they may be still be compliant but resist the incorporation of that role standard into their own professional identity. The may then cause identity disequilibrium.

Where local, policy driven protocols on child development surveillance are developed without the involvement of individual health visitors, there is a risk of a lack of collective agreement on the relative importance of the protocol to their role. A change management approach is needed that is participative and emergent (McDonald 2004; Higgs and Rowland 2005; Karp 2005). The aim should be to establish a stable collective referent point against which individuals can continually reaffirm the nature and value of their professional role identity, in relation to child development screening.

Smoking Cessation

Smoking cessation work was an example of practice some participants' classified as their public health work and includes: screening; prescribing; lifestyle information; and behaviour change support. It is also guided by a protocol based on regularly updated information on best practice produced by the National Institute for Clinical Excellence (NICE 2008):

> *NICE guidelines seen as important evidence underpinning smoking cessation practice (P2 Ob 1)*

There were few disagreements on the medically determined aspects of this work such as the prescription of nicotine replacement therapy. However there was some variation in approach to practice noted, around the use of different strategies for engaging people in smoking cessation.

In an ethnographic study of the effect of protocols and processes on practice in a critical care setting, Manias and Street (2000) suggested that nurses use protocols to legitimise their knowledge in an interprofessional working situation with medical professionals. They suggest that expected standards of care are made explicit in the protocols which gave reassurance to the nursing staff. This has echoes of the work of Benner (1984) who concluded from her study that protocols gave role confidence to those practitioners with less expertise and became less important with experience. They may explain understanding why the nurses in Manias and Street's study valued protocols, critical care being a highly medicalised environment. In their study, the protocol also provided a shared platform for dialogue with doctors. However the study concludes that the doctors, preferred to rely on their own experiential knowledge in decision making rather than the protocol. This adds an interesting dimension to the earlier discussion in this thesis about the relative perceived autonomy between doctors and nurses.

As a system for practice then, protocols may provide role standard clarity which gives feedback to individuals on the role expectations of others. Power and control are factors that affect the development and implementation of protocols. Once constructed,

protocols could be a form of political power, legitimising the existence of hierarchies through an inbuilt imbalance in powers of professional autonomy. This supports the work of Williams and Sibbald (1999) who suggest the current erosion of professional power in the healthcare system may not be occurring evenly across the range of professions. They further suggest that professions such as nursing may be more susceptible to erosion of their power than stronger, longer established professions such as medicine. Manias and Street (2000) conclude that whilst protocols are useful, professional autonomy to make decisions remain important for managing unpredictable outcomes in complex situations, not anticipated in preparing the original protocol.

Data has suggested there was greater consistency in the use of this protocol than with child development screening. However fewer practitioners engaged in protocol driven smoking cessation work. Had it been mandatory, as in the case of the child development screening, data might have emerged indicating a similar variation in the degree to which the work was supported or rejected as legitimate to their professional role identity.

Earlier discussion of the experience of Participant four suggested a whole team approach to smoking cessation in her GP practice. In a medically led team working to with nationally imposed disease orientated public health targets, it is perhaps unsurprising that smoking cessation is an uncontested shared goal. Health visitor involvement in this work will be legitimised if they view themselves as an integral team member. This process of legitimisation would occur through positive feedback from practice staff and feedback via the achievement of targets and by compliance with the protocol. In this case, the collective identity feedback comes from the interprofessional primary healthcare team and not necessarily from the uniprofessional health visiting team. In addition, where a health visitor has a professional identity strongly associated with being a nurse, a medically focused protocol with an evidence base located in a medical knowledge domain, would legitimise their involvement in the work. The primary care nursing team may also be used as a collective identity reference point.

However, the discussion in this thesis indicates that some health visitors gave greater priority to work located in the social knowledge domain, and they were not as influenced by medical professionals. For example participant six, who worked with

homeless and transient families, said specifically that smoking cessation was not a priority in her work:

> *I mean smoking cessation, I've undergone the training and I've had several clients that I've supported with that but it's very time-consuming and of course there has to be a commitment on my part .... in some ways it wasn't a priority and unfortunately families in need do take priority ....it can be to the detriment of the mothers* [to give up smoking] (P6 426-434)

Family support is identified as her main priority, and previous data examples indicated a particular interest in women's mental health. Her collective referent point would be health visitors with a similar perspective and the wider multi agency team with which she interacts in her daily work. Through a process of feedback from individuals and systems and self referent feedback, she can legitimise her role in action as a health visitor and align that work to her core values. However her participation in the Whole Systems Pilot (DOH 2001c) working with health visitors with different perspectives was portrayed negatively. The lack of shared identity with some of her health visiting colleagues could potentially affect collaborative public health work with them, such as a whole team approach to smoking cessation. Despite a clear protocol for smoking cessation practice, some participants evidently chose not to undertake that work as part of their health visiting role, in a system that gave them the choice.

Post natal depression

Screening and support for women with post natal depression was an area of work with an apparently well developed consensus of professional role legitimacy. Several participants talked about a locally developed screening protocol, in both PCTs, which used the Edinburgh Post natal Depression Score (Holden, Sagovsky and Cox 1989) to identify those women at risk from post natal depression:

Afterwards we discussed EPDS. A protocol had been devised in the PCT by a multi-disciplinary group and based on best evidence. All women are screened by the health visitors at 6wk, 12wks and 8 months. There is an expectation that at least one of these

contacts is person to person at home. The HVs are getting training in PND support. "the 3 month contacts are no problem because I do my weaning visits at around that time anyway". (P2 Ob 1)

The only one that there's formal protocol set is maternal mental health ...(P12 495)

Both PCT areas had protocols devised by an interprofessional group, based originally not on policy but on best evidence in the professional domain and the systems available in the local context. NICE guidelines have since been published lending further legitimacy to this area of work (NICE 2007). The participants clearly felt that maternal mental health was an area of work in which they had a strong public identity and role legitimacy. The protocol thus provided an uncontested role standard across the group of health visitor participants, providing a collective reference point for maintaining identity equilibrium. Mental health practice overlaps in both the preventative/ social domain and medical/nursing/treatment knowledge domains discussed in chapter six. This being the case, either domain the health visitor most closely identifies with could be used to legitimise their involvement.

This illustrates the point made in earlier chapters that a defining feature of health visiting is the ability to employ knowledge and skills across a medical, nursing and social care spectrum, contemporaneously to meet the needs of clients as they arise. Some participants operationalised their maternal mental health work through community focused, new parent support groups. This approach recognised social isolation as a trigger for depression and the benefit of facilitating peer support networks to prevent it. Those practitioners with this approach were perhaps more likely to identify themselves in the social care practice domain. Others undertook individually focused work for prevention, screening and management of post natal depression. Once an individual assessment was undertaken, the woman was referred if necessary, to a GP for medical treatment. In addition the health visitor capitalised on the home visiting, relationship building aspect of their identity to provide listening support in an individual family context. For those with a strong nursing identity they could see the contribution of the interpersonal skills and confidence, well developed in their previous nursing role.

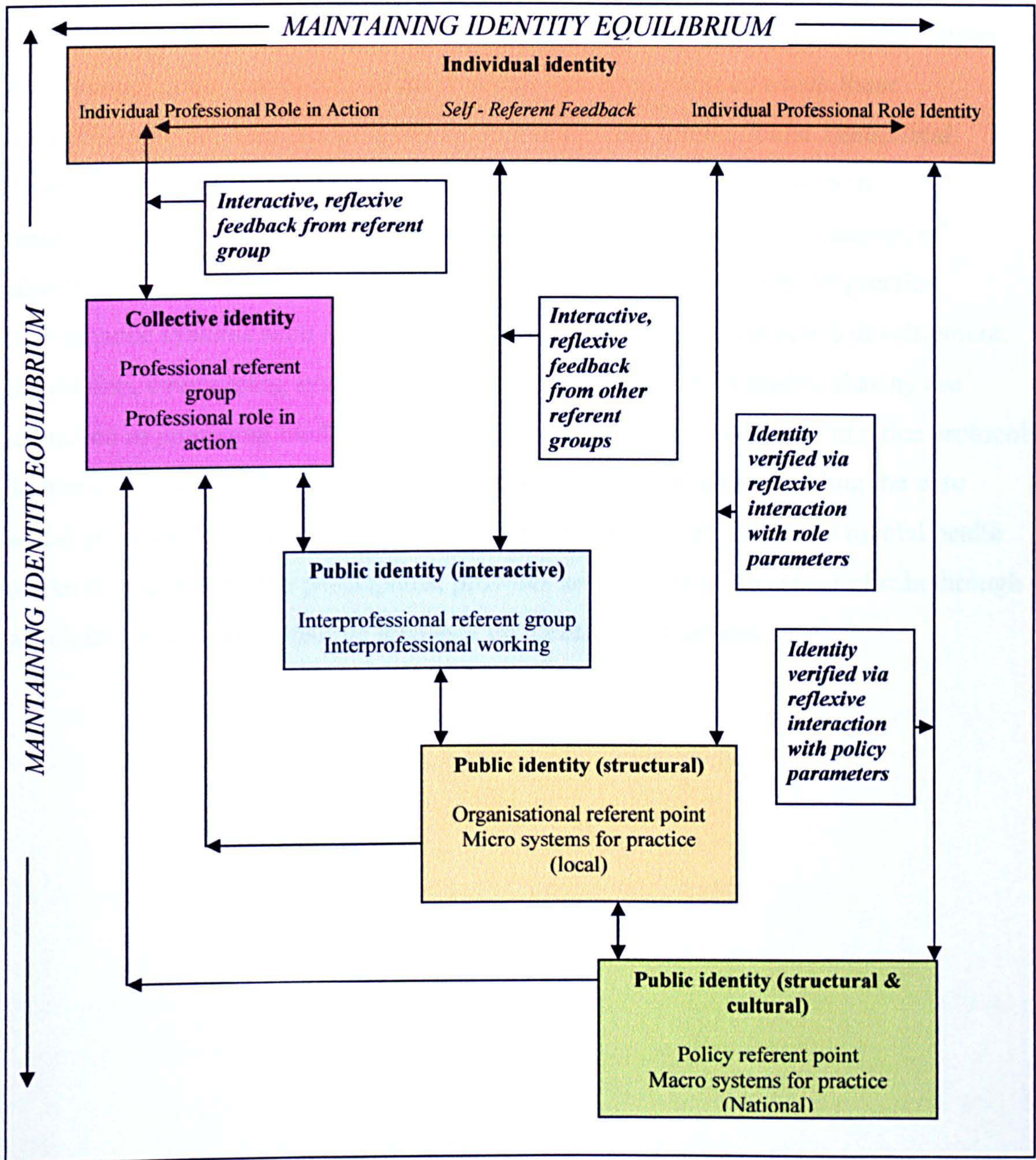
Indeed participant four suggested that mental health nursing might be a useful foundation for health visiting practice.

As an area of practice, the prevention of post natal depression and support for women sufferers provides an idea of the potential for establishing a collective professional identity across the health visiting group. Its fits with characteristics identified as core to health visiting: home visiting; relationship building; preventative, empowering approach; work with families with young children; and work with women. The clarity around the role and responsibilities meant that there was not only a shared understanding within the health visiting group of its relevance to their professional role identity, but this clarity also provided a referent point for working in an interprofessional context with a predictable role standard.

Figure sixteen below, completes the process model which identifies the interplay between components in the complex practice environment of the participants. Reflexive feedback processes to the individual, influence the perceived legitimacy of their professional role identity. It also identifies the process of maintaining identity equilibrium at an individual level and across a system. Applying this to the maternal mental health area of practice, there is an opportunity for positive, reflexive feedback at all levels: with individuals and the collective health visiting group, including managers; with the interprofessional workforce across both health and social care domains of practice; with local systems supporting practice including GP practice attachment and protocols; and by reference to national policy. Mental health is a public health priority, and support of families is at the heart of the children's workforce development agenda. This then is one aspect of practice that is likely to maintain both the internal equilibrium of individual professional role identity and the maintenance of external, public identity across the interprofessional health care system at both a local and national level. However, this thesis suggests that where protocols are used differently by individuals there needs to be a feedback mechanism to ensure changes are collectively considered in an ongoing collaborative change process. This will minimise the risk of fragmenting collectively agreed role standards. Changes in the use of the protocol should be considered within each professional group using it, to facilitate collective reframing of practice in a way that fits the essence of their existing role identity. Once this is clarified it should be considered again collaboratively with the interprofessional group using it to

maximise their awareness of any role change. Figure sixteen presents the completed process model:

Figure 16: **Maintaining Identity Equilibrium – the systems dimension**



Theoretical Summary and Conclusion

This chapter was the last of four findings chapters which have discussed the reasoning behind the development of the primary conceptual model presented in chapter five. Previous chapters have analysed participants': professional role in action; professional role identity; and interactions in their interprofessional working context. This chapter has considered the complexity of the dynamic system context in which these interactions occur. This fits with this study's Integrated Interactionist Theoretical Framework which considers everything in a situation to be of relevance in understanding the social processes inherent in it. As discussed in this chapter, of significance to the identity maintenance of participants in this study are practice maintenance systems such as human resource management and practice development. In addition, overlapping systems such as those supporting information sharing are identified as providing feedback on identity. Finally, the discussion of practice protocols demonstrates the utility of the process model (figure 16) in understanding the core social processes involved in maintaining identity equilibrium. Maternal mental health works as depicted by the participants, provides an example of an aspect of role through which they experience positive feedback on identity at all levels.

Chapter 10 – Significance of the Findings

"Examine each question in terms of what is ethically and aesthetically right, as well as what is economically expedient. A thing is right when it tends to preserve the integrity, stability, and beauty of the biotic community. It is wrong when it tends otherwise".

(Aldo Leopold - Environmentalist - 1887-1948)

Introduction

The preceding four chapters have discussed key factors in the interactive practice context of participants, which influence their role identity, namely: professional role in action, professional role identity, interprofessional working and micro systems for practice. The "maintenance of identity equilibrium" has been identified as a core social process which influenced health visitors' interpretation and interaction with their changing professional practice context and its impact on their practice. In the current turbulent healthcare system, other professional roles are experiencing similar challenges to their role identity in an increasingly integrated collaborative working environment. This chapter considers the findings of the study in the wider professional practice context. The next chapter returns specifically to the experience of the participants to conclude the thesis with its relevance for the health visiting profession.

Summary of key findings

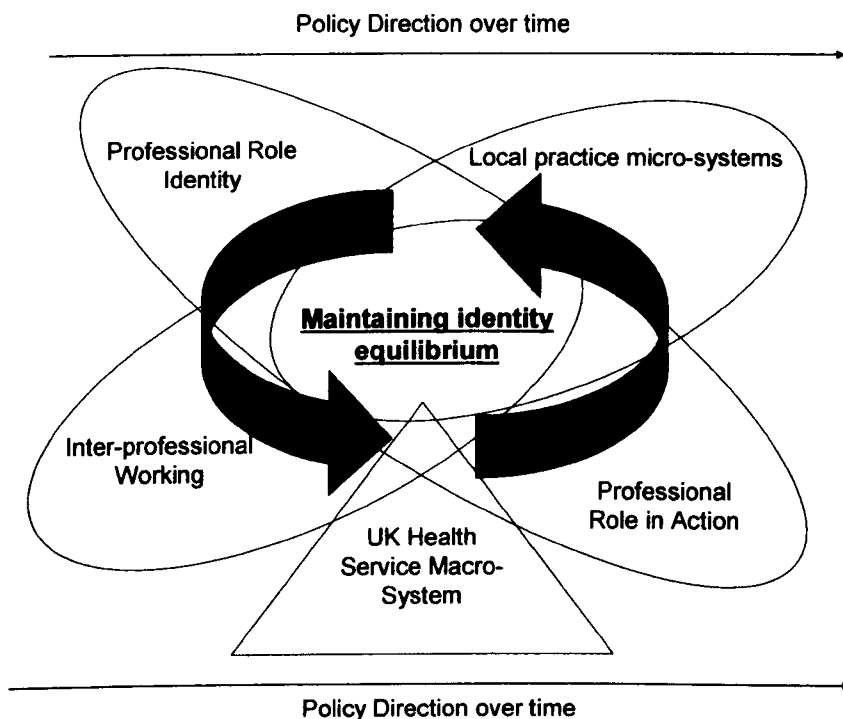
Data analysis has suggested that the participants' professional role identity is influenced by feedback from internal and external sources. This fits with the Integrated Interactionist Theoretical Framework presented in chapter two. The thesis has argued that in a complex practice environment, characterised by interprofessional working and overlapping systems, participants renegotiated the legitimacy of their role in an ongoing sense. This influenced their perceptions of the value of their role and the degree to which identity equilibrium was maintained in their changing practice context. Change challenges the psychological equilibrium of individuals which left unresolved, can

result in identity crisis (Caplan 1961). In the context of this study this has been applied to the concept of role identity crisis.

Models presented

"Messy maps" (Clarke 2005) or "rich pictures" (Kogetsidis and McRoy 2008) of the participants' practice context have been presented in other chapters (figures 3, 5, 9, 11, 13). Two key models have also supported the discussion. The first (figure 4) is the primary conceptual model, conceptualised from the data through the process of constant comparative analysis once data saturation was reached. Whilst complete assurance of the latter is difficult (Clarke 2005), I was confident that the key data categories of relevance had been identified. The model gives an overview of the key areas of influence on the participants' identity:

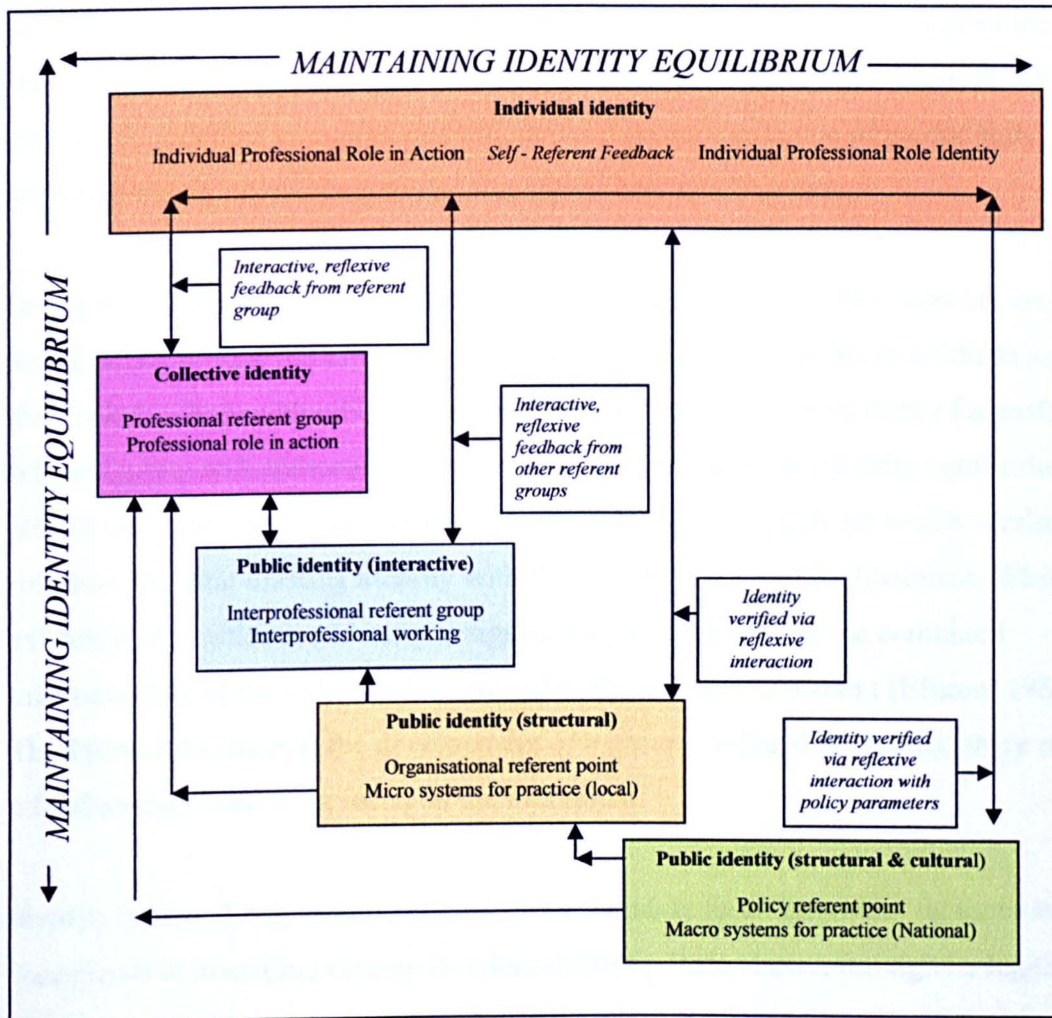
Figure 4: Maintaining Identity Equilibrium - A Conceptual Model



The second model is re presented below (figure 16). It is more explanatory and was incrementally constructed through the discussion in the findings chapters (figures 10, 12 and 16) to demonstrate theory development. It illustrates the process of feedback

between influencing factors, through which an individual's role identity is legitimised and its equilibrium maintained:

Figure 16: Maintaining Identity Equilibrium – Interaction in context



This second model emerged once constant comparative analysis became selective and theoretical (Strauss and Corbin 1990) and thesis writing had commenced. Through an in depth consideration of the primary conceptual model in relation to a wider body of theoretical knowledge, some theoretical assertions were generated. These are captured in figure sixteen which shows not only *what* influenced the identity re negotiation of participants, but also the feedback *process* through which this occurred.

Figure sixteen suggests that identity equilibrium is partly maintained through a self referent process within the individual. This has echoes of the well documented process

of learning through reflection in and on practice (Argyris and Schon 1996). This thesis also proposes that in order to minimise the risk of role crisis, a sense of collective professional role identity across a group is important. The collective identity of the group, with which an individual most readily identifies, acts as a referent group, through a reflexive feedback process. This influences the degree to which the equilibrium and legitimacy of their role identity is maintained. In addition, a stable collective identity is important in an interprofessional working context. Consistency in the public role identity of different groups of practitioners can provide a degree of predictability and stability in their interactions within a complex healthcare system.

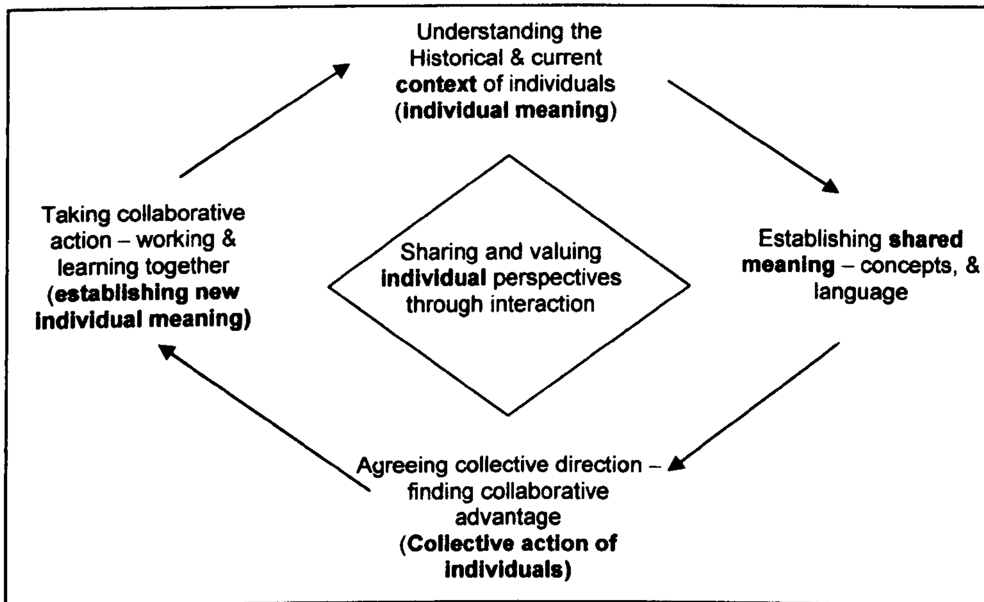
In this study, there is no sense of a strong collective identity in the group of participant health visitors. This has clearly been problematic both for them as individuals and for their relationships with others. Fragmentation of the collective identity of a professional referent group will compromise the process of maintaining its identity equilibrium. Where this is the case, individual judgements would need made on which version of the role best fits their existing identity with the least psychological adjustment. Whilst the existence of a collective identity is significant, it exists only as the combined understanding of the individuals involved in the interactive context (Blumer 1969). Therefore in facilitating the development of a groups' collective identity, there remains a fundamental need for a focus on the individual.

Identity is also clearly acknowledged in the literature as an important factor to be considered in managing change (Mcdonald 2004). Role clarity, through its legitimacy, adequacy and support, is a pre requisite for optimum role performance (Machin and Stevenson 1997). In an uncertain, turbulent UK healthcare context, promoting ongoing role clarity is an important task for those managing a changing professional practice environment (Williams and Sibbald 1999). None of the literature reviewed identified the importance of maintaining identity equilibrium in the management of interprofessional, collaborative change. The following section proposes a model of role change management which may be of use in a range of collaborative settings, such as the NHS, where ongoing role development and change are inherent. It begins with an account of the process of its development and includes a discussion of factors of influence over the course of my reflexive PhD journey.

Managing change - reflection on experience

Through my PhD studies I have been sensitised to the importance of valuing individuals through interaction and the significance of the change facilitation approach. This influenced the way in which I carried out my role as Director of Interprofessional Education in a recent interprofessional curriculum development. It was a complex process involving eight separate health profession programmes linked by shared modules and interprofessional learning. Drawing on the emerging theory from this study, my approach aimed to ensure colleagues felt their individual professional perspectives and roles were valued. In addition by producing a paper to help the interprofessional team clarify their shared goal, a collective group identity was established early in the process. Concurrently with preparing a paper reflecting on this experience, for presentation at an international conference (Machin and McGovern 2007), my thesis was reaching its theoretical conclusion. This process helped me to conceptualise my curriculum development experience within a theoretical framework. This was illustrated in my production of a "Symbolic Interactionist Framework for Collaborative Change" (figure 17).

Figure 17: SI Framework for Understanding Collaborative Interaction

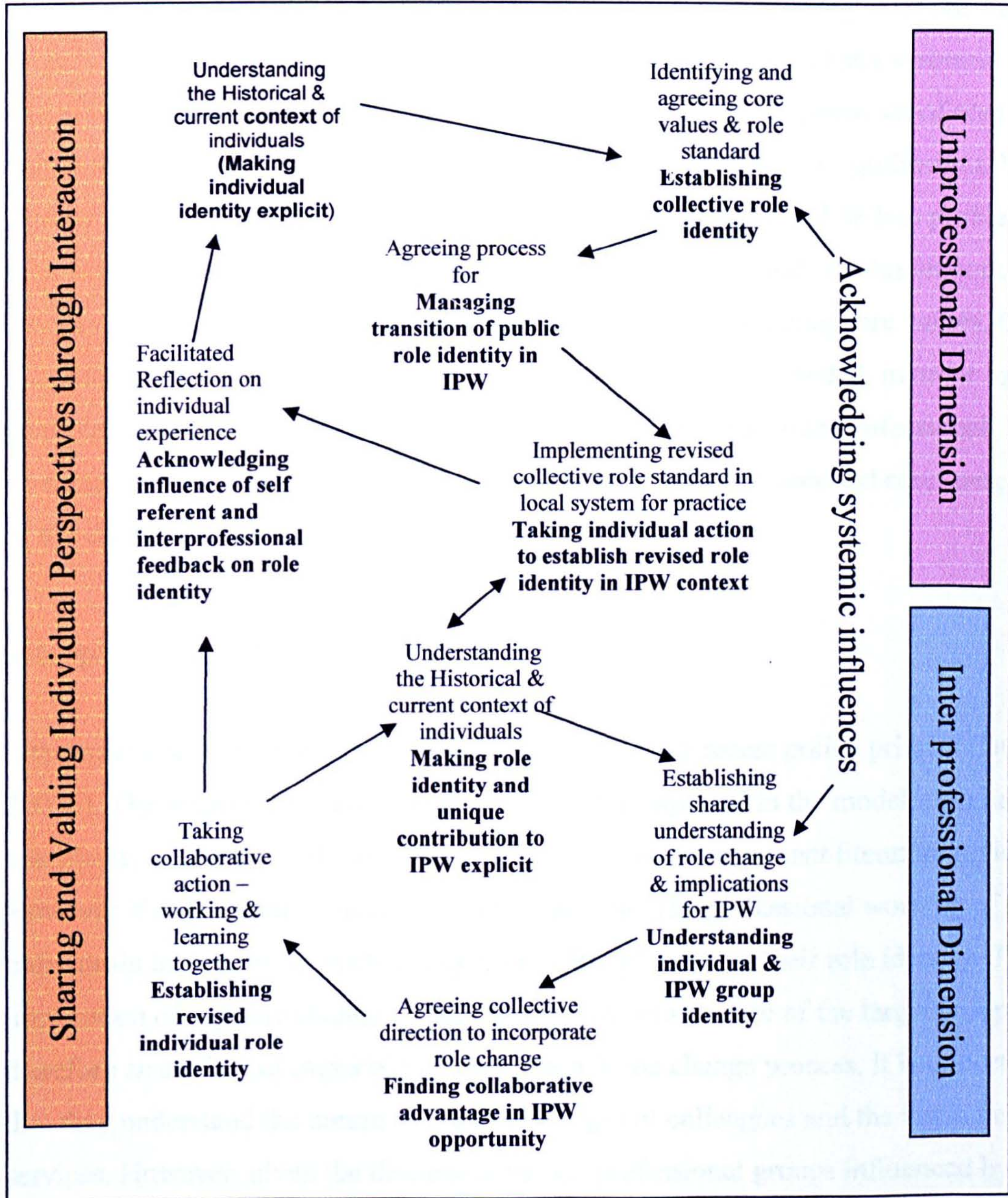


This model was based on my interpretation of how an interprofessional group of academic staff achieved the successful validation of a new integrated curriculum. In this

process it was possible to highlight points in the process at which successful collaborative working was most at risk, such as in the development of shared meaning and terminology. The model as presented (figure 17) does not make explicit the notion of identity equilibrium, which emerged as significant only in the closing stages of this study. However on reflection, the risk points identified and the actual conflicts arising from them related to issues like terminology, professional traditions, lack of role understanding, which are all identity related issues. There was also lack of agreement on many issues within the different profession specific academic teams, which particular individuals had the job of representing.

This thesis has shown that a cohesive collective identity is needed within a professional group, to avoid the development of role fragmentation and "tribes" (Castells 1997). Whilst the interprofessional change process undertaken (figure 17) was successful, it was a difficult journey for all individuals involved, especially those who had leadership roles within their professional groups. In order to help facilitate "objective" decision making to take the pressure of individuals, policies, professional body requirements and information from external partners were used. However, this thesis has shown that there can be variation in the way in which these macro level information systems are interpreted and applied. On reflection this variation may have contributed to the lengthy process in getting interprofessional agreement on a range of key issues such as grading of practice learning. A different approach, acknowledging individual values and identities within professional teams as well as in the interprofessional group may have helped. Taking this into account, I have further developed my original model (figure 17) to propose that facilitating change that impacts on roles, should take place in a uniprofessional dimension prior to engaging in interprofessional change. Figure eighteen is a pictorial representation of this, the third model developed in this thesis. Valuing individual perspectives through interaction and the importance of a process of feedback are core to the "Interprofessional Role Change Process":

Figure 18: Interprofessional Role Change Process



Uniprofessional dimension

The model acknowledges that each interaction within their changing professional practice context will cause individual practitioners to reinterpret their experience in relation to their professional role identity. This being the case, at each new meeting about the role change individuals will bring to it a revised or reaffirmed understanding of the relevance of the change for them. It proposes that a collaborative change process should begin by making explicit individual role identities and values within the

professional group affected by the role change. Beginning with the perspective of the individual has echoes of the transformative model of change (Karp 2005). The next stage in the process is a group consideration of the role change and any systemic factors which will influence its implementation. The goal would be an agreed set of core role values that incorporate the change whilst maintaining their identity equilibrium. Where a group has a well developed collective identity this process would be less problematic than would be the case where it did not, as in the case of the study health visitors. In the latter case more time would need to be spent debating and agreeing core values. Once clarified, an explicit strategy of public identity management is needed, in order to consistently convey changes to the existing role standard in an interprofessional working context. This should include consideration of service user and carer perceptions of the change and its impact on their use of services.

Interprofessional dimension

Interprofessional and integrated services are a relatively recent policy priority (DOH 2001b). The interprofessional dimension of change captured in the model introduces a complexity that is not well documented in the change management literature reviewed. However, the data from this study indicates that the interprofessional working of individuals in their local practice context has an influence on their role identity. The implication of any role change for others in the system outside of the target group is therefore an additional important consideration in the change process. It is important that they understand the nature of the role changes of colleagues and the impact on services. However, given the discussion above, professional groups influenced by the role change of others should also have an opportunity to convene to consider the changes in a uniprofessional dimension. It is proposed that this will minimise diversity in the response of individuals and maintain the cohesive collective identity across interprofessional the staff group. Key to the whole process is a mechanism for ongoing professional discussion and feedback on role experience.

In order to judge the credibility of these findings, the next section provides a summary critique of the process of their development.

How useful is this study?

Methodological rigor

As discussed in chapter four, a qualitative study cannot be judged by the canons of quantitative research (Chenitz and Swanson 1986). Qualitative researchers have used different terms to facilitate a process for checking the rigor of qualitative research: authenticity and trustworthiness (Lincoln and Guba 1985); "an auditable process", "systematic and appropriate" data collection and analysis, "rich description" and "reflexivity" (Johnson and Wakefield (2004 p. 129); and "credibility", "transferability" and "dependability" (Koch 2006). Strauss and Corbin (1990 p.253) suggest a list of seven criteria to be used in judging a grounded theory study:

1. How was the original sample selected and on what terms?
2. What major categories emerged?
3. What examples are there to evidence the existence of the categories in the data?
4. How did theoretical sampling proceed and how representative were the categories produced?
5. What were some of the hypotheses about the relationships between categories and properties and how were these explained and examined?
6. Were there discrepancies between these hypotheses, what was actually seen and how were these explained?
7. How did the core category emerge and on what grounds were the final analytical decisions made?

These criteria are more specific than those put forward in the original method text (Glaser and Strauss 1967). In this early work it was suggested simply that grounded theory should be "understandable", should "fit" with the context of the substantive group for which it is intended and be "general enough" to provide "control" for those whose use it subsequently in an effort to better understand everyday situations (Glaser and Strauss p.249).

A checklist approach to critiquing the qualitative research process has some utility in providing a reader with a framework to ensure that a study has been systematic (Hoddinot and Pill 1999). It can also be useful for novice researchers who can plan their

research on the basis of the criteria it will be judged against once completed. However, a checklist approach has been criticised for artificially reducing a qualitative study to a list of essential elements which potentially limits a full account of the process of theory development (Barbour 2003). Indeed Glaser (1992) criticised Strauss and Corbin (1990) for creating an unnecessarily mechanistic approach to grounded theory, through the production of checklists for several aspects of the research process including the criteria listed above. Barbour (2003) also argues against the use of a checklist of key criteria, especially when used in relation to judging studies worthy of publication. They may lead, she suggests, to a possible inattention being given to articulating the process and rationale of decision making where, for example, themes in grounded theory mysteriously appear (p.1022). However, not all checklists are the same. Criterion three of Strauss and Corbin's (1990) checklist requires that such decision making should come under scrutiny in evaluating the rigor of a grounded theory study. This suggests that not all checklists will limit a full explanation of the process of theory development or an in depth explanation of the researchers decision making processes. It is perhaps better to suggest that checklists are useful as a guide but should not be the only judge of the rigor of a study.

The Integrated Interactionist Theoretical Framework (page 23) of this study maintains there is no objective truth that sits outside of the interpreted reality of individuals and the meaning generated in the context of their social interactions with other people and objects. This being the case the same applies to the role of a reader in judging a grounded theory study. However it remains important to look for methodological characteristics that facilitate a shared understanding between individuals as to whether the study can lay claim to being grounded theory. The checklist (Strauss and Corbin 1990) therefore has some utility in this respect. As this study has followed a grounded theory process there are clear examples from all seven criteria in Strauss and Corbin's checklist. For example, in looking for evidence of original sampling decision making (criteria 1), chapter four includes a full discussion about the choice of first participant (page 78). In addition there is a full account of subsequent theoretical sampling decisions (criterion 4) in appendix five. Criterion 6 requires consideration of the process of exploring hypotheses and scrutinising new and existing data. Again there are many examples throughout this thesis, often depicted in the form of my reflections on the research process. For example "reflection on research 13" (page 131) considers the

significance of the principles of health visiting (Cowley and frost 2006) to the core category of professional role identity. On page 90 "Reflection on interview with P7 Nov 05" shows how questions about the significance of interagency and interprofessional working in relation to strategic work were generated.

Readers of this thesis are invited to use the checklist more fully to assist in their judgement of its rigor. However, even when using a checklist each individual will apply a degree of interpretation to *how* the criteria are applied. For example: the degree of emphasis on certain characteristics; how much evidence might be needed to support the existence of categories; and based on the readers own level of knowledge of the subject area, whether the articulation of theory is convincing. This being the case a checklist cannot be applied in a definitive way as the single "true" way to look at a study. Whether something is plausible, whether it feels right and how much it resonates with the reader will be an entirely individual process.

To assist in external judgement on the rigor of this study, its limitations have been considered throughout the thesis (see for example pages 85-88). For example the influence of the defined time frame of a PhD and its effect on the degree to which data categories and their properties were "saturated" in the constant comparative process was discussed. This issue of time frame influenced the decision to stop observing participants, though it was also anticipated that continuing to observe would add nothing new to the data category of "Professional Role in Action" (page 82). In the final chapter recommendations for research set out opportunities to further expand knowledge generated by data categories less developed than others (page 290). In order to set the scene for the final chapter which summarises the potential influence of the findings on the broader UK healthcare context, further consideration is warranted, of the degree to which the findings presented are of use more broadly.

Generality of the study findings

It is not my intention to claim that the findings from this study are generalisable in the positivistic sense, in terms of probability and predictability (Bowling 2002). Chapter four of this thesis introduced the notion of "moderatum generality" (Williams 2000). As discussed, Williams suggests that the outcome of research undertaken with any social

group is likely to have a degree of resonance with the same social group which shares that history and context. In that sense, the experience of health visitors in this study is likely to reflect to some degree the experience of other health visitors working in the UK context. This is especially the case for this grounded theory study which has generated a theory based on dynamic processes and ranges of experience and perceptions, not static factual "truths" (Glaser and Strauss 1967).

Barbour (2000) suggests that claims to generalisability in qualitative research can be made through the production of new models or "typologies". The theoretical propositions generated and reflected in the proposed explanatory models in this thesis, might therefore be said to be "theoretically generalisable" (Barbour 2000 p.158) to those who share a similar practice context to the study health visitors. However the theory generated is also of relevance to other professions in the field of healthcare and potentially, more widely. Other professions in the UK are experiencing similar contextual changes and challenges: new roles and role change in their workforce; increasingly complex, dynamic, interprofessional practice delivery systems; the changing nature of professions in society; and policy driven change. The theory developed from this study has several general concepts, such as identity, role and profession and it provides plausible propositions about the relationship between them. These are suggested to be the required characteristics of a well developed grounded theory study (Glaser and Strauss 1967). In this sense the models generated might be said to represent "practical wisdom" (Macnaughton 1998), providing others with an opportunity to "control" their situation (Glaser and Strauss 1967). The theory presented will therefore be of use to others in seeking to understand and maintain their own professional role identity equilibrium in times of change.

Conclusion

This chapter has summarised the key points of the thesis and presented again the primary conceptual model (figure 4) and the process model (figure 16) produced in support of the discussion. A third model (figure 18), an "Interprofessional Role Change Process" has also been introduced. Built on a philosophy of valuing the individual, the overall aim of this model is the maintenance of identity equilibrium, both within

individuals experiencing change and across the interprofessional health care system. It is my suggestion that this process, and the other models presented, are of relevance to other professional groups experiencing role change. They are also of relevance where the introduction of a new role impacts on others in the system. This is especially the case where new roles overlap and have the potential to impact on others' working experiences and professional role identities in an interprofessional practice context. The next and final chapter considers these models in relation to the initial research question in order to clarify the implications of the thesis for health visiting as a professional group. From this discussion explicit recommendations for practice, education and research are made.

Chapter 11 – Summary and Conclusion

"Is it wise to be bleeding in a shark filled sea?"
(Richard Thompson 2005 - Songwriter/Musician)

Introduction

This chapter concludes the thesis by returning to the beginning to consider the research question:

"How are health visitors' interpreting and interacting with their changing professional practice context and how has this influenced them and their practice"?

The simple answer is "in different ways as individuals". The individual responses of the participants were dependent on feedback they obtained from a range of sources. Participants' individual reflection on their practice experience with service users occurred through a "self-referent" feedback mechanism. This offered an opportunity to consider the legitimacy of role changes in relation to their existing role identity. In addition, feedback from their professional peer group was influential. Further feedback came from their interprofessional working context where other people working in the system could influence their role. Finally feedback came from the local and national systems in which the health visitors worked. Policies, protocols, human resource management and practice development systems were influential in providing legitimacy and support for role development. Data from this study suggests that for several of participants, the interactive feedback process identified did not maintain the desired level of "equilibrium" in their role identity.

The picture of health visiting professional role identity portrayed is one of diverse practice, confusion and differences of opinion on the relative value of aspects of work carried out under the auspices of the health visiting role. This lack of cohesion in interpreting and interacting with their changing professional practice context, presents a risk of role fragmentation leading to unpredictability in an interprofessional working situation. As has been discussed, disequilibrium in identity can precipitate role crisis

(Caplan 1961) in individuals. The risk of this clearly needs to be minimised. In addition, the insight into a specific practice context that this study provides reflects ongoing national debate on the future of the health visiting role and its public identity. There is therefore an urgent need to re establish identity equilibrium in health visiting both at the level of individual in the context of their practice and nationally across the professional group.

It is proposed that the "interprofessional role change process" introduced in chapter ten offers opportunity to re establish collective identity at a local level, as part of an ongoing process of achieving identity equilibrium in the health visiting profession. This chapter considers this proposal, summarising identified factors of relevance for health visiting in both the uniprofessional and interprofessional dimensions of their work. Implications for the education of both the existing and future workforce are also identified. The chapter concludes with a list of suggestions for further research and recommendations for practice arising from this thesis.

Re establishing Equilibrium in Health Visitor Role Identity

The Uniprofessional dimension

Despite the picture of confusion portrayed, it was possible to identify some similarities potentially representing the core components of the participants' collective health visiting identity: home visiting context; a focus on work with families with young children; role autonomy; and a primary focus on work in a preventative paradigm. However, these core elements were not part of an explicit statement of role standard collectively agreed by the participants. They were implicit in the practice I observed and they discussed. The principles of health visiting (Cowley and Frost 2006) are a useful public statement of the intent of the health visiting profession. In addition, their breadth can legitimise the diversity of practice seen in this study. However they can also endorse role fragmentation across the health visiting group as individuals exercise their autonomy to choose the focus of their own practice. This variation can lead to confusion in an interprofessional context. Role expectations were often unclear leaving individuals feeling open to internal and external challenges to the legitimacy of their professional

role identity. This was particularly evident in relation to the policy driven development of the public health role which was the trigger for this study.

Nationally there is an indication that different models for public health work are emerging (Pearson et al 2000; Abbot et al 2004; Brocklehurst 2004; Carr et al 2003; Goodman-Brown and Appleton 2004; Smith 2004). This was shown to be the case for participants in this study. Of particular note was a lack of clarity in relation to the concept of public health work and its fit with their existing health visiting role identity. Whilst the resource pack for health visitors produced a continuum of public health practice and set out examples of work considered to be public health (DOH 2001a), there was no strong indication from the participants that the policy had resulted in a consensus as to the relevance of the changes for them. Indeed some were ignoring it and continuing to practice in the way that best fit with their professional role identity. In particular there was disagreement in the local context on whether or not public health work was core or marginal (Craig 2002) to their role. This disagreement had caused open hostility between participants leaving some feeling undervalued by their peers and causing disequilibrium in their professional role identity.

Most participants had been involved in the Whole System's Pilot (DOH 2001c) initiative which aimed to develop the public health role of health visitors and other nurses in a primary care setting. However data suggests the process was not perceived to have addressed the issue of existing professional identity, core values or agreed role standard as the starting point for change implementation. Indeed, the initiative was perceived by some participants to have devalued one of the core elements of their identity, a home visiting context. The project focused nature of this role change initiative was also suggested to have compounded the notion that public health was not mainstream work. Clearly there is the potential for role change initiatives to add to the general confusion and disagreement within the target group if not facilitated in such a way as to maintain the group's identity equilibrium. Facilitating the development of collective identity at a local level may provide a firmer foundation on which to base future role change. It may also strengthen the response of the professional group when new roles are introduced into the professional role context in which they practice.

Systemic Influences on the role change process

Policy

The policy impetus for the professional role change of health visitors has been well documented in this thesis. Of notable concern is the directive that individual PCTs should operationalise the health visiting role to fit the local context (DOH 2007a). In using this approach there is a risk that this will add to the lack of role clarity in the healthcare system. It may also reduce the transferability of health visiting skills to different contexts nationally, adding to role fragmentation across the professional group. This will be further influenced by the introduction of GP commissioning, the success of which will rely on the GP's understanding of the health visiting role. This study has shown that in the interprofessional teams the participants interacted with there was a general lack of awareness of their role. The lack of transparency and clarity in their public identity is likely to have been exacerbated by the unclear role standard within the professional group.

The data suggests health visitors in a leadership role to be aware of policies and their implications for local practice. However some other practitioners only became policy aware where there was a direct impact on their practice. The lack of connection with national policy until it impacts at a local level, limits the opportunity of health visitors to "influence policy affecting health", one of their four practice principles (CETHV 1977; Cowley and Frost 2006). In effect they become recipients of policy driven role change, disempowered by policy implementation processes which do not routinely seek their participation.

Local systems

From the data it was clear that no single practice system supported mainstream health visiting. Most participants were attached to GP practices managing individual caseloads, a well established model for the organisation of health visiting services (Craig and Adams 2007). This experience is perceived to be affected positively or negatively by the participants' relationship with the GP in the practice, their degree of autonomy and their individual approach to practice. Participants who valued their

autonomy sometimes experienced dissonance and disequilibrium in the struggle to maintain control of their role, evidence of the existence of an individual resistant identity (Castells 1997). Some participants had experience of corporate caseloads as a practice support system. Data from this study suggests that for some, this experience did not fit with their existing professional role identity, causing disequilibrium and stress in their role. The internal systems of allocation of work in the corporate caseload system were noted to increase the risk of responsibility confusion and to reduce relationship building potential. Some participants also worked in what has been termed "atypical" or specialist" health visiting or public health roles, in more than one overlapping system. This resulted in conflicting priorities and potential demands on them resulting, in some cases, role confusion.

Protocols

The final systems related issue which influenced the professional role identity of participants related to protocols. Protocols appeared to provide some degree of clarity relating to a particular aspect of their role. However the degree to which this was congruent with the identity of participants varied. Protocols may be said to represent a challenge to the participants' much valued professional autonomy. Consistency was of particular note across the group of participants in the assessment and management of post natal depression. This protocol, in both PCTs, provided a vehicle through which the variation in participants' health visiting professional role identity could be legitimised. As a public object it also defined clear expectations of what other people in the interprofessional context could expect from health visitors. Significantly, the local development and implementation of the protocol was facilitated through an interprofessional planning group. This involved health visitors who regularly consulted with their professional group during the development process. Such as participative approach, is argued to be effective in facilitating change whilst maintaining the identity of the individuals involved (McDonald 2004). This type of change is in contrast to the widespread method of policy dissemination in the NHS, through which individual compliance with change is often assumed.

Facilitating policy driven role change

Centola and Macy (2007 p. 703) suggest job information, such as the role change policy relevant to this study, can be spread rapidly through "weak ties" or networks, where those in the system are geographically distant. However, changes which are complex and contentious require "independent affirmation" through a more interactive change process. The latter is clearly the case for health visiting public health role development which is of national significance but not national agreement. However, management of this was left to individual organisations in which individuals have clearly had different experiences. Milligan's (2003) previously discussed study of the effect of spatial changes on identity also concluded that nostalgia played an important role in facilitating identity transition in times of displacement. For health visitors, facilitating discussion in the uniprofessional dimension would legitimise discussion of the past in a nostalgic way. This would enable individuals to consider what has been lost from their role that they previously valued and "grieve" for it as basis for moving forward.

This type of discussion would be appropriate only in a context of a group of individuals who have a shared understanding of the past context and that particular professional role's history. In this study it is suggested that this discussion could be actively facilitated in the uniprofessional dimension of the interprofessional role change process, as a means of establishing the history that individuals bring to the table and the meanings attached to it as part of their identity. In an interprofessional context, lamenting the past may be perceived as resistance to change by those outside of that professional group who have limited understanding of the role change implications.

Influence of a nursing identity

From the data in this study the relevance of nursing to the health visiting professional role identity is unclear. However it does appear that the degree of identification with a nursing identity may influence a health visitor's approach to practice and the knowledge evidence used to justify the choice of approach. In seeking to establish a clear role standard and collective identity for health visiting, this issue needs further

uniprofessional debate and resolved, in order to provide clarity of role purpose and its status as a healthcare profession. This is by no means an easy task.

Health visiting must decide if it is indeed a specialist nursing role, as defined by the professional register (NMC 2004a) or whether it is a profession in its own right. If it is the latter, there is a need to collectively agree the defining features of its professional role identity and undertake a process of public identity management. However, if there is agreement that health visiting is a specialist nursing role, then the literature on nursing values and identity needs to be collectively considered for its fit with the health visiting role standard. In this case, there would still be a need to articulate the core function of health visiting as an occupational paradigm. However in this scenario the role contribution would represent added value to an overall nursing identity. This clarification is vital to maintaining the visibility and credibility of the health visiting role which is danger of being further subsumed into the nursing profession (DOH 2007b).

Interprofessional dimension

Collaborative working

The interprofessional working experience of participants influences their professional role identity through interaction in their practice setting. In addition to the issue of relative autonomy in their work with GPs as discussed, a lack of role awareness and the existence of stereotypes were a source of feedback on identity and perceived self worth in their local context. As the NHS becomes increasingly complex and integrated, services are being internally redesigned to make the service users' experience in the system as safe and effective as possible. Integration is also happening with other systems such as social care, education, voluntary sector and the private sector to make the best use of public sector resources. This overlap in systems was evident in the study in relation to the changing children's workforce and in health visiting roles which serve as a bridge between other services. Given the potential range of professionals with whom health visitors work, it is essential that they have some form of stable collective identity with which to enter the interprofessional working setting.

The participants describe being individual representatives in multi agency groups which also makes having a sense of collective identity important in order to avoid role confusion. In addition to this, there is a need for health visitors to be comfortable with the role overlap that evidently exists. The degree of confidence with which role overlap is managed will be influenced by a strong sense of belonging to the group with which they have professionally bonded through education preparation and socialisation. Confidence in an interprofessional working situation can be enhanced through ongoing interprofessional learning and working.

Using the interprofessional dimension of the collaborative change process (figure 18) would enable groups of different professionals to come together to consider issues impacting on how they work together. This is especially important at times of significant role change, including changes in an organisation's expectations of a professional group. Furthermore the current UK healthcare and public sector context is experiencing a proliferation of new roles and technologies. Understanding the implications of integrating these into mainstream systems is increasingly important.

New roles

A study by May et al (2003) suggested that evaluation processes can play a part in the normalisation of new technologies into existing practice. They propose a Contingency Model as a framework for identifying and evaluating the impact of a range of factors that can influence the acceptance of new technologies as mainstream. This model has some potential applicability to understanding the implications of introducing new or reconfigured roles, into existing complex systems and networks. The mobilisation aspect of the model presents a framework for introducing "new actors" in the system, in relation to knowledge and technology. However it does not make explicit the interprofessional nature of the healthcare system and its complex relationship with the professional role identities of individual actors in the system. It does however acknowledge the need to organise expectations in practitioner communities and change the infrastructure and processes to allow for the change. The interprofessional role change process (figure 18) may be used in this context to collectively convince a

uniprofessional group of the relative value of a change for their professional group, be that the introduction of a new technology or a new role. In the interprofessional dimension the subsequent implications of accepting the change for their working relationships with other groups can also be understood. This way equilibrium within and across individuals, groups and systems might be maintained.

The data in this study suggests that the introduction of new roles can have a negative feedback effect on the professional identity of those in existing roles. For example new roles in Surestart and the use of nursery nurses in support roles, challenged some of the participants to consider the implications for them and their role. Using the interprofessional role change model in the interprofessional dimension would enable an open discussion of perceptions, identities, meaning and interpretations and facilitate agreement on a collaborative approach to incorporate the change into the local system context. Where the individual professional groups have a related opportunity to strengthen their "in group" perception of their collective public identity (Foley 2005), this gives individuals from those groups a stronger position in the interprofessional context. Clarity of role contribution and an opportunity for continual renegotiation is an important pre requisite for successful interprofessional working and maintenance of equilibrium of the negotiated order (Strauss 1959, 1997) in the organisation.

Public identity – service users

As discussed, public identity feedback can provide the health visiting group with valuable insight into how they are viewed by others. However collaborative working in health visiting is not just about partnership working between professionals, it includes service users and carers. Service users and carers provide valuable feedback on public identity to the profession through research. However, they also provide this in their daily interactions with individual professionals. This is an important source of identity equilibrium, internalised through the self referent feedback process at an individual level. Service user and carer involvement is being increasingly embedded at all levels of the health care system, including policy development. The opportunity for feedback to the professional group on the perceived efficacy of their service, by those people who receive them, should become mainstream practice. The development of a collective role identity should be by reference to health visitors' experience with service users and their

views on the best service that can be provided within the resources available. My own role change described in the introduction, was supported by a survey of those using local services who wanted more association with their GP practice so as not to be stigmatised by their area of residence.

The health visitors in this study clearly valued their relationship with their clients and it is likely that this feedback implicitly informs developments. However there was no evidence in the data of service user feedback informing organisational developments. It would be interesting to seek service user perceptions of health visiting in a collaborative, public health working context and compare it to existing research on the subject, which largely focuses on work with individual clients and families. Using service user feedback to continually improve practice through the interprofessional role change process, will further support and legitimise the collective decisions made by the professional group.

Health visiting has been described as a profession in crisis (Craig and Adams 2007). Individuals need support to reinstate and maintain equilibrium in their professional role identity, including their public identity. However, given the complexities of systems and the diversity of practice priorities noted in this study, it would be naive to think that simply implementing an interprofessional role change process (figure 18) would provide an immediate solution to the crisis. However, change needs to begin somewhere. This study suggests that simply introducing new policies will not necessarily effect change in perception and identity. Indeed, policy makers need to be aware of how the language used within them might potentially be interpreted differently by the recipients of the policy. This is especially the case when policies are intended for a range of different professional groups. If the policy language leans towards the professional discourse of a professional group then it may be perceived by those not sharing that perspective as being less relevant.

Changing culture

Fostering an open culture through the use of the model, where people feel comfortable being honest with one another about their identity in the uniprofessional dimension, will give staff an opportunity to bond within their professional group, to feel part of the

network of health visitors. For participants in this study it may offer the opportunity to get back to basics and redefine their unique contribution in their local workforce. It may also help to resolve the conflicts being experienced around what is and is not considered public health work and its relative value to other aspects of their work. Having these discussions and establishing a sense of collective identity will provide peer support for individuals in their collaborative working with other professionals and service users in the interprofessional dimension. It is clear in this study that interactions with others in the local context, affect the identity of individual practitioners and their role in action.

The interprofessional role change model proposed, links collaborative development in the uniprofessional and interprofessional dimension, in a continuous and cyclical way. As individuals engage in interprofessional working with colleagues and service users, their experience will cause them to reinterpret how they see themselves in their role. In order to maintain some level of consistency in the uniprofessional group identity, there needs to be an ongoing feedback opportunity. This will enable new perspectives to be expressed openly, both in the interprofessional working domain and in the uniprofessional domain. Facilitating a constant interplay between "in group identity" and public identity will ensure some degree of congruence. This will in turn minimise the risk of role expectation confusion, feedback from which can cause disequilibrium in the identity of individuals.

To add complexity, professionals do not work in isolation from others in their interactive professional practice context. An interprofessional, collaborative approach to role change, would not only involve the professionals and agencies involved in the overlapping organisational systems, but also the recipients of the service. Interaction with service users and the feedback from the process can play a key role as a referent point for the formation of professional role identity. As the power relationships between service users and professionals change there will need to be a readjustment in the system to create an open, supportive, learning culture more receptive to collaborative working and continuous service improvement.

Education implications

Developing skills for collaborative working

Throughout the development of this thesis, the need for collaborative working in the current system has been emphasised. However, it cannot be assumed that individuals have the skills and confidence to work collaboratively. Not all participants in this study had had positive feedback through their interprofessional working with others. Indeed some were open about a lack of confidence in group type situations, which impacted on their perceptions of their adequacy (Machin and Stevenson 1998) for the collaborative public health role.

New entrants to health visiting

Given the confused picture of the current position of health visiting it is likely that new entrants to the profession may also be confused about what it means to be a health visitor in the current practice context. Previous discussion has identified a lack of role standard in relation to public health work in health visiting, yet programmes leading to registration on part three of the NMC register have "public health" in the role title. In addition, given the diversity of opinions on the relative value of public health work in health visiting and its application to practice, students on the health visiting programme are likely to get mixed messages in terms of their practice education experience and role modelling of the role standard. There is clearly a need to re establish the equilibrium in the health visiting role identity as discussed earlier, in order to avoid perpetuating the current situation though education and socialisation into the role.

At a local level at least, there is a need for practice educators to provide congruent practice education context that reinforces and supports the ideas of the curriculum. This being the case using the interprofessional role change process would enable practice educators to come together as a group to debate and discuss the core role standard that can be conveyed to the students they have a responsibility to educate. There is also a need for new health visitors to be equipped with the knowledge skills and attitudes to work in a collaborative, interprofessional way. They need to be able to articulate what is unique about their professional contribution in the local context of their practice.

Interprofessional education is now accepted as the most effective learning and teaching approach to foster the culture to support collaborative working (Barr et al 2005). Much of this educational activity is focused on pre registration health and social care, implemented early to minimise the development of negative professional stereotypes and build confidence working with other professionals. It is now a curriculum requirement that all UK health and social care programmes demonstrate evidence of interprofessional learning (IPL) in the form of small group interactive learning between students from two or more different professional groups. This being the case it is increasingly likely that student health visitors will have had some IPL in their pre registration nursing programme to equip them with collaborative working skills.

However, most programmes leading to registration as a specialist community public health practitioner are classed as continuing professional development programmes, given the pre requisite for first level registration. This being the case, there is perhaps less of an emphasis on IPL. Therefore student health visitors may not have an opportunity to learn with other students about where their roles might overlap and how best to work together for the benefit of people using their service, which ultimately is the aim of IPL.

Existing workforce

Health visitors in the existing workforce are likely to have different development needs, more explicitly linked to a revision of their existing role identity than socialisation into a different one. Providing formal interprofessional learning opportunities to the existing workforce is logistically more difficult, due to time constraints in the practice system context. Engaging in the interprofessional dimension of the role change process (figure 18) offers an opportunity for different professions in a local context to learn with, from and about each other in the process of collaboration. However there is a need for individuals to find a shared reason to come together to work collaboratively. This may be triggered by an external trigger such as a new role, role change or policy or it may be in response to service user feedback. However if the local team have been able to establish an ongoing discussion group for all issues affecting the interprofessional team as recommended, in effect this embeds an interprofessional learning opportunity from which all could benefit. A process of reflection following such meetings either with the

interprofessional team or the uniprofessional team will provides a continuous reference point for maintaining identity equilibrium.

Developing skills for leading collaborative change

Increased service integration means managers will necessarily be leading multiprofessional groups of staff. Many health visitors in leadership roles have developed their career pathways from clinical practice and have not had the opportunity to refine these leadership skills in a multi or interprofessional situation. Organisations should provide collaborative learning opportunities that allow leaders of different professional groups to work through the interprofessional dimension of the proposed interprofessional role change process (figure 18). In doing so, they also will have an opportunity to learn with, from and about each other to establish mutually agreed goals for service improvement that are supported by a collaborative working ethos (Freeth et al 2005).

Research Opportunities

The production of this thesis from the research study undertaken has generated several other potential lines of enquiry that could be pursued to add depth and understanding to the theoretical assertions and proposals made. These are outlined below:

- The process model (figure 16) identifying the feedback mechanisms that are used to maintain identity equilibrium, could be tested in an applied way to a range of other practice contexts and professional groups. Using it to understand the experience of individuals in new roles where there is no well established, collective role standard for example may help to understand how collective professional identity is formed in an interprofessional, healthcare system. It may also highlight the potential risks to the success of their integration into existing practice cultures.

- There is also the potential to continue to explore the situation of health visitors through collecting data from the other professionals who interact with them. The aim would be to examine the accuracy of the health visitors' perceptions of their

public identity, when matched against the actual expressed views of others with whom they interact. The feedback to health visitors from the findings would provide useful contextual information that could inform how the profession manages its public identity and impression management processes. The process could be reciprocal to engage all groups involved in open dialogue to establish a sense of shared identity at the level of interprofessional service provision.

- The interprofessional role change process proposed in this study is based on the theoretical assertions made about the different feedback processes through which individuals formulate and maintain equilibrium in their identity. However, this needs to be subject to further research to rigorously examine its feasibility as a model for successful role change management in an interprofessional healthcare context. Given the double loop, interactive nature of the model it is suggested that a research approach such as action learning would enable the model to be implemented in an organisational context and evaluated at different stages.

- The recently published child health promotion programme (CHPP) (DOH 2008a) is yet another policy directive expecting a change of role for those involved in its implementation. Given its focus on child health, this means more change for health visitors (Adam and Newland 2008), at least a change in the perception of others in relation to the role of health visiting in the process. Instead of simply cascading this as information into the system, an active interprofessional role change approach offers the opportunity to test the efficacy of the model. Using a longitudinal approach to test the model as a process of team development, would enable further exploration of the model's applicability to the facilitation of continuous improvement in service delivery.

- The service user perspective has not been the main focus of this thesis. Further research could explore how the service user voice informs all levels of identity feedback to individuals and organisations. Understanding the effect of different types of feedback mechanism on the interprofessional role change process, may inform the development of an embedded model for continuous service user

involvement in the ongoing development of the health visiting role identity and the services provided.

Recommendations

1. The degree to which public health work in health visiting is task orientated, or is integral to the professional role identity of all health visitors, needs to be agreed within the collective health visiting group. This would go some way towards establishing identity equilibrium within the health visiting group in relation to public health role expectations.

2. Health visitors in an organisation should establish regular opportunities to convene to discuss issues of professional relevance. This would provide a mechanism for ongoing feedback on role from practice and the ongoing maintenance of identity equilibrium. Embedding systems to sustain changes should be a priority.

3. The development of a cohesive collective health visiting identity at a local level should become a priority of those managing the services. A participative approach to change facilitation should be implemented. The interprofessional role change process proposed in this thesis should be initiated as a pilot, with the aim of testing its efficacy for the purpose.

4. The outcome of local level consultation on a collective health visiting professional identity should be fed back to those leading the profession nationally to inform ongoing professional policy development.

5. Further consultation with the national health visiting workforce should be undertaken urgently to establish the degree to which health visiting is a profession independent from nursing.

6. Once a collective identity has been established within the health visiting group a deliberate strategy to raise awareness of others should be undertaken, to promote the value of the health visiting profession in the healthcare system. Based on collaboratively developed resources for consistency, this process should be facilitated by individuals in their own practice context.

7. Interprofessional teams should establish a regular meeting opportunity as feedback mechanisms through which the practice development and the implementation of role change can be managed.

8. Interprofessional team meetings should be recognised and valued as interprofessional learning opportunities and maximised through a process of facilitated reflection on practice.

9. Given the importance of collaborative working skills to ongoing role identity negotiation, interprofessional learning opportunities should be embedded into programmes leading to qualification in the health visiting role.

10. Interprofessional leadership skills development should also be available to those managing the changing professional practice context.

11. Service user perspectives should be sought on any further proposed changes to the health visiting role to ensure it remains fit for purpose and continues to be valued by those who need their services.

Conclusion

In essence, this thesis has established that the health visitor participants in the study are experiencing role identity difficulties in negotiating their role at a local level. The proliferation of policies affecting their role has been cascaded in a variety of ways, adding to a lack of clarity in the expected health visiting role standard. In addition they have been subject to challenges to their public identity through the change in role title and role confusion in an interprofessional working context. Whilst this study has not

focused on the service user perspective it is likely that the effects of this role confusion will extend to those trying to effectively access and use the services available. Negative feedback from service users is likely to compound any disequilibrium in the professional role identity of individual practitioners who evidently place much value on their relationships with their clients. The turbulence in the participant health visitors' identity is also reflected in the health visiting professional literature. If health visiting is to strengthen its position in the healthcare system of the future, urgent action needs to be taken.

This study suggests that for health visitors to continue to be credible contributors to the interprofessional healthcare system, a process of support and facilitation is needed. This will enable them to re-stabilise their professional role identity and re-bond (Putnam 2000) with their professional peer group. This study has shown that this stabilising process needs to be actively managed. The interprofessional role change process identified in this thesis offers a potential model to facilitate this. Role change left to the interactive and interpretative experience of individuals, results in diverse practice and lack of clarity in individual and collective professional role identity. This in turn could lead to the potential fragmentation and devaluing of the health visiting contribution to healthcare. For health visitors, influencing policy affecting health is a core principle and individual practitioners in this study valued their autonomy. There is a need, therefore, not only to empower individuals to respond effectively to policy, they also need to be empowered to collectively contribute toward the shaping of new policy. This influence needs to be integrated at both a local and national level, through ongoing uniprofessional and interprofessional learning and working.

The more coherent the professional role identity of health visiting, the more their voice will be heard locally. The greater the national stability of their collective professional role identity, the more strength there will be in articulating to policy makers their unique contribution to the healthcare system. However, this collective identity cannot be assumed or taken for granted in the production and implementation of policy. The process of role change needs to value individuals and their perspective. To be effective in maintaining role identity equilibrium, the process needs to incorporate the meanings they attach to their interactions with others, in their local professional role context.

The system in which healthcare is delivered is becoming increasingly complex, driven by technological advances and higher service user expectations. Feedback from those using health services suggests that it is the individuals they come into contact with who make a difference to their experience. People matter, not just systems and processes. For professionals to maintain optimum performance they need to feel a high degree of adequacy, legitimacy and support in their role. In a professional practice context characterised by turbulence and change, individuals need to have a strong sense of role identity and purpose. In addition, cultivating opportunities for individuals to develop a sense of belonging is essential. They need to feel that their contribution in the system is essential to its performance not anonymous or superfluous. An NHS committed to valuing individuals, both service users and staff, will provide a firm foundation on which to build a culture of collaborative working.

Health visitors have an important role to play in promoting public health through their work with individuals, families and communities. It is time for them to collectively celebrate their past achievements, to re-establish a strong professional identity bond based on agreed principles and values, and look forward to the future with optimism, working together for better health.

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Appendices

Appendix 1: Table of policy

Date published	NHS Workforce policies	Public Health Policies	Nursing & Health Visiting Specific Policies	Relevance to health visitor role/practice context
1997a	The New NHS: Modern Dependable (DOH)			Shift of emphasis to primary care; Services redesigned around service users; Primary Care Trusts established; need for more collaborative working to improve public health. Role for health visitors on PCT boards.
1998		Surestart (Home Office)		Targeted early years provision to areas in most need; "new" family centred public health role" for health visitors; potential change to practice context of health visitors.
1998		Acheson Report		Governments' vision for reduction in health inequalities through public health approach; Public health definition clarified; collective responsibility for public health affirmed
1999a			Making a Difference (DOH)	All nurses have a contribution to make to promoting and protecting public health; health visiting identified as the key nursing role for public health
1999b			Our Healthier Nation (DOH)	New labour Government revision of an earlier policy – the health of the nation. Sets out collective responsibility for health and tackling major causes of morbidity and mortality in the UK.
2000a	NHS Plan (DOH)			Need for a collaborative workforce, service user focus, public accountability for all professions working in the NHS
2001a			Resource Pack	Continuum of public health

			for Health Visitors	work in health visiting identified. Examples of good practice in public health work with individuals, families, groups and communities. Focus on a collaborative working, identification of some skills needed for public health work. Framework for Whole Systems Pilot.
2001		Health Select Committee Report		Review of public health service provision. Establishment of public health specialist team sin PCTs. Eligibility for professions other than medicine to lead these teams. Health visitors identified as having a key public health roles.
2001b	Learning together working together (DOH)			Governments' vision for educational development needed to enable professionals and others to collaborate effectively in a modern NHS. Interprofessional learning endorsed as most effective learning and teaching method to meet this aim. Articulated as a requirement for all pre registration professional preparation.
2002			Hall Four (Hall and Elliman)	Replaced Hall 3 (1996). Recommended child development programme; re emphasis on universal child developmental surveillance by health visitors, with increased provision for children in families most in need.
2002a			Liberating the Talents	Major workforce development strategy. Acknowledges the role of health visitors in public health
2003		Every Child Matters (DfES)		Comprehensive, cross departmental policy directive to reorganise children's services; collaborative working across agencies is core to the new children service provision; children's centres established to absorb

				Surestart centres and better link health, social care, education and the wider community; health visitors identified as key professionals in children service provision; emergence of new roles to undertake work traditionally undertaken by health visitors.
2004a 2004c 2004b			UKCC superceded by the Nursing and Midwifery Council (NMC) as the professional regulatory body for nurses, midwives and health visitors Standards of Proficiency for Nursing (NMC) Standards of Proficiency for Specialist Community Public Health Nursing (NMC)	New 3 part register. Part 3 not exclusively for health visitors. Part 3 is for Specialist Community Public Health Nursing (SCPHN). Open to nurses on part 1 of the register who have undertaken a recognised preparation programme for public health working and/or can demonstrate through portfolio, competence to transfer to part 3 and practice as a SCPHN Proficiencies of practice leading to registration on parts 1 & 3 of the new register published.
2004b	Agenda for Change (DOH)			Vision for a streamlined workforce. Bandings for pay and associated responsibility introduced, that were not profession specific, but related to the overarching knowledge and skills framework for all NHS staff. Need for staff to be able to articulate their ongoing personal and professional development contributing to the NHS as a learning organisation. Linked to public accountability.
2005a	Independence Wellbeing & Choice (DOH)			Adult green paper. Firmly endorses the government's commitment to integrated services, responsive and

				flexible to the needs and choices of service users and their carers
2006			Principles of Health Visiting Revisited (Cowley and Frost)	Key professional document re affirming the Principles of Health Visiting as current and clarifying current issues in health visiting, including the public health role.
2007			Health visiting role review (Lowe 2007)	Review of strengths and weaknesses of HV role and service provision. Place of health visiting in healthcare system clarified and supported. Proposed focusing of HV on work with families and children where evidence base of effectiveness is clearer.
2007a			DOH response to health visiting role review	Report endorsed by central Government.
2007b	Modernising Nursing careers (consultation (DOH)			Consultation on the future of nursing. Proposed model challenges the existing model of four branches of nursing followed by CPD specialist preparation, including preparation for health visiting role. Focused on service user groups such as children and families. Potential for direct entry to undertake public health work with children and families.
2008a		Child Health Promotion Programme launched (DOH)		Reconfigured child health promotion programme with a cross organisational view. Child health very firmly every body's business. Can both reaffirm health visiting contribution whilst generating increased role overlap.

Appendix 2: Sampling questionnaire

Sampling Questionnaire

The information that you provide on this form will help to inform the sampling process for this study. Once the sampling process is complete this information will be destroyed. Please complete and return it to Alison Davidson in the envelope provided. Thank you.

1. What is your job title?

2. What are your professional qualifications?

3. Who is your employer (please tick)?
   PCT
   GP
   Other (please identify):____________________

4. Do you do public health work (please tick)?

   Yes No

If you answered "Yes" go to question 8

If you answered "No" please continue:

Would you like to do public health work (please tick)?

Yes No

PTO

6. Please give an example of the public health work you would like to do:

7. What would you say is the main reason for you not doing public health work?

Thank you for completing this form

Continued from question 4:

8. On a Scale of 1-5 how much of your work do you think can be described as public health (please circle a number)?

Less than 10% 100% public health

1 2 3 4 5

9. Please list the areas of public health work in which you are currently involved:

Many thanks for completing this form. Please return to Alison Davidson in the envelope provided.

Appendix 3: Information for professionals

Information for Professionals

A research study is being undertaken in your practice area. The researcher, Alison Davidson, is a PhD student with the School of Population and Health Sciences at Newcastle University. She is also a registered nurse and health visitor. The study aim is "to understand how nurses working in primary care are interacting with the changing primary healthcare policy context which advocates an increasingly public health approach to practice".

What will it involve?

A grounded theory research design will be used to address the research aim. This is a qualitative methodology which involves the collection and analysis of data from a variety of different sources in an attempt to develop a theory about the research subject – in this case the public health work of primary healthcare nurses. This study will involve an initial postal questionnaire to be completed by nurses working in primary care (enclosed). The information provided by this process will facilitate sampling. The data for the study will be collected by observation of primary healthcare nurses' public health practice and follow up individual interviews. Your help is greatly appreciated. If you are chosen for observation or interview you will be contacted individually and asked for your consent to take part. If you agree, a date, time and venue convenient for you will be arranged. Your anonymity will be protected and any reference to identifying factors removed from any reporting of findings. The researcher will also share with you her interpretations of the data collected from you to check that it is a valid reflection of your perspective. If you consider that the nature of an observation setting has become delicate, you may ask the researcher to leave at any time. If there is any information that you do not want included in the transcription of notes or tapes please inform the researcher.

Why is this important?

This study will highlight how current changes, which recommend a public health approach to practice, are affecting you as an individual practitioner. It will also show how and to what extent your individual practice is changing as a result of the public health policy agenda. This information will help to inform the process of role development in primary health care nursing.

If I have any questions?

If you would like to discuss any issues further please contact the researcher, Alison Davidson on 2156375 or the project supervisor Dr Pauline Pearson on 2228761.

Appendix 4: Sampling matrix compilation

Summary of questionnaires			Matrix Code
1. Job title:	health visitor	26	1A
	specialist HV	2	1B
	DN Sister	7	1C
	Practice nurse	10	1D
	Clinical nurse lead	2	1E
	Nurse practitioner	1	1F
	Student HV	1	1G
	Specialist nurse	2	1H
2. Qualifications:		RGN	2A
		RM	2B
		RHV	2C
		BSc (hons)	2D
		CPT	2E
		Diploma HE	2F
		RSCN	2G
		Multidiscplinary practice teaching cert	2H
		Obs cert	2I
		MA	2J
		DN	2K
		Nurse Prescriber	2L
		BTEC in health promotion & education	2M
		RN Dip HE Child Branch	2N
		Practice Nurse Cert	2O
3. Employer:		PCT	3A
		GP	3B
4. Public health work:		Yes 42	4A
		No 7	4B
5. Would you like to do ph work		Yes 3	5A
		No 3	5B
6. Examples of work you'd like to do:		Work proactively with the community	6A
		Don't know	6B
		No response	6C
7. Reasons for not doing ph work:		Too busy doing chronic disease management	7A
		Not enough time in the day	7B

Workload and caseload can vary		7C
not able to take on extra work		7D
No time		7E
Busy caseloads		7F
Leaving job soon		7G
Do do some in everyday work but not defined as ph		7H

8. On a scale of 1-5 how much work is ph work:

1	4	8A
2	7	8B
3	10	8C
4	12	8D
5	7	8E

9. Areas of work currently involved in:

Clinical quality/ governance	9A
Change activist	9B
Aim to achieve target of NSFs	9C
Raising awareness	9D
Health needs assessment	9E
Proactive health promotion	9F
Primary/secondary/tertiary prevention	9G
Cervical cytology	9H
CHD/ rehabilitation	9I
Sexual health	9J
Smoking cessation	9K
Dietary advice	9L
Elderly assessment	9M
Well person clinics	9N
Groupwork	9O
Home visits	9P
Telephone support	9Q
Out reach work	9R
Multi-agency working	9S
Working with community groups	9T
Links to strategic homelessness groups	9U
Facilitating access to GP services	9V
Well being of homeless & asylum Seekers	9W
Professional support for local food co-op	9X
Public events	9Y
Screening	9Z
Imms & vacs	9a
Child health surveillance/ CH Clinics	9b
Parenting	9c
Baby massage	9d
Weaning	9e
Mother & toddler group	9f

Nursery/ school liaison	9g
Child protection	9h
Maternal health	9i
Behaviour management	9j
Safety advice	9k
Postnatal support groups	9l
Breast feeding support	9m
Relationship counselling	9n

Extract from compiled matrix

Questions	1a	1b	1c	1d	1e	1f	1g	1h	2a	2b	2c	2d	2e	2f	2h	2i	2j
Potential participants																	
2	*								*	*	*						
3			*						*					*			
4	*								*	*		*					
5	*								*	*	*	*					
7a	*								*	*	*		*				
10									*			*		*			
12	*								*		*						
13									*			*	*				
14	*								*			*	*	*		*	
16			*						*			*					*
20	*								*		*						*
21	*								*	*	*						
22			*						*								
25	*								*								
26	*								*			*		*			
30	*								*		*						
32									*	*							
33									*			*					

Appendix 5: Theoretical sampling summary

Time Line	Partici pant	Summary of Reason for Selection	Data Collection
March 03	*1*	*Sampling matrix used. Questionnaire indicated a perception that 100% role was public health. On PCT executive committee as a practice nurse. Working in a unit for healthcare of transitional families. Assumed they would be able to articulate a perspective on public health work. Observation indicated work not normally described as public health. Needed to find out more about individual perceptions of public health, previous experience that underpinned this perception and understanding of policy/ policy influences on practice.*	*Observation and Interview*
March 03	*2*	*Previous interview gave a practice nurse perspective. Needed to collect data from a health visitor because public health defined in policy as a key part of a health visitor role. First participant had a "medical" perspective on public health. Need to explore to see if there were any others. Needed a different practice context to enhance understanding of the influence of context. Sampling matrix used. Questionnaire indicated 100% role was public health.*	*Observation and interview*
May 03	*3*	*Worked in same locality as participant 2. Wanted to explore context issue more. Had a defined role as a "change activist" in the whole systems pilot for developing a public health approach to primary care working. Only indicated public health to be 60% role. Interesting to explore differences in role and differences in perception of public health within that. Participant 2 trained less than 5 years ago.*	*Observation and interview*

		Interested to explore influence of practice experience & education on perceptions. Been health visitor for 20 years.	
June 03	*4*	*Interested in exploring range of public health practice and further understanding of context of practice. This participant was a health visitor who worked in same locality as the others. Sampling matrix used. Questionnaire indicated 80 % role was public health. Described a range of activities they were involved in that they perceived to be public health. Some of which I'd observed with the other participants e.g. smoking cessation. What was the rest of their practice if not public health? Was it different? Interesting emerging issue of the influence of others on the degree/perceived value of public health work as a health visiting activity.*	*Observation And interview*
July 03	*5*	*The previous interview had indicated that participant 4 had felt she constantly had to justify to health visiting peers the aspects of her work that were considered public health and not mainstream practice. She felt others devalued that work with the opinion that she had spare time to do it when they didn't. If other people and local expectations have such an influence then this needed to be explored in another context where the people & practice would be different. From my knowledge of the locality I knew that this health visitor worked in different locality in the same PCT. Questionnaire indicated 20% public health work. Also had a role on PCT executive as HV – potential follow up to interview 1 and any common factors. Influence of "management" had emerged as an issue. This participant had a part clinical and part role managing and leading the*	*Observation and interview*

		primary care nurses in the locality. Qualified less than 5 years ago. Potential to explore the influence of education. Local policy/ protocols and their influence on practice was emerging. This HV through their role on the PCT was involved in policy development. Opportunity to explore this.	
Nov 03	*6*	*The issue of whether or not public health work was part of mainstream health visiting practice was emerging. If it was "core" then everyone should be doing it? On the sampling matrix questionnaire this HV indicated that very little of her work was public health (10%) as she didn't have time to do any. She worked in the same locality as participants 1-4. Interested to follow up why her perceptions might be different. I had also shared a caseload with this health visitor and knew that her mode of practice was similar to much of what I had observed with the others. I also knew that she worked in a very collaborative way with the community her clients lived in. As a result of this insight I was confident that observing her work would add nothing new to the emerging data category that was an analysis of the range of practice perceived to be public health. I therefore decided not to observe her but to interview her.*	*Interview*
Dec 03	*7*	*Interview analysis from participant 5 indicated a perception that public health working was the responsibility of all primary care nurses. The first interview with a practice nurse indicated that any public health work was about disease prevention/ screening for ill health, individual model of practice. Interested in exploring same locality as participant 5 but different nursing discipline to explore the*	*Observation and interview*

		relevance of public health work to practitioners other than health visitors. This participant was a district nurse in a leadership role in the same locality as participant 6. Sampling matrix questionnaire indicated 10% public health work. Another potential interesting avenue to explore was that of gender in relation to the influence of others on practice. Power and autonomy had emerged as an issue. All other participants had been female. This one was male. I was interested in observing to see if different forms of work were within district nursing activity that might add to the category "the nature of public health work".	
Dec 03	*8*	*Education was an issue of relevance, especially the influence of practice based learning on perception of the nature and value of public health work, and the influence of the individual practice teacher supporting the process. This participant was a community practice teacher and may have been able to add more depth to understanding that data category. She also had a role of liaison with A & E in relation to childhood accidents. Working with others was emerging as a key category therefore by the nature of that role there may be something new to add to that data. Indicated on the matrix that 40% of her work was public health.*	*Observation and interview*
March 04	*9*	*Context and interactions with others was emerging as a key factor in understanding perceptions and actions of the participants. This participant worked as a HV in a different PCT. The context would therefore be different. In addition organisational influence might be different. She would hopefully be articulate about public health as the matrix indicated she thought her*	*Observation and interview*

		role was 100% public health. Interestingly the sampling matrix indicated that this participant was also a qualified district nurse. This might add useful data in relation to the relevance of a nursing identity to perceived role as a health visitor and in public health which was emerging as a potential issue of relevance. This HV also trained over 10 years ago. The perceived influence of initial and ongoing education for public health was emerging as an issue. Observation may indicate different forms of work perceived as public health.	
May 04	*10*	*This HV worked in a locality within one PCT not yet explored. Whilst she did not complete a questionnaire for the matrix I knew that the demographics of this area are different in that there is a high percentage of affluent families. This HV also worked in a GP practice with a high number of clients from different ethnic backgrounds. I was interested to explore any different issues relevant to different context and public health work related to different population groups. This HV agreed to be interviewed but did not feel comfortable with my observing practice with clients who did not speak English. Influence of nursing identity was emerging as a significant influence on perception of public health working and relationships with others. Opportunity to explore this further.*	*Interview*
May 04	*11*	*As "context" of practice and local working relationships were emerging as perceived influencing factors I was interested in exploring a range a different practice settings defined as public health on the sampling matrix to see there were any constant themes that did not seem to be affected by context.*	*Observation and interview*

		This health visitor said she ran a "baby club" that she though was public health (link to participant 4) and that her work was 80% public health. She also worked in the same PCT as most of the other participants and the same locality as participant 10 i.e. an area generally more affluent than the others. Given that public health is about reducing inequalities I was keen to explore the demographic issue further. I also knew that she had also trained as a health visitor at the same time as participant 4 so this was another opportunity to explore educational influences.	
May 04	*4*	*Given the changes in policy, the professional register and local development relating to public health, I was keen to explore any difference it had made to the perceived relevance of public health working. I selected this participant as one of the early participants (June 03) to re interview. She had also recently taken on the role of community practice teacher. She had been very articulate about her perceptions therefore she may be able to add depth to the emerging categories and their interplay.*	*Re Interview*
June 04	*12*	*This HV worked with a population with high ethnic minority population (link to participant 10) but in a different PCT (link to participant 9). Further exploration of influence of context, population demographics and working with others at a local level needed. Did not complete a questionnaire for matrix. Participant 10 suggested she may be an interesting participant given the different locality which was more socio-economically deprived than hers. It was clear that how smaller staff groups worked differed across localities within*	*Observation and interview*

		organisations. Influence of management and policies emerging as significant. Participant 10 and 12 trained as HV at the same time over 10 years ago. I was keen to follow up the education aspect.	
Sept04-Sept05		***Study suspended for 1 year for personal reasons***	
Oct 05	*13*	*Reflecting on process and progress to date (reflective diary evidence from May 04 observation participant 8) it was evident that direct observation was no longer contributing to* ***theoretical*** *depth of the data category relating to the nature of public health work or indeed other emerging categories. Further depth was needed in relation to individual perceptions for which individual interviewing was considered the best data collection. Decision made to interview only (rationale elaborated on in method section). Picking up on the education theme I selected this participant as she had only recently qualified as a health visitor. Given that the public health role of the HV was now embedded in policy and the professional register (see literature review) my perception was that education programmes would need to explicitly contain education for public health working. I was keen to explore this issue. She had also been a student HV with participant 4 as her community practice teacher so there was an opportunity to explore perceptions of both theoretical and practice learning.*	*Interview*
Dec 05	*8*	*Given the extended time frame and evidence from P4 that things had changed in the locality I made the decision to some further interviews. Participant 12 had talked at length about their corporate caseload model of practice. Participant 13 also talked about the corporate caseload model she worked within. The*	*Re interview*

		literature suggests this is meant to facilitate better collaborative working, which underpins much of public health work. Participant had changed jobs since the last interview and was now working in a corporate caseload. She was also working in a locality with a Surestart centre and I was keen to explore the relevant of this. Additionally, she was working in the same team as participant 13. This interview had indicated that team members had affected her perceptions of public health work and her practice as a newly qualified practitioner.	
Feb 06	*6*	*Participant 6 had changed roles since her first interview. She was now in an atypical role supporting transient families which, as an organisational role, was potentially very different from her traditional caseload work and may have affected her perceptions of public health work. Significantly such a role would require cross agency working. Interaction with others had been established as a key category within the data. I was interested in whether that was different when the "others" were outside a health field and if it made any difference to models of practice.*	*Re interview*
May 06	*14*	*The second interview with participant 6 had indicated that her view of public health working had indeed changed but that despite her a typical role she still felt it was very much health visiting and a legimitate way of working although she felt she had to convince other HVs of that. I was interested in exploring some other roles undertaken by health visitors in relation to the impact of role on professional identity and how they legitimised their approach to practice. This HV was working in a management & leadership role within the PCT,*	*Interview*

		influencing practice at the level of local organisational policy. She also managed a number of the study participants. I was keen to find out again whether in this role she still identified with being a health visitor. I was also interested in her perspective on public health work in health visiting given that a number pf participants had talked about the influence of management on their work.	
May 06	*15*	*This HV worked as a health co-ordinator within the Surestart centre in the same locality as participant 8. This may add depth to the evidently core relevance of the context of practice for how public health work is perceived and carried out. As a professional role, not entitled health visiting, in an organisation set up in a public health collaborative model of practice, it may also add specifically to the key relevance of professional identity and the depth of the category relating to public health practice. Skills for public health work was also an issue of relevance. Did working in a different role as an HV require different skills?*	*Interview*
Feb 07	*16*	*The interview with participant 15 indicated that despite it being a different organisational role she still felt she operated within the Principles of HV practice. This participant also had an atypical public health role and was linked to a different PCT, in fact the public health part of her role was with the acute health Trust. I was keen to explore again whether she felt this was different to health visiting and the influence of others on her professional identity. Additionally the other part of her role was caseload health visiting so she may have a different perspective on how public health work fits with*	*Interview*

		health visiting practice i.e. whether it's mainstream or not.	
March 07		*Opportunity to get a male HV perspective. Works in same organisation as participant 16 – context link. Works with looked after children team and links to child protection. CP has been used as a reason for not getting involved in public health work and has been identified as public health work. Interesting link here.*	*Interview*

Appendix 6: Expanded observation fieldnotes

GP attached HV working from an adjacent PCT building. Shared office with 2 other HVs.	Proximity to GP location of work Working with others routinely
HV reported that that morning she had seen a smoking cessation clients and prescribed NRT/ offered ongoing support Had liaised with GP over family with ongoing child protection issues	Individual contact (smoking cessation support) Nurse prescribing psychological support Communication with GP Child protection responsibility
Informed she had booked 2 visits - described as:	Planned home visits
A child protection visit – young mother, father with a history of violence – aim of visit: Compliance with care team requirements "Weekly support" "Monitoring of situation" "see how they're coping with their new baby"	Child protection (CP) work Family work Prescribed CP role Psychological care CP Surveillance role Surveillance/ assessment of coping ability
R: how do you see that work fitting with PH agenda?	
"Well it doesn't really – public health involves the public in the process. It's working with people. This is work that has to be done whether they want it or not"	Not public health work. Family have no choice. Public health is about collaboration.
An elderly visit – follow up visit from previous visit after referral from GP. Needs assessment done previously, referred for services. Walking stick was ordered. This visit is to see if other services have been started and to deliver walking stick.	Work with an older person ongoing work Initial GP referral previous assessment Referral to other agencies ordered equipment Evaluation previous referrals Provide equipment
Visit 1 Arrived at house with scales to weigh baby. Met at door by the mother who said she had to go out. Because this was an enforced contact mother asked if she could go to clinic in the afternoon instead. HV asked if she could come in for 5 minutes just to see if everything ok. Father present – also	Weight monitoring Asking HV permission to change arrangements

grandparents. HV welcomed asked to sit down. Talked to baby. Asked about father's health and whether the couple were getting any sleep. Introduced the Edinburgh Postnatal Depression screening tool "we do this with every new mother". Agreed they could come to clinic. Afterwards we discussed EPDS. A protocol had been devised in the PCT by a multi-disciplinary group and based on best evidence. All women are screened by the health visitors at 6wk, 12wks and 8 months. There is an expectation that at least one of these contacts is person to person at home. The HVs are getting training in PND support. "the 3 month contacts are no problem because I do my weaning visits at around that time anyway".	Access still gained for monitoring purposes Extended family present Family complied with HV presence Men's health assessment Assessment of parents coping Screening for postnatal depression universal screening explained to MotherHV Giving permission to change details of contact Postnatal depression multi-disciplinary working protocol working evidence based practice universal screening at set times prescribed home visiting in service training in PND some of protocol fits with normal routine unproblematic routine contact at 3 months for weaning
R: has the "whole systems pilot work made any difference to your work"	
"yes I think it has. Before that I wasn't really aware of the wider community. Now even when I see individual families I am linking them much more into the community. I know a lot more about what is going on out there"	Policy has made a difference greater community awareness since WSP Linking families to community resources Greater awareness of community resources
Visit 2 Very deaf older lady. Services ordered had been started e.g. day centre visits, care call. Lots of questions asked as part of ongoing assessment and evaluation. Checked lady knew how to use bath seat and care call telephone. Reiterated information about recently prescribed medication for constipation. Advice re diet. Asked about social support. Follow up phone call to lady's sister to get a better picture of how she was coping.	Older person resources accessed Assessment and evaluation monitoring safe us of equipment Nurse prescribing client education dietary advice assessment of social support extended family contribution to assessment assessment of coping
"I only do the elderly because the previous HV did. So one of the GP refers everything to me. That's all well a good but it's a bit much when I've got lot of new mums and	existing elderly caseload GP refers elderly to HV Mums and clinics seen as priority Unsure of role with older people Cross agency working

clinics and things to do. Plus I don't really know what I'm doing. I'm having to play it by ear. A lot of what I need to know I've found out by asking social services."	
R: Do you prioritiose GP referrals?	
"Yes I do tend to do them as soon as possible. I suppose out of a sense of obligation"	GP referrals prioritised. Feels obligated
"it must be worse for people based within the GP practice building. I'd never get any of my own work done for referrals from the GP"	Being located outside PG surgery keeps the number of GP referrals down
If HVs worked in teams and weren't attached to GPs there perhaps would be less of an obligation.	Organisational influences on work Teamwork alternative model for work GP influence on HV work
Lunchtime meeting with Rep from Nicotine Replacement Therapy company.	Liaison with private sector Smoking cessation
3 HVs/ 1 PN/ 1 Nursery nurse/ rep.	Multi-disciplinary working
Discussed the success of a recent health promotion activity. The HVs and nursery nurse had a stall in the local supermarket to discus smoking cessation with members of the public. Lots of interest. Information given about the availability of NRT on prescription. Most people thought you had to pay for it. Used carbon monoxide monitor on people. Gave out leaflets. Information given about HV run smoking cessation groups.	Positive evaluation of HP work Collaboration with local business Raising awareness of smoking cessation support Information giving raising awareness Screening Distributing HP written material Information giving about local services
Shocked at the number of school kids who said they smoked and at their carbon monoxide levels. Discussion re doing an event in the local schools targeting young smokers. Said they could involve school and school health advisors. Rep said could supply some posters etc to help.	Assessment raised existence of hidden health need planning PH activity Multi disciplinary private sector involvement resources identified
Discussed asking local employers if they could access workplaces with the smoking cessation info. Occupational health nurses reportedly not doing anything at present.	Planning raising awareness in the workplace

Importance of tailoring advice to occupation discussed with rep. E.G. taxi driver might not want inhalator.	Rationale for targeting and tailoring services to meet need
Discussed methods of assessment and motivational strategies.	Process of smoking cessation support work
NICE guidelines seen as important evidence underpinning smoking cessation practice	Policy underpinning SC practice
Discussed targeting pregnant women	Identification of at risk population
	Clinic work well babies
HV run Well baby clinic	
Open clinic room in PCT premises. Numerous health promotion posters on walls covering a range of topics such as SIDS, healthy diet, home safety, dental health. Baby scales in corner of room, seats around room, changing tables for undressing babies. Reception desk where parents hand in child health records.	Trust premises HP information on walls Receptionist doing admin Weight monitoring Parent held records
Scales manned by nursery nurse who weighs and records weights. Immunisations done by practice nurse in a separate room. HV on first name terms with parents.	Nursery nurse weighs babies PN does Imms HV knows parents Preschool children Imms by appointment drop in to see HV
Pre-school children of varying ages	Developmental assessment
Those attending for imms. had appointments. Others just drop in to see HV.	Support for mother Medical assessment
HV: "So what's he been doing" – referring to development	Resources for play provided
Discussion with mum re career and going back to work	HV NN collaboration Communication with parents
Discussion re baby's chesty cough.	Anticipatory guidance, verbal and written
Lots of children playing in clinic on floor with toys provided.	
Conferring between HV and NN over weight conversion and plotting on centile chart. Weight reported back to mother	Parents expectations of development assessment Changes to routine surveillance Hearing screening unchanged

Discussion with a mum re sleep pattern, weaning diet, written information given.	Advice on request about weaning. Partnership approach
Babies crying	
A mum asked when next check was due. Told by HV that they are only done now if there is an identified problem except will get routine hearing screening at 8 months.	Information requested information given to link with another service Referral by NN to HV for medical assessment
Weaning discussion: asked what Mum was doing now and made suggestions re variations - leaflet info given which was produced locally by dietician.	Fathers and Mothers Mainly mothers interacting with HV
Mum asked re local toddler groups. Given central number for children's information services as HV information might not be up to date.	
Baby on scales. Mum asked NN about baby being off his food and a bit off colour. Told will need to speak to health visitor.	
! family from ethnic minority background. Both parents came. Dad asking questions while Mum handling baby.	
Other dads came. Tend to be in support role. Mum interacting with HVs in the main.	
Mums talking to each other about what to have for T	Opportunity for social discussion for attendees
HV prescribing paracetamol Queries to HV about minor medical complaints – seeking reassurance	Nurse prescribing Medical advice sought
HV assessed rash on baby's chest – discussion re changing washing powder. NN include din this discussion, asked by HV for opinion. Reassurance to parents	Medical assessment and advice given HV NN collaboration emotional support

Appendix 7: Interview guides

Interview Guide 24/7/03

Tell me what you think about the current drive for public health work?

How does this relate to how you practised previously?

What do you think are the main drivers for the change?

What sort of things do you think might inhibit/ help the development of public health practice?

Has the current climate of change affected you personally, if so how?

Interview guide 27/10/05

What do you understand by the term public health and how that relates to health visiting?

What was your experience prior to being health visitor?

Do you feel skilled for public health work?

Describe how your HV training prepared you for public health work? In theory and in practice settings?

What has been your experience of public health work since qualifying as a health visitor?

Interview guide 17/2/06

Tell me about your new role?

Could you describe what you understand by the concept of public health and how this relates to health visiting?

What support for your public health work is there in your local practice setting?

How have recent policy changes affected your practice?

What is your view on the changes to the NMC register?

Interview guide 10/5/06

What is your understanding of the public health role in health visiting?

Could you give me an overview of your professional development to date?

What is your perception of the changes to the policy agenda and its relevance for health visiting?

How have required changes been implemented in practice?

What is your perspective n the NMC register change and how health visiting relates to nursing?

How is the health visiting workforce responding to change in your local PCT area

Appendix 8: Interview transcript example

Interview 2 on 27 02 06

Alison Ok, so this is a follow up really to the last one and it's going quite well, your last one, so we'll need this. What I'm interested in is two different things, because I know you've changed roles so I'm interested in your new role and your changed context if you like, but also there's a time ?? between the last time we spoke and I thought trying to catch if there's any change if there's any relation to that. So do you want to just start by telling me a little bit about your new role here and your sort of general em, demographics, and you know, …

Well I'm new to ***** and it's a bigger geographical patch and I lead the corporate team, there are some of them are, five of us in the team, four health visitors and one nursery nurse, the other health visitor's part time and I'm part time, but I'm not full time commitment to the team because I'm the equivalent of fifteen hours responsibility for paed's liaison role because I've only got the equivalent of three days with the team but I'm here based here at the clinic, and they do have a fast line surgery in *** so they come along there as well, and then we've three practices within *** and that we cover, so within the corporate team we're covering three practices plus the fast line practice. So between us we cover four clinics a week em, and liaise with three different GP surgeries, em, and I'm aligned to *****medical practice, we're all aligned, apart from one of us, we're all aligned to one of the surgeries with the health visits so the GPs have a link with …

Alison So like the …

… with the main health visitor, and I'm linked to the practice here, so I'm actually based in an office which is over by the surgery, so I'm based with the district nurses who just work the ***** practice and I'm based with the nursery nurse who works with team. Unfortunately we don't have one office which is a huge disadvantage so most corporate teams which have one office in which the team is based, we actually have two keypads between us so you're constantly between offices so the active case load level is housed in our office and the inactive case load is housed in the office of three other health visitors plus the public health nurses and that PCT creditors, so all the rest of the building appears to be PCT premises but it's joined on to GP premises, it's quite complicated. But it does make communication more difficult,…because we've two message books to check. Two answer phones to check, with doors locked in between.

Alison Right, so just explain what you mean by active and inactive case loads

Em, the way that the corporate working em, is designed em, and organised em, an active case load consists, is allocated to each health visitor, so they have a time place which is updated weekly by the clerical

support, supposed to be anyway, if they've got time to amend it and give it in to the clerk to alter, but it's amended weekly and they have a weekly allocation meeting at which new work is allocated. The active caseload consists of all children under the age of one and any children's' special needs, any child protection care, and children in need and they look after children, any children or families where there are ongoing health needs and a health visitor input, active health visitor input, whether it's ?? or whatever, so there're obviously referrals em, and children and families coming in to the active caseload weekly through the allocation meeting. Once you've finished a piece of work, if the health needs are complete and there are no ongoing needs for involvement em, then the health visitor's responsibility to cross them off the active caseload, put them into inactive.

Alison — Right, so the inactive is actually a ....

Both talking together

... and then it would go into your inactive caseload, em, and we all have children from all the practices within our active and inactive, it would be an active caseload what was allocated and the active caseloads are all allocated to one of us.

Alison — Right, so how is the decision made in terms of allocating, just who's got capacity ...

Well it's supposed to be, it was supposed to be allocated according to the hours that you work, so we have got ratios and we do volunteer nursing, em, and I've got ratios that I'm supposed to keep to, but I'm not sure that we always look at the ratios of what people have on a Monday and I think that's something we do need to look at because people can very easily become over-burdened if you don't keep checking what peoples' numbers are and we've had changes of staff, which has made it really difficult and we have one member of staff who's left, who's newly qualified and has only been here for months and we've now got another newly qualified member of staff who needs support, who isn't functioning quite, who's actually the four day member of staff, so she should have the biggest caseload but isn't quite at that level yet, but she's on the team, em, but it's supposed to be according to the number of hours that you work, your capacity and also things like holidays, so if you go on holiday the week after, ideally you're not supposed to be on a case that needs work because you wouldn't then be able to plan it for the week later, so we do allow for ideally we're looking at the capacity and workload of team managers. I personally at the moment don't feel that's working very well in the team, em, for various reasons, yeah

Alison — I suppose if you're all working different hours, if you can all work the same standard hours that might ...

In effect there was two of us who are, because in effect **** works three days a week, but two of us are covering three days a week, ***s the equivalent of two and half because they work ?? and **** four days, so in effect you know, they're not hugely different around the fact you think a caseload which isn't a newly qualified member of staff, so in some ways it's fairly equal in distribution em, but it depends on the you know, the sort of quality of the work that comes up, and people on the sick and holidays, and em, the waiting isn't, it's sometimes can be restrained, but we are conscious that we need to look at that. Communication is a massive issue, massive issue and I feel that I'm struggling to maintain continuity of a kind and I'm struggling to maintain effective communication and a lot of time, I don't think the workload's a ??but the organisation takes a massive amount of time and because we're in two different offices and people working different days huge amount of time I've spent communicating relevant information to the relevant person, and they each cover all the clinics so the clinics go on the relative so you do take up people's times at every clinic every week and then you've got to communicate all of that and I feel as if I'm a headless chicken and I'm completely em, I'm really, really stressed about it.

Alison It sounds quite a reactive way to do things, whereas I know like with previous sort of discussions with you and stuff you talked a little bit about em, reports of establishing relationships of kinds and stuff like that so I can see that each time meeting somebody for the first time would be quite ...

Talking together

And a lot of the time you get phone calls in from people, they're helping us with ?? around, yes they get immediate response but they don't get an immediate response from someone who they've got a relationship with, and my clients will ring and I know all the background, when someone else has dealt with a query because it sort of de=personalises the service a lot. ..

Alison Yeah, yeah

To my mind I feel that the advantages of corporate working are for the staff but the disadvantages I feel are for the client, from having worked in both ways, but it may be that that's my perception having come from a long time working in em, GP attachments in a caseload that I know extremely well and had very good relationships with clients, in fact I'd done a lot of perceptive work, I don't feel I start to be effective, I work here and I'm not even getting a hand ?? and I've been here six months. Em, I also feel, I've recently had meetings and discussions with the GPs as well, which ?? thoroughly dissatisfied

Alison Do you think you might go back to practice in the catchment then?

I doubt it because the manager's really keen, so I have actually personally don't know what to do but I personally requested the manager, but I don't feel that function, I feel as though ...

Alison Yes

.. and there's recently been an incident that em, caused a lot of difficulties where every member of the team was involved and that wouldn't necessarily have happened if it hadn't been corporate

Alison Yes, so the sort of model of practice that you're describing and the fact that you don't feel as if you're able to em, pause for breath and consider what you're doing almost, I would guess pro-active public on site work is sort of under that burner, is that right?

Definitely, I feel as if I'm not even doing my routine health visiting work, never mind moving on, I am doing some of it because it's in my, you know, weekly plans, so I am doing, taking my turn in the support group and I do my massage group, em, but in terms of preventative health of families it's very much going back seat, and yet at the same time you'll know that ****** have recently re-introduced all this about the assessment of children and chose it as a priority and we have to do them. That involves a six week check from the GP, em, a seven to nine month development check from health visitors, a one year review from the health visitor, a two year development check fro the health visitor and a four year development check form the health visitor as well as three EPDS contacts. And we just don't know how we're going to do it, we've actually em, mobilised the nursery nurse em, to em, to do group sessions where we've given individual appointments in group sessions and we each take turns just to quote her with facts that we've taken at each session just to cover it

Alison And the driver for that changing policy's and em, it's overboard isn't it?

Yeah, which is actually referred back to where we were before and although we fought to keep what we felt was their bonus as a developmental surveillance system, management took it from us and is now re-implemented a more em, a much more comprehensive development surveillance, which seems to us a bit repetitive, even if you go to see a child at seven to nine months why do you have to complete a one year review?

Alison Yeah, yeah

So it's going to be really difficult to meet the demands of public health, of em, support child and protection work, developmental suburban, em, it just feels impossible and ...

Alison — So in terms, I mean you've said that you couldn't go and see em, the manager, do you feel that management have been supportive at the minute or do you, are you just sort of ...

The hands off management. We see them once, well we see *****but she isn't manager anymore, she's doing professional development, em, she does once a month, we have a professional forum em, where we're updated on issues but that's for all health visitors across the whole locality so if there's something there you could bring it to the team, but otherwise you would see a manager if there was a problem or for a team briefing which would be half an hour to have this for the district nurses that's going through and the PCT em, briefing period.

Alison — But presumably if you were to be em, having to try and organise a new public health initiative that would be fine so long as you were doing your developmental ...

?? has had to do everything else

Alison — Do you feel that there's been a shift then because I know the last time you spoke it was sort of em, I think it was just after the whole systems pilot finished and people were quite sort of fired up in relation to public health at that point ...

Everybody's feeling the same and everybody's being pulled in different directions and I just feel that I've got yet another direction we're being pulled now because the corporate working ...

Alison — Right

... and not only are we expected to work in couples, but what I didn't say before we're expected to work corporately but because we're allowed to practise it I've still got huge demands from the GP practice so because I'm attached to the practice most dynamic I'm expected to input things on to remit, I'm expected to attend a practice meeting for two hours once a week and a lunch-time and they communicate with me all the time and I'm constantly dealing with their e-mails, their practice notes to with other members of the team because often they're not, you know, like family, em, so I think there has been a shift but I think I don't feel I've em, I feel that yes the management is more hands off, so we're being what the policies are but without actually being given the support to em, to prioritise or implement the workload on a day to day basis, we're being left to manage by ourselves and they would argue that we were being paid at, you know, a management level to self-manage and mange within practice, but very, very difficult to manage if you haven't got enough resources or enough time to implement what's being expected

Alison — Not enough time out to look at what you're doing and see if you can change it.

I don't

Alison Did you consider sort of allocating families on the basis of geographical location for instance, or was it about sort of resource related?

It was a sham when I came into the community centre, it was already set up and I think, I suppose against your graphical location would be that you wouldn't get the right amount of waiting which I've ?? and things like that

Alison But that could still be shared if you do a geographical patch

There'll have to be something done, I mean I'm not the only member of the team feeling like that, and I've spoken to my colleague who's also a practice teacher in the team, and she says exactly the same and we were talking about maybe whether we need to go back to maybe having more than one person allocated to one clinic so at least there's continuity in the clinic, something like that

Alison Yes, which in some ways it would be a little bit more like a geographical model if that was the ...

Yeah, I know, I mean that would be one option, em, but I feel we need to organise some more, I mean there are various changes that we've made, and I started off very enthusiastic when I came and we implemented quite a few smaller changes without me railroading in but we had a member of staff with a lot of problems and difficulties, who's now left the service, em, which had a massive effect on the team, I don't think it's quite recovered from that. And we've now got another member of staff who needs a huge amount of support and has come from somewhere where she didn't get that, so we've been asked to give that. So I don't feel we're functioning at full power either but some of the changes that we implemented were for example to have plans of the clinics so if the clients wanted to follow up to see a particular health visitor they would know where they would be available, in which clinic

Alison Right

Alison And you don't get that any more, did you expect that the corporate working was going to be something different then before you came?

I expected that, I think I'd thought the advantages would be that to have more resources than in a team because to benefit the client because em, not everybody is a jack of all trades and I think in some ways that does because you've got a nursery nurse who's excellent who shares within the team, and it means that all clients access those services and she's got fantastic em, resources and em, huge amount of input to the work that we do, she's got weaning group, practical weaning groups set up, em, she

does all the organisation and preparation for the ?? classes, em, she is really, really good from a practical point of view and offers support to all our clients on em, you know, developmental and behavioural issues em, but you know, I've worked in areas where you still get that, working in GP attachments, and I don't know that there are any advantages, I can't see the other advantages really, but what I've tried to work out is how much of it is because it's corporate working and how much of it is because it's part time staff and I think that's having a massive impact and I think if there were, if there was say, two or three, instead of having four part time, because I'm part time with the team, instead of having four part time you had you know, two full time and half time, or three full time, I just wonder of it would be different

Alison Because you'd have continuity when they're actually there in the area.

Yeah, because you would be accessible to your clients, you know

Alison Have you had any feedback from them in relation to the service then in terms of dissatisfaction and stuff?

Em, not in relation to corporate, it's only ever evaluated from, they have evaluated it I think earlier on but we haven't done that recently

Alison I suppose it's about expectations and perhaps …

It is

Alison … you mean the service wouldn't …

That's right, I don't think they do, and they get used to seeing lots of different people at clinics, em, and I suppose I try and get round it with them by saying, you know, I'm your allocated health visitor and obviously if you have any difficulties, you know, I would like to know and if I'm not at clinic, please do ring me, em, or if you'd like, you know, like me to come out or you know, discuss anything, you know with me personally then leave a message for me, em, so it gives them the option to know that if they prefer just to see me that's, you know, that is there and if they happened to take advice from one of those in the team, that's also fine em, but just to know that they can have that continuity if they want it.

Alison One of the things that em, that I am quite interested in is finding out whether people have any em, feelings or anything at all about the fact that the NNC register was changed, ….I just wondered em, whether you had any thoughts or feelings about that one or whether you feel it's in the difference in relation to the role model or anything like that

I don't know it has because I think it's sort of on a day to day basis removed from ?? people will still face the health visitors and call themselves health visitors and em, you know whether it makes a

difference to the future of em, the new students coming through and you know, the way that they're taught and their thinking on that, em, but certainly from a practical point of view I can't, it hasn't really made a major difference

Alison Not much difference, have you had em, have you got a student at the minute?

I haven't

Alison I just wondered, because the new programme's just started and ...

That's right, I haven't got a, I'm supposed to have a student but one of the other practice teachers has now gone off on ling term sick, so I've been asked to cover a student while she's off and I don't know how long she's going to be off, I've had one meeting with her and I'm going to be covering that from a distance which is going to be quite difficult and I'm also having a student from next week, we've got two students coming in and I will have to be ???. So yeah it will be interesting to get the effects ...

Alison Right, OK, thank you

End of tape

Appendix 9: Information for service users

Information Sheet for Members of the Public/ Patients/ Clients

For Your Information

A research student from Newcastle University is working with primary healthcare nurses in your area. She would like to participate in this clinic/ meeting / visit/ contact . Her name is Alison Davidson and she is also a registered nurse and health visitor.

What is it about?
The research study is about public health work in primary healthcare nursing.

How is it being done?
The researcher will be:

- selecting several primary healthcare nurses and, with their permission, accompanying them in their work.
- observing what nursing staff are doing and making notes about it.
- doing tape-recorded interviews with the nurses on their own about their work.
- analysing the information to help to understand the public health work of primary healthcare nurses.

Once the study is finished the tapes and the notes made will be destroyed.

How will it affect me?
The researcher's job is to observe what primary healthcare nurses are doing. Reports of the research will **not identify** any individual professional or the people they work with. If you would prefer not to have the researcher present please tell the nurse. If after the meeting you do not want the notes made by the researcher to be used in the study please tell the nurse or the researcher.

If I have any questions?
If you have any questions please discuss them with the researcher, the primary healthcare nurse or contact Dr Pauline Pearson at Newcastle University on telephone 2228761

Thank you for your help.

Appendix 10: Consent Form

Consent Form

Study title: Public Health Work in Primary Healthcare Nursing Practice

I hereby give consent to my participation in this research study. I agree to the information I give being used in this study. I understand that my name will be removed from the transcript of this interview/ meeting and that I will not be identified in any reports written from the research. I understand that I can withdraw my participation at any time during the study. I have read and understood the information sheet provided.

Participant
Name (please print):

Signature

Date

Researcher
Name:

Signature

Date

Appendix 11: Information for other professionals

Information Sheet for Other Professionals

For Your Information

A research student from Newcastle University is working with primary healthcare nurses in your area and would like to participate in this meeting. Her name is Alison Davidson and she is also a registered nurse and health visitor.

What is it about?
The research study is about public health work in primary healthcare nursing.

How is it being done?
The researcher will be selecting several primary healthcare nurses and, with their permission, accompanying them in their work. The researcher will be observing what nursing staff are doing and making notes about it. She will also be doing tape-recorded interviews with the nurses on their own about their work. The information will then be analysed by the researcher to help to understand the public health work of primary healthcare nurses. Once the study is finished the tapes and the notes made will be destroyed.

How will it affect me?
The researcher's job is to observe what primary healthcare nurses are doing. Any information relating to you will be held in the strictest of confidence. Reports of the research will **not** identify any individual professional or the people they work with. If you would prefer not to have the researcher present please let her know. Additionally, if after the meeting you do not want the notes made by the researcher to be used in the study please make your views known.

If I have any questions?
If you have any questions please discuss them with the researcher, the primary healthcare nurse or contact Dr Pauline Pearson at Newcastle University on telephone 2228761

Thank you for your help.

Appendix 12: Additional data examples by Category/property

Professional Role in Action

Property	Dimension	Data example
Approach to Practice	**Individual**	*I tend to go in* [to the home] *and help out, with just the statutory visits and clear the backlog of those. If I stay longer than four months (*in post*) I start to pick up my own caseload, I start to go in* [to the home] *and decide where I need to offer some support (P16 558-561) I visit anybody irrespective of whether they have children, so I visit couples, em, single people, people who have school age children, as well as people who might have pre-school children. (P6 15-19)* *Mum asked re local toddler groups. Given central number for children's information services as HV information might not be up to date (P2 Ob1)* *Clients seen individually...Anticipatory guidance for weaning & feeding.....Home visiting for follow up support planned... ....Babies weighed (P9 Ob1)* *Recently I've taken on board and this is individual work, but I've offered it em, to the locality because it's a need for the locality, em, to take referrals from all health visitors within the locality from clients who have colicky babies, so I can then offer support with baby massage for all those babies who wouldn't normally be able to access groups (P8 283-287)* *So we looked at actually some target work with the most vulnerable children around their confidence, self-esteem, peer pressure, who've taken drugs and alcohol (P15 86-88)*

		We have health events and really I would say that those that come to them mind it's quite interesting and they're usually fit, you know, and you get the odd, the ones that I've picked up with hypertension have been young, you know, didn't have a clue and the elderly are fine (P15 222-226) *"So what's he been doing"(P2)? – referring to development ....Discussion with mum re career and going back to work (P2 ob1)* *New transfer in to surgery seen and information given on local services (P9 Ob1))*
	Groups	*Church hall, run by HV and Nursery nurse. Described as "informal". HV chatting with mothers. Welcomes new attendees. Gives the information about the group. New people introduced to others........HV also gave verbal and leaflet information to the whole group about the HIB vaccine campaign, the availability of smoking cessation support and on local baby massage classes....Individual mothers seek HV out to ask about sleep, teething, feeding routines. (P4 Ob1)* *Having never known anybody in the street with a baby, they've never known their neighbour because they're at work all day, they actually have met new mums and gel and then meet somewhere, so to me it's a sort of a social get-together, getting a group together to give them some sort of em, networking, which I think is important (386-389)* *Group offered opportunity for breastfeeding mum's to*

		meet and give each other support, swap ideas & experiences. The group largely now runs itself with support from the HV (P8 Ob1)
	Populations	*I was asked to get involved with em, COG, which is childhood obesity group, which about eighteen months ago to a year we met with people from all aspects of public health in the city, social services, education, em, school sports, all that kind of thing, and we brought a strategy for the city (P16 99-104)* *I'm on the homeless strategy group (P6 165)* *That, whatever needs, it needs smaller communities and really there's a lot of community champions out there, they just need a little bit of help and then they're away, they do it all themselves (P15 548-556)* *Yeah, so it's on a strategic level, if it's not me it may be another member of the team but also looking at the priorities you know, how can we, whether it's just em, advertising the smoking cessation clinics, how can we get the message across to the public that these services are available, this is how you access them and we can support them maybe with funding as well should they need it, (P15 49-55)* *There are a couple of community groups, we are working together to develop things.....they were pleased to see me as I has been some of the women's health visitor....I helped get them some safety equipment for the premises they were developing, this enhanced our relationship....we've go a lovely group that can influence public health work (P3 310-317)*
		We're (health visitors) becoming more involved in really

		assessing the health needs of communities. Em, analysing those needs and deciding what initiatives and actions can be taken to actually improve the health needs of the community (P8 14-19)
Issues of collaboration	**Role overlap**	*There are, I mean lots of examples of that within individual case work, em, so several cases just be about be in touch with housing, the waiting list at the moment for council housing are at hundreds, em, absolutely huge, em, so there's lots of cases where you'll be involved with social workers, housing em, with other voluntary agencies (P8 105-109)*
Principles of health visiting	**Assessment of health need**	*I mean I normally visit somebody as a primary visit and then I would visit them probably weekly for three or four weeks till they had to come to the clinic for their six day week check and in those three or four visits at home, I now know what they're like as a family. Not just what the baby is doing or anything like that because I can suss out the family dynamics in those three or four visits, and it means that when they come then to the clinic, which is quite false setting, I can usually spot what was or appeared to be, you know, a happy, straightforward family, that suddenly they've gone a bit sort of stressed or whatever (P9 312-320)* *Babies weighed.....developmental screening, family needs assessment, health promotion, dietary advice.....Discussion re medical advice for minor complaint and whether client should see GP or not. (P12 Ob1)* *If you are visiting in the home you can assess the development anyway and some of the more serious developmental problems that you come across, like*

		autism (P4 51-53) *I seem to remember as a health visitor you're going for a reason, so it might be housing or it might be a minor check or it might be safety and talk about that, but while you're there you then expand on lots of other things (P6)*
	Facilitating health enhancing activities	*Now working on a CHD campaign at the local high school with the school health advisor which is also involving dietician and local leisure facilities (P3 Ob1.)* *and now we are hoping to set up a group in a school to try and tackle smoking and obesity, so we will be working much more closely with them. (P2)*
Knowledge underpinning practice	**National public health priorities**	*We (health visitors) visit the MIs, we do the ……………., we visit the coronary artery bypass patients, (P2 85-86)* *I'm involved in the multi-agency child accident prevention…(P8 114)* *I also do training em, across all the disciplines in recognising that it's not just a medical issue [*growth and nutrition], *P16 398-340)* . *"So what's he been doing* [referring to development]*"* *(P2 ob1))* *Clients seen individually…Anticipatory guidance for weaning & feeding…..Home visiting for follow up support planned… ….Babies weighed (P9 Ob1)*
	Health/social domain	*A child protection visit – young mother, father with a history of violence – aim of visit: Compliance with care team requirements … Weekly support…Monitoring of situation….see how they're coping with their new*

		baby..... (p2 ob 1) *I have a sort of a drop in here em, also the other issues around the teenage support..(P15 80-82)* *My remit is to visit and support anybody that comes into either bed and breakfast accommodation or temporary accommodation as a result of circumstances (P6 23-25)* *Yeah, very, I'm also a member of the foster panel as well, em, but no, it's all about linking and maintaining good relationships with em, trying to maintain good relationships with people from other disciplines (P17 98-101)* *And I sit on ...., which is the organisation that supports women who are in a domestic abusive relationship or have left one and need support. I'm also involved with....which is the organisation that supports children who have witnessed or heard domestic feuds. I'm also em, on the Domestic Abuse advisory board, they're the main ones, (P6 199-205)*

Professional Role Identity

Property	**Dimension**	
Essence of health visiting	**Home visiting**	*You can't do everything in one visit, but if you have visits spread about you are reaching everyone (P4 35-36* *)* *But I think health visiting's just one of those things because it's not tangible what you're doing, em, as I*

		say for example, you know you're working parenting, or working domestic violence, overall addressing public health issues, yeah I think it is a public health role (P12 20-24)
	Professional autonomy	*A nice part of health visiting is if you have got an interest you can develop what you want, (P4 905)* *I'm a health visitor and an agenda builder (P16 7-10)* *We don't need managed, we should be managing ourselves (P3 49).* *The public health role is woolly in policy but yet we're told it's not an option"(P5 Ob1)*
	Challenging traditional practice	*And a lot of work has been done mainly on an individual basis in the past. (P8 61-62)* *When you plan go out and do some visits you might already have it in your mind that you're going to raise various issues, because it's considered a public health issue .... sometimes it's planned and sometimes it isn't, just because you never actually know what is going to crop up when you go and do a visit (P6 40-55).*
	Policy driven change	*I have to admit it probably did irritate me at the time (*changes to the NMC register*) but I never really looked into the whys and wherefores, I don't know enough about the agenda behind that and why that came about (P16 493-494)* *I am a bit uneasy about them (the changes). I think that it is a backwards step. If the checks aren't needed then they aren't needed but I think that we are not as involved with families as we used to be. (P4 28)*

		No, I see these things and just think, oh, you know, no just I cannot be bothered to think that far in all honesty (P6 499)
		I'm just finding it really frustrating (P8 219)
		I am going out doing lots of public health work. We are really empowering them. (P2 201-202) *I think it is a good idea on the whole but it is not a great deal different from what we've always done (P4 6)* *I don't think we're community workers, ……. Other people could lead on groups I think, and I just think, leave us visiting everybody in some form. (P9 77-83)*
		I hear people grumbling about the fact they're worried that more posts aren't going to be re-filled when they become vacant and that there's going to be an almost nightmare scenario where you have maybe one or two health visitors based in the locality with nursery nurses, health visitors, health visitor assistants etc., etc. (P17 320-325)
The meaning & significance of public health	**Addressing health inequalities**	*Public health fundamentally is about addressing inequalities in health and ensuring the health of the population and that can encompass em, a broad based public health context involved in social health (P14 27-29*
		Based on statistics, heart disease. But I just don't think that enough thought goes in to it. In our area we decided to look at heart disease prevention, (P4 11-12) *Yeah I suppose some of it's mainly preventative……*

		it's giving people choices, it has meant to give these choices like smoking cessation (P13 66-67)
	Public health role in practice	*We are supposed to meet more with the public health nurses and school nurses to do more group work and working together, not just ourselves but with the wider community (P4 63-65)*
	Commitment to public health work	*Now for those health visitors who you know, just from an ethical and moral point of view, professional point of view, they just nodded profusely and then gone off and done their own thing anyway and said, well that's very nice but I'm still going to search for health needs, I'm still going to have regular contact and just not going to put them under the auspices of child health (P14 352-358)* *I think again just the caseloads are so diverse you know, those who work in the more disadvantaged areas their priorities have got to be around the child protection issues, but they're the areas where we need to be getting the health em, public health messages across (P15 312-324)*
	Adequacy for the public health role	*It seemed an awful waste of everybody's time. I don't think anything new came out of it (P4 16).*
	Degree of comfort with public health work	*The more experienced you get the more adept you are at raising issues, recognising issues and em, better at addressing them. I think that's more about perhaps my personal growth than someone coming saying to you that you've got to raise your awareness, if that makes sense (P6 108-112)*

		It was easier for me because I was a school nurse and I was doing loads of teaching in schools, and I was doing loads of group work at lunchtimes with young girls so I have been doing that for years and years, so I felt very confident to do it. However I think some who had never done it, say a nurse coming out of hospital, doing their training as a health visitor and then having to cope with that, it would be quite daunting I think. (P2 230-235)
Nursing as a foundation for health visiting identity	**Professional credibility**	*My dad said to me a couple of weeks ago, what are you called at work, are you called sister or are you higher than that, and I said, no and he said, well what do your families call you and I said, well* [by my first name] *and he seemed quite disappointed with that and it seemed like you know, if you were a nurse, a sister, he could, that was something to be proud of, but actually you're just called* [name], *oh right, wasn't sure about that. (P9 592-597)*

Interprofessional Working

Property	Dimension	Data example
Working with medical professionals	**Relative autonomy**	*I've still got huge demands from the GP practice so because I'm attached to the practice………….. I'm expected to attend a practice meeting for two hours once a week and a lunch-time and they communicate with me all the time and I'm constantly dealing with their e-mails, their practice notes….(P8 233-237)* *GPs are just, if it's not their practice, it's not income generation for their practice, then the sort of the health of the population in the neighbouring practice is not*

		their interest. (P14 273-276) *Relationship with GP has changed. They ask for information (relating to targets) from me about the caseload. (P3 Ob1)*
	Working with nursery nurses	*We now have a nursery-nurse. I reduced my hours from a 5 to a 4 day week and those hours were converted into nursery-nurse hours, so we have a nursery nurse who does sleep visits, behaviour visits. So I am using her a lot more for things like that. So I don't think my clients are suffering because I am going out doing lots of public health work. (P2 197-201)* *by looking at a sort of technical rational viewpoint in terms of sort of putting in you know, a nursery or another you know, nursery nurse or another worker and delegating one aspect of care actually by putting that one person in that's fine if you only want that one area dealt with but if you want to be able to be more responsible and provide that flexible service which that review demonstrated, then that's perhaps not the best use of resources for home visiting. (P14 413-419)*
The interagency dimension	**Role awareness**	*I mean it was, I went to the director of housing regeneration and environment and I went to the chief executive for the PCT and raised the issues and said that, you know it's impacting I would say on the health of these families in some of the particular bed and breakfasts (P6 188-192)*
		I spent a day with ......social services, I remember coming out of an allocation meeting they had being absolutely full of indignation about the way they decided whether or not they would get involved with somebody,

		whereas we (health visitors), we opened our arms and we wrapped them round everyone who was in the community …….., and now I think it's ridiculous, and I think that was just, em, I don't think the education we got as health visitors was really as rounded as we were perhaps led to believe it was. That kind of process was never explained and when you are, you know, you're qualified and you're fired up with enthusiasm and you're going to go out and change your little bit of the world, (P17 267-275)
	Power and control	*Other than acting as an advocate, you're not always able to have a major effect on public policy and housing policy. (P8 89-90)*

Local Practice Micro-Systems

Property	Dimension	Data example
Practice maintenance systems	**Corporate caseload**	*We have had a high turn over of staff in HV team due to stress of the caseload. Now work in a corporate caseload. HVs and nursery nurse. Can more fairly share the work. (P12 Ob 1)* *I suppose I try and get round it with them by saying, you know, I'm your allocated health visitor and obviously if you have any difficulties, you know, I would like to know and if I'm not at clinic, please do ring me, em, or if you'd like, you know, like me to come out or you know, discuss anything, you know with me personally then leave a message for me, em, so it gives them the option to know that if they prefer just to see me that's, you know, that is there and if they happened to take advice from one of those in the team, that's also*

		fine em, but just to know that they can have that continuity if they want it. (P8 334-343) *Really it just means that you don't have your own caseload as such, but in saying that you're kind of following the philosophy of corporate caseloads quite loosely and in fact we do, you know, if you've done a primary within six weeks because you know the family and you're probably going to do the three months as well because you know the family...... we all have whilst no great knowledge on any specific family, we've got that wider picture, em, and I would think accountability and responsibility's shared with others in the team (P12 87-102)* *I think for many of the health visitors who are diligent, who want to provide accountable care then they struggle with it because they're not clear about their own professional role and accountability. (P14 517-519)*
Resource Management approach	**Availability of staff resource**	*I know we are finding it hard to get health visitors to fill vacant posts – I think they've not looked ahead at the resources need to do these things (P4 97—100)* *Because we've been short staffed a lot of the time, you know, there's six hundred and fifty kids and me, (P12 60-62)* *You need the staffing levels. It is impossible if the staffing levels aren't right. There are lots of problems in our area at the moment. (P4 150-152)*
	Focus of	*No IT resources, bad premises, lack of staff....Clincal*

	organisational priorities	*nurse lead work is about professional development but has little time for it due to operational management. (P5 Ob 1)* *I don't have complete control and there have been specific difficulties in being a public health nurse employed by an Acute Trust (P16 123-124)* *We have just employed someone for the ..... practice who will be coming soon but the hours are much less than that practice used to have in the past. There is another practice that has got another GP taken on but apparently they can't have an extra health visitor put in because the patients come from the same area so you are supposed to use your present resources. (P4 152-157)* *The new structure takes the CNL out of practice. 30% of work maintaining clinical credibility but not actually having a caseload.....That's where I think clinical credibility is the key issue. So it's about, em.., I've seen a medical model where consultants do less work but become more involved in managerial roles and I think it's about clinical credibility so I think it'll be really important that that time is valued and protected. (P5 72-80*
	Degree of caseload equity	*Generally people are looking at caseloads again very soon and there's talk that although they won't ask people to move from caseloads if someone leaves then we evaluate what's needed in that practice (P4 518-520)*
	Management support	*No, I haven't had any support in anything I've done, yes, with my colleagues in the work that we've done*

		locally, em, I suppose it's clinical lead level, em, I get the feeling they're happy with what we're doing ...(P10 218-220) *The management has been very supportive of us doing it (public health work) but in one way, we've not got the vacant posts filled quickly enough. (P4 177-178*
System overlap	**Influence of infrastructure**	*It was more an affluent area that I was thinking of moving to but it does have pockets of quite severe deprivation, which aren't sort of seen because they're figures of the wards, they make it look the best area in the borough whereas in perhaps this small pocket, which is very, just as bad as pockets where I work now, and the health visitors down there are trying to target service areas. And there's a lot of homeless people live in the area that I was going to work in, bed and breakfast, a lot of people moving around, a lot of people isolated from their own families that have moved their jobs and things, so I didn't see the job as much different really (P4 493-503)* *, it's limited of what's on the register and what is like in your face child protection, but I wouldn't be surprised if there's a bit of hidden stuff, you know, that, but most of like neglect more than physical or sexual abuse, I think. But, so we don't have that much working with social services either, em, I mean we've got bits of Surestart now, so we've got like bits, I think maybe one or two of my families at the most are within a Surestart area, em, but no I think this is sort of, I think we're it, we do good work, em, you know, within our, well I haven't got a team of nurses but there are nursery nurses that you can sort of use within a sort of a big*

		team. (P9 238-246) *I think we're becoming a bit sort of protective of these middle class areas I think if we go too far down to only looking at deprivation we're going to miss out on a huge agenda in our middle class areas here, and we feel on the defensive all the time, which is a shame I think really. (P9 103-109)*
	Influence of national policy	*I mean our PCT Strategic Objectives, you know, are about inequalities, you know, and raising those inequalities in health (P9 148-149)* *In PCT development NSFs are a priority (P5 Ob 1)* *Whatever service we're delivering regardless of whether you've actually got formal public health in your title, that we're addressing the health inequalities which are really in terms of what the PCT were set out to do. It is a written determinant of the PCT, addressing how the inequalities, I think sometimes that's lost. (P14 42-46)* *So the policy tends to come from the DOH and then is rolled out and there's not a huge amount of opportunity for local variation .... In the GMS contract which is going to influence the way we provide services, in my opinion, some things will improve things and in fairness the policies are developed after extensive public consultation, but not at a local level. So at a local level you don't have room to be that flexible. (P5 166 – 172)* *If they're waiting for em, for other staff that isn't what they're about, they say, regardless of what policy*

		strategies or what Department of Health changes happen, what performance indicators change, what the strategic health authority do, it's business as usual (P14 255-258).
	Information sharing	*I was asked to get involved with em, COG, which is childhood obesity group, which about eighteen months ago to a year we met with people from all aspects of public health in the city, social services, education, em, school sports, all that kind of thing, and we brought a strategy for the city (P16 99-104)* *An active case load consists, is allocated to each health visitor, so they have a time place which is updated weekly by the clerical support, supposed to be anyway, if they've got time to amend it and give it in to the clerk to alter, but it's amended weekly and they have a weekly allocation meeting at which new work is allocated. (P8 47-51)*
Protocols for practice	**Post natal depression**	*Locally an audit of an EPDS protocol is being conducted. This was developed by a multi-professional group looking at mental health of new mothers. The questionnaire is being administered at set intervals. The results and the subsequent follow up and results are being recorded and will be collated into a report to evaluate the effectiveness of the service. (P4 Ob 1)*