WHITHER HEALTH VISITING … AGAIN?

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ABSTRACT

This descriptive, qualitative study asks "Whither Health Visiting…Again?" and provides a window into a significant period for the profession of health visiting, from September 2004 - December 2009. It explores the professional identity of health visiting from its inception to its recent past, whilst considering the notion and construct of professional identity. The study examines the nature and degree of influences affecting the role and identity of health visiting, whilst investigating the contextual discourses associated with its service.

The participants in this study are senior health visitors, and health visitor educators engaged in the training and education of health visitors throughout England. This inquiry demonstrates the considerable confusion and uncertainty that presently exists around the role and identity of health visiting and it shows how health visiting is subject to a significant degree of multifaceted influence. The most significant influences are shown to be those derived from government and its associated bodies, particularly those with NHS strategic, operational, commissioning, managerial and professional regulatory authority. The Nursing and Midwifery Council, and specifically its new nursing regulatory register, is considered to be the most influential factor on the professional identity of health visiting.

Individual health visitors appear to have minimal power and influence over their role and identity. The findings also indicate that the general public and consumers of the health visiting service are perceived as having some of the least influence on health visiting. This study indicates the strong desire of health visitors for more effective leadership, within their own profession, nursing, and wider governmental bodies.

The study recommends that further research is conducted to investigate the nature and degree of the influence of provider and purchasing bodies on - the workforce numbers of health visitors; the design and commissioning of health visiting services, and health visitor opportunities for leadership within the realms of family and child health services.

CONTENTS

Length of thesis

The word count for the main body of text is 60,142; the Bibliography consists of 6,711 words. Making a total of 66,853 words.

No part of this thesis has been previously submitted for any degree other than this degree of Doctor of Education.

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How infinitesimal is the importance of anything I do,
But how infinitely important it is that I do it.

Voltaire

CHAPTER 1

INTRODUCTION

Whither health visiting … Again?

Purpose of thesis

This enquiry represents a journey of exploration into the professional role of health visiting and its professional identity. This research study investigates the journey of health visiting from its inception to its recent past. The landscape of the journey that started five years ago has continually evolved, changed and been challenged by the shifting scenery in which it has found itself. It ends for me here with this thesis but the journey for health visiting continues.

What has remained consistent over this period of time has been the focus for my interest - that of the contemporary, multi-faceted influences, impacting on the professional identity of health visiting. This enquiry explores these influences and its originality lies in its contribution to the emerging knowledge and understanding of them and their impact upon health visiting and its professional identity.

The primary empirical data generated for this study adopts a staged approach to garnering the perspectives and opinions of senior health visitors and experienced health visitor educators currently engaged in the training and education of health visitors throughout England.

During my EdD studies the professional identity of health visiting has been subject to such significant, ongoing analysis, discussion and suggestions for its future practice that the focus, content and context of my research has broadened and permutated considerably. Certain influences were anticipated, others unanticipated. The principal period of study occurred during September 2004 - December 2008, yet significant discourses continued after this time and are therefore reflected in the final sections of this document.

Personal context

My interest in this area of study is firmly linked with my occupational life as a health visitor for thirty years, first as a health visitor in practice and latterly in higher education as leader of the educational programme that trains new health visitors for the counties of Norfolk and Suffolk.

Professional context

At the beginning of my doctoral studies the initial focus and prompt for me to undertake this enquiry were the recent and significant changes to the Nursing and Midwifery Council (hereafter referred to as NMC) professional regulatory framework. The introduction of its new professional register for nurses heralded a potentially major impact on the unique discipline of health visiting, and its title, role and positioning in the wider nursing world. This professional, regulatory and emerging strategic situation within nursing strongly influenced the content, design and completion of the first stage of this study (Stage 1).

Stage 1 explored the potential impact of these changes on the role and identity of health visiting with a small number of participants chosen for their significant profile, publications and professional position within nursing and health visiting who were aware of, and/or involved, in the development of the new NMC professional register. Yet as I completed and wrote up this stage of the study it became obvious that the influences on the professional identity of health visiting were far more multi-faceted than just those emanating from the N M C. This led to a further exploration of the contextual nature and discursive practices of these influences that are explored and discussed in Chapter 3.

The changing backdrop for health visiting over the course of my study period should not have been a surprise for me as any cursory review of 'nursing' literature illustrates clearly how health visiting has, throughout its quite lengthy existence, experienced various occasions when its identity and purpose has been examined and questioned and it has 'feared' for its survival.

During one of these occasions in the late 1980s (when a market-economy health service required all health care practitioners to show their short-term effectiveness and hence affordability in order to continue to exist), Shirley Goodwin (General Secretary of the Health Visitors' Association) gave a keynote speech. She entitled her speech, 'Whither health visiting?' (with a play on whither/wither, 1988). This speech made a declaration (and prompted a national debate) about tackling, clarifying and ensuring the purpose and future of health visiting.

The overall title for my enquiry reprises the same question as once more the debate on the potential and future professional role and identity of health visiting is contested by a variety of discourses – often of contradictions, uncertainties and confusion.

Aims of the enquiry

The recent, and continually changing, political and professional context of health visiting has informed and directed the development of the key aims of this enquiry. These aims are:

- to consider the current state of the professional identity of health visiting;

- to explore the historical context and meaning associated with health visiting;

- to examine the range and influence of discourses currently debating the role and identity of health visiting;

- to consider what changes these discourses may have on the professional identity of health visiting.

Organisation and structure of the thesis

The thesis is organised for the purpose of exploring the various concepts, contexts and discourses pertinent to this study, as well as considering the substantive details, findings and conclusions of the staged primary research exercise.

Chapter 2 considers the professional journey and identity of health visiting and some of the meanings attached to it over the years. It provides the underpinning context for this study and some understanding of health visiting for those not familiar with the profession. This chapter also explores the notion of professional identity and the various theoretical approaches that have been applied to its analysis.

Chapter 3 provides a backdrop to this study by contemplating the contemporary discourses that have significance, and meaning for the recent debate concerning the professional role and identity of health visiting. It covers predominantly the period between 1997 (the commencement of the Labour government) and 2008.

Chapters 2 and 3 provide important empirical data for this study. The data collected and analysed for these chapters is selected and analysed using Foucauldian and discourse analysis elements and provides the important contextual element within which my primary research activities were undertaken.

Chapter 4 outlines the methodology influencing the data generation and analysis for this study. It considers issues of role complexity, reflexivity, discourse and its analysis, as well as the methodological design, organisation and undertaking of these research activities.

Chapter 5 considers the presentation, findings and analysis of the data from this study. This data is not only from the staged primary research activities (i.e. Stages 1 and 3) but is also from the discursive analysis of key documents discussing and debating the role and purpose of health visiting published between June 2007 and December 2009, a key period of interest for this study. This chapter is presented in two sections – Section 1 considers the presentation of data and Section 2 focuses upon the analysis and interpretation of that data.

Chapter 6 draws together the concluding thoughts of this thesis, the most recent contextual picture and provides some tentative recommendations for further research areas.

The overall aim of this enquiry can be summed up by reiterating Shirley Goodwin's closing words in her keynote speech (1988) which echo Socrates, it is, in respect of health visiting, to:

<div align="center">

Discern the Past

Understand the Present

Declare the Future.

</div>

CHAPTER 2

THE FIELD OF HEALTH VISITING AND THE IDENTITY OF ITS PROFESSIONALS

What is the meaning of 'health visiting'? This is a valid, but complex question to answer. The first part of this chapter outlines some of the meanings attached to health visiting over the years. The second explores issues pertinent to the professional identity of health visitors.

Health visiting is best considered as a construct – practised within changing discourses at differing historical times and junctures. Like any other construct knowing it represents many challenges. This is particularly so as health visiting has been subject to a continual process of adaptation and change depending on which "regime of truth" (Foucault, 1980) has held sway at any particular time.

A review of the literature in relation to the broader diachronic and interpretive frameworks associated with the nature, purpose and meaning of health visiting shows a range of discourses - political, professional and philosophical. Since its inception, health visiting has prompted persistent discussion and at times "heated debates about the role and purpose of health visiting, its relationship to nursing, and preferred approaches to practice" (Cowley, Buttigieg and Houston, 2000, p. iii).

This chapter is constructed to provide a context for this study and introduces the nature and values of health visiting. It is an attempt to locate health visiting historically and to analyse the strands of discourse and practices dealing with its genealogy (Rabinow, 1984).

Origins of health visiting

Dingwall (1977) notes that the antecedents of health visiting stretch as far back as 1769 and have evolved at the same time as the early development and interest in social reform and environmental public health (Craig, 2002). The most frequently repeated account of the first "health visitor" is that of the Manchester and Salford Ladies Sanitary Reform Association who employed 'respectable' working-class women in 1867 to assist the lady volunteers of the sanitary reform movement (Dingwall, 1977). The Association was founded "to give information that the poor could use with advantage and to aid the infirm and enfeebled" (Ottewill and Wall, 1990, p. 32).

From the beginning it was visualised that the health visitor was to be a health teacher and social counsellor with the primary role of preventative health care. Thus began domiciliary health visiting, an enterprise viewed by many at the time as a social and political movement, "legitimated both to convey, and to attempt to modify, prevailing societal values concerning the conduct of family life and child rearing" (Robinson 1998, p. 97).

For Kelly and Symonds (2003) the discourses of the nineteenth century on poverty concerned its management, not its eradication, linked with the parallel discourses of imperialism and motherhood. The idea of responsible motherhood as the antidote to infant mortality became a favoured opinion and 'motherhood' became increasingly the focus of state intervention.

By the early years of the twentieth century, with a decline in the birth-rate, and national concern over the survival of babies being born, impetus was given to the state sponsorship of health visiting. As state legislation grew, so health visiting became the province of middle-class women. Their role expanded significantly following the 1907 *Notification of Births Act,* which placed in statute the requirement for health visitors to visit all mothers of newly born infants from 1909, to better their chances of survival and so to construct responsible citizens.

With the enhanced focus on child welfare, health visiting moved to the centre stage of state policies. Pressure for adequately trained 'practitioners' with 'qualification' grew and in 1916 the Board of Health recommended that health visitors should have both a sanitary inspector and a midwifery certificate. By 1919 'health visiting' was formally established as a 'profession' in its own right when the Ministry of Health and Board of Education jointly initiated an official scheme for the training of health visitors, which attracted interest from a range of occupations, including medicine, midwifery, sanitary inspection, teaching and nursing – yet separate training courses were established for the training of nurses and non-nurses (Craig, 2002).

From the perspective of Kelly and Symonds "the state created this new profession" of health visiting (2003, p. 19), with its professionalisation process being fuelled by the *Maternal and Child Welfare Act* of 1918. This Act required local authorities to set up clinics and services to monitor the health of nursing and expectant mothers.

By the 1930s the discourse on the quality and quantity of the population focused upon two main issues - the declining birth rate in Britain (faster than any other similar

European country) coupled with a rising marriage rate, and relatively high rates of maternal mortality (from 1923-1933 these rose by 22%, Ministry of Health, 1937). As a consequence, health campaigns and public policies intent on improving the health of women and children followed, along with the increased hospitalisation of childbirth and the state organisation and employment of midwives (*The Midwives Act,* 1936).

The interwar years witnessed the beginning of a change in ideology towards motherhood and child-rearing, with an emphasis on technical skill, underpinned by scientific theories and manuals on child-rearing and child development, "most of them written by male 'experts'" (Kelly and Symonds, 2003, p. 31). For health visitors this 'scientific' shift towards the 'natural' tasks of motherhood (childbirth, child-rearing, child-feeding, the role of motherhood) placed them in the contentious position of being expected to challenge traditional and popular methods of mothering. Such a focus generated for health visiting a role and identity more centred upon the monitoring and control of developmental processes and responsibility for the nutritional status of young infants.

Health visiting during the Second World War

The report of the Chief Medical Officer of the Ministry of Health (1939-45), *On the State of the Public Health During Six Years of War* (Ministry of Health, 1946), sums up the role and contribution of health visiting during these six years of war:

> Throughout the war years, the demand for health visitors has exceeded the supply …The shortage of medical officers …has undoubtedly thrown a heavier burden on the available health visitors, many of whom have had to undertake …special work in connection with the war-time nurseries, evacuation and the civil defence services. To meet these demands, more health visitors are certainly needed …and it would seem that, with the cessation of hostilities, and the possible recruitment of more trained nurses for this work, increased training facilities will be required. (p. 215)

Post-war Britain

The newly created National Health Service in 1949 adopted a philosophy firmly focused and based on access to medical expertise within the sphere of hospitals and institutions, rather than that of a collectivist public health approach (Klein, 1989). As a consequence health visiting became increasingly based within the private, gendered sphere of the family. Yet the state focus upon 'the child' became more pronounced as the effects of the Second World War became progressively more visible (e.g. *Family Allowance Act,* 1945, *Children Act,* 1948, *Adoption of Children Act*, 1949).

If the pre-war gaze of health visiting had been on the improvement and maintenance of the 'physical efficiency' of children and mothers (Dean, 1999, p. xvii), then the post war concern focused on that of 'social efficiency'. With the increase in state interest and activity in the child and family, new categories of 'problem families' were defined (McKie, 1963, p. 28), such as "the broken family", and the "abnormal family" (McEwan, 1951, pp. 93-94). As a consequence the work of health visitors expanded to involve the protection and monitoring of child welfare. Yet the dominance of the curative, bio-medical model of the new NHS reduced greatly the role and influence of preventative, public health services. Health visiting being positioned between health and social care and "did not 'belong' totally in either sphere" (Kelly and Symonds, 2003, p. 48).

The social welfare legislation of 1946–1948 considerably impacted on health visiting. The *Children Act* of 1948 extended the functions of the health visitor by requiring her to give "advice as to the care of persons suffering from illness and as to measures necessary to prevent the spread of infection" (Section 24), as well as carrying out her existing functions. A wide field of interest was given to health visitors but their functions within these 'fields' were not precisely defined. The social welfare initiative generated a growth of workers (from differing agencies) required to meet 'family health' needs. Such growth in endeavour generated confusion, and overlapping of roles, activities and the required training.

The government, realising that clarification was necessary, embarked on a 'series of studies'. The first of these being the 1953 inquiry into health visiting chaired by Sir Wilson Jameson - "To advise on the proper field of work, the recruitment and training of Health Visitors in the National Health Service and School Health Service" (Introduction to The Jameson Report, Ministry of Health, 1956, p. A3). The Jameson Report acknowledged that:

> The health visitor is in the difficult position – indeed dilemma, of being in every sphere of her activity only one, if …a major, contributor to the total effort so that some thought must be given to the work of other contributors also (p. 4) …Health Visitors are "willing horses" and it is clear to us that some of them are set to a remarkable variety of tasks. There is an obvious risk of overloading, of creating jacks-of-all-trades who are masters of none. (p. 103)

The Jameson Report recommended that the care of the mother, young children and school-children should continue to be the major preoccupation of the health visitor

(p.108) but also set out new, expanded responsibilities for health visitors which included a focus on 'health education and social advice' for the 'household' as a whole, advice on the care of people who were ill, and measures to prevent the spread of infection. Collaboration with other professionals such as social workers, GPs and hospital almoners was also to be required. This extension of practice meant an increased need to recruit and train more health visitors, with a period of development "assumed to be ten years. In this period some additional 3,500 Health Visitors would need to be recruited" (p. xiii).

Reorganisation and re-discovery in the 1960s and 1970s
The emphasis of the NHS on hospital services and personnel remained paramount during the relatively affluent 1960s and 1970s, yet criticisms of its inadequacies were growing (spiralling cost, shortage of beds and nursing staff). Welfare services were also being subject to scrutiny and criticism from many fronts and poverty was 'rediscovered' (Abel-Smith and Townsend, 1965).

Moves to re-organise the NHS and make it more efficient and democratic led to a streamlining of nursing (the Salmon Report, DoH, 1966; the Briggs Report, DoH, 1972) yet the emphasis remained on, hospital nursing, with community nursing playing a largely subordinate role. The 1974 reorganisation of the NHS and local government, however, had far-reaching effects on health visiting, as the responsibility for their services shifted from local authority control to the health service, where they were placed within primary health care and attached to GP practices.

The ambiguities of health visiting practice and particularly its relationship with social work, as highlighted by the re-organisation, heralded another call for a clearer definition of health visiting duties. In 1962 the *Health Visiting and Social Work (Training) Act* received Royal Assent and the Council for the Training of Health Visitors (CETHV) was established to oversee the training, recruitment and function of health visitors. In 1977 the CETHV set out the defining principles and aims of health visiting practice as part of a lengthy enquiry into how best to teach and practise the profession.

The 1962 Act was highly significant as it sought to separate health visiting from social work, an action that for some commentators "moved it into nursing, a changed conflict, with new opponents" (Robotham and Sheldrake, 2000, p. 14). Yet within a short time the CETHV was disbanded when nursing was unified under the 1979 *Nurses, Midwives and Health Visitors Act*, and the responsibility for health visitor

education passed to the new National Boards. Now for the first time registration as a nurse became a pre-requisite for entry to health visitor training and practice.

Although registration of nurses began in 1919, the formal registration of health visiting as a type of nursing came only with the *Nurses, Midwives and Health Visitors Act* of 1979 (operative from 1983). This Act for the first time created a single regulatory body for all nurses, midwives and health visitors – The United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC). This unified body integrated the curative and preventative branches of the nursing profession.

The UKCC subsequently generated a register to record and regulate all 'nurses' that consisted of fifteen 'parts', one part for each type of nurse on the register. Separating 'nursing' into its various component parts – prevention, promotion, intervention, rehabilitation and terminal care (Kelly and Symonds, 2003). Health visiting was identified as part eleven of the register, with the title of "health visitor".

For Robotham and Sheldrake (2000) the loss of the CETHV and its unique function for health visiting led to its management and education becoming,

> …progressively squeezed by nursing into almost a generalist, marginalised and heavily criticised profession with, at the end of 1998, the very real prospect of losing its unique registration status. (p. 14)

Ironically such a prospect, discussed further in Chapter 3 was to become a reality in 2004.

The 1980s and beyond

Throughout the 1980s, the welfare state became subject to an emerging political and cultural philosophy that supported the primacy of the individual over the collective and the 'rolling back of the state'. It viewed public services as inefficient, undemocratic and costly. The remedy proposed was the application of the discipline of the market and the values and organisation of private industry i.e. efficiency and cost-effectiveness.

The White Paper, *Promoting Better Health* (DoH, 1987), changed the focus of the NHS from an "illness" service to a "health" service, yet the ordained shift to community and primary care based services was still to be medically-led. As Trevor Clay stated (1988, as Royal College of Nursing leader at this time) such proposals were,

> …fundamentally concerned with medical service, not with primary health care …General practice is still centre stage; district nurses and health visitors are confined to walk-on parts. (p. 6)

Not for the first time, the question was asked, "Whither health visiting?" (Goodwin, 1988). The Health Visitors' Association (HVA) supported a mass lobby of Parliament to protest against the "marketisation" of the health visiting service. Goodwin, General Secretary of the HVA, in a widely publicised speech argued that health visiting represented a declining profession under threat that needed to "reinvent" itself, to work to strictly specified targets and standards and become a "slim-line" and "new-look" service that targeted vulnerable groups rather than remaining universalistic.

The knowing and meaning of health visiting
The sociologists Abbott and Sapsford (1990) suggest that when trying to know and understand health visiting and health visitors, there are three main issues to be faced: "*Who are they*?, *What should they be doing?,* and *What is their status*?" (p. 125).

Who are they?
The literature reflects a long acknowledged position of health visiting as an occupation located firmly in the philosophy, and schools, of environmental and public health related to maternal and infant well-being (Poulton, 2003). The landscape that health visiting is seen to inhabit and embody is grounded in the sociological, epidemiological, political, psychological, biological and economic, as well as that of medicine and nursing. With such an eclectic mix of underpinning epistemologies and discourses it is no wonder that people ask – Is it nursing, public health, environmental health, social work, or social policing?

One of the discourses associated with health visiting is its involvement with aspects of social control and reform. Since its origins it has been defined by its involvement in 'child health surveillance'. This broad term includes developmental screening and surveillance, immunisation, growth monitoring, detection of child abuse and management of chronic and acute illness (Lancet, Editorial, 1986). In particular is the requirement to, where possible, prevent, identify, and/or respond to children who may be at risk of harm from child abuse and/or neglect at both primary and secondary levels. Many authors have considered the complexity and challenge for health visitors of engaging in surveillance over the private sphere of everyday life (Dingwall *et al*, 1983), particularly as such a service "is often unrequested by families" (Ling and Luker, 2000, p. 573).

For Abbott and Sapsford (1990) the "uncertainty" of who or what a health visitor/visiting represents centres on whether or not it is a form of 'social policing' and 'social control'. For them health visiting plays a surveillance role on behalf of the state,

in monitoring and preventing the breakdown of the family unit, surveilling and ensuring 'normal' child development and encouraging certain patterns of mothering and child care. Their interpretation is influenced by the ideas of Foucault (*Discipline and Punish: the Birth of the Prison,* 1979) and his interest in exploring ways in which modern Western society has become increasingly disciplined, controlled, regulated and kept under surveillance. For Abbott and Sapsford, health visitors (along with doctors and social workers) have become the new receivers of confession – the collectors of inner thoughts, attitudes and assumptions of private citizens, interveners in the lives of individuals and populations, laying claim to expert opinion, definition and determination of social and family worlds.

Robinson (a member of the Association for Improvements in the Maternity Services) in her article *Health Visitors or Health Police?* (2004), suggests that health visiting is increasingly being dominated by 'surveillance' not 'support', with all mothers being assessed for risk of child abuse at the first meeting. For her health visiting has always had two aspects – providing care and support to mothers and babies whilst operating a surveillance system for faulty or dangerous care. These two aspects often require a health visitor "showing who's boss" and presenting as "the spy with the smile" (p. 4). She concludes by calling for an open debate as to why the surveillance role has, in her belief, "tipped too far towards policing".

Kelly and Symonds (2003) construct the meaning of health visiting to be linked with their eighteenth-century origins of being utilised in the governmentality of a society experiencing significant social and economic change. Hence health visiting development has followed discourses around a variety of issues - the management of poverty; the perception of infant mortality as a social problem; the need for training and education of mothers and their infants; gathering of national public health data; identification of environmental concerns; and the medicalisation of birth and childhood surveillance. For them the role of the health visitor, in his/her everyday practices in health care, has been to provide a mechanism for order on behalf of governments.

What should they be doing?
Many opinions expressed in the literature show clearly the degree of role ambiguity of health visitors and health visiting as can be seen from the following titles of articles *Managing health: ambiguity as a theory of health visiting (*Littlewood, 2000), *Conflicting paradigms of health visiting: a continuing debate for professional practice, (*Twinn, 1991). In spite of numerous definitions provided a general lack of clarity about its role still appears to persist (Brocklehurst, 2004). Reasons from various authors are

varied – for some it is an outcome of health visiting's high level of autonomy; its tendency to personalise and individualise patterns of working and health (Rigler, 1982); the broadness and diffuseness of its core principles - that leads to considerable plurality of activity and lack of clarity of practice (Hunt, 1977).

Yet health visiting has been one of the first of the 'caring' professions to clearly articulate its occupational aims (see Glossary) (CETHV, 1977) re-affirmed by Twinn and Cowley in 1992, and updated by Cowley and Frost in 2006. Health visiting textbooks (Robotham and Sheldrake, 2000; Cowley, 2002; Robotham and Frost, 2005; Cowley 2008; Sines *et al*, 2009) provide examples of the many conceptual frameworks, theories and models, both interpretative and predictive, considered reflective of the important components of health visiting practice:

- those associated with health promotion (e.g. Green *et al*, 1980 – the PRECEDE model for change; Pender, 1987 – the health promotion model; Prochaska and DiClemente , 1984 – the transtheoretical model of change; Becker, 1974 – the health belief model);
- those associated with public health activities (e.g. Beattie, 1991; Chalmers and Kristajanson, 1989);
- nursing principles and proficiencies (for Specialist Community Public Health Nursing, NMC, 2004b) and models of nursing – Neuman, 1989);
- theories and paradigms specific to health visiting (Twinn, 1991; Chalmers, 1992).

An analysis of health visiting models of practice by Elkan *et al* (2000) show two principal models for practice, one predominantly a disease-based model (structured and prescriptive) and the other a model of participation, control and empowerment of the client, centred on befriending, support and advocacy (unstructured, individualistic and negotiated). Both models are regular features of a health visitor's role and identity yet only the disease-based model offers many opportunities for structured evaluation as the second participative and non-directive model of health visiting is often difficult to articulate, measure and is often perceived as invisible and ambiguous.

Malone, in her review of *A history of health visiting and parenting in the last 50 years* (2000) suggests that health visiting over the last 50 years has contained two distinct, but interwoven strands - the first being its increasing preoccupation with childhood behaviour and the second an enhanced role in 'social action'. Literature demonstrates that health visiting historically has come to mean a form of practice firmly rooted in a socio-economic model of health care centred on issues of public

health and strongly associated with preventative child and maternity welfare services. Their meaning and identity has often been as key players in the interplay between health and social disadvantage, inclusion, deprivation and particularly the identification and response to 'vulnerability' and 'risk'.

What is their status and relationship to and with nursing?

From the earliest days of nursing the literature shows clearly the considerable ambivalence and uncertainty around the nature, ways and construction of 'nursing', and particularly the two emerging, and differing, strands of caring represented by health visiting and nursing in the eighteenth and nineteenth centuries.

Florence Nightingale saw a clear distinction between sick nursing and health visiting "[the health visitor] must create a new work and a new profession for women" (correspondence with Frederick Verney, chairman of North Buckingham Technical Education Committee, cited in Kelly and Symonds 2003, p. 176). She continued,

> …it seems hardly necessary to contrast sick nursing with this [health visiting]. The needs of home health-bringing require different but not lower qualifications and are more varied. (quoted in the Preface of *An Inquiry into Health Visiting*, Ministry of Health, 1956)

She perceived that such a "new" "community based " "home" visitor would combine the roles of inspector, social worker and teacher, a largely preventative role that she supported to undertake the containment of epidemics and implementation of social order. In her *Notes on Nursing* (1859) Florence Nightingale championed giving priority to preventative work, for in her opinion the delivery of health care without attempts to improve the social and economic circumstances of populations was a waste of effort.

Since the profession of health visiting began, political, professional and philosophical debates have persisted about health visiting and its relationship to nursing. With the creation of the United Kingdom Central Council for Nurses, Midwives and Health Visitors (UKCC) in 1983 health visiting became encompassed under the generic umbrella of nursing. Once again, for some, the discourses of discipline, order, homogeneity and obedience had prevailed over the heterogeneous position of health visiting, from which until then had been separated organisationally, managerially, geographically and ideologically.

The practice of health visiting has historically assumed and adopted what could be termed a natural post-structuralist position, a position that appears to challenge the

positivistic, curative, bio-medical driven approach of traditional health care services and most 'institutionalised' nursing. It represents a paradigm centred around the ambiguity and uncertainty of contextualised life experiences and meaning, and the impact of these on wellness.

Some authors have explored the differences between nursing and health visiting in respect of knowledge bases, ways of knowing and forms of knowledge. The comparison is made between the ways of thinking required in nursing – rational, scientific, objective and positivistic, which Bordo (1989) describes as the "masculinization of thought", and the more "feminine modes of knowing" (p. 439) as favoured by health visiting. For Ling and Luker (2000) such feminine modes of knowing include the qualities of subjectivity, intuition, implicit and tacit knowledge which, they suggest, are key to understanding the complex, uncertain and idiosyncratic meaning of health visiting, particularly in their work of protecting children. Such a way of knowing, i.e using symbols, mental constructs, interpretative approaches and feelings, gives to health visitors the capacity "to *make* rather than to *express* meaning in the process of protecting children" (p. 573, my italics). Such self-knowledge, Ling and Luker suggest, is vital to the contentious, often emotionally charged, awareness and vigilance required of health visitors for their preventative and protective role, often conducted in the invisible setting of a client's home.

Health visiting illustrates well the dichotomy laid out by Kelly and Symonds (2003) – that if identity of types of nurses is defined by their *site* of practice then their form of life demonstrates clearly an ambiguous and complex position. The contradictions of *site* rotate around their ownership of a public health role that is largely conducted within private homes; their role is universal yet expected to include individual targeting. Their *everyday practice* has both directive and non-directive elements; they have an educative, supportive and caring role, yet their safeguarding and child development role involves them in screening, monitoring, detecting and elements of control; their public health role is conducted with individuals, families, groups, communities and wider populations. These contradictions are inherent in everyday practice and need to be perpetually managed by individual practitioners.

The literature generated from within both nursing and health visiting reflects the uneasy relationship between these two identities. These debates have represented alternative, equally legitimate viewpoints, informed by differing theoretical and cultural perspectives and views and competing professional agendas and differentiated entities. For some, any consensus between health visiting and nursing is 'unlikely' as

these 'contradictions' have remained unresolved and have persisted through centuries of political, professional and philosophical debate (Cowley, Buttigieg and Houston, 2000). The most markedly divergent views, however, appear to pivot around how health visitors should be educated and regulated in relation to other nurses.

So far, I have charted the journey of health visiting from its origins and through the various historical and prevailing influences. This discussion has covered a span of approximately one hundred and forty years – yet some themes related to the identity of health visiting endure throughout this time. These themes are closely connected with the monitoring, surveillance and support for the physical, social and mental health of mothers, infants and their related communities. The close links that health visiting has held with the public health of the nation, and particularly with its more vulnerable members, since its inception as an occupation, is still an enduring premise and cornerstone of its identity.

An important part of my research journey has been a consideration of the identity of the health visiting professional: what is it that defines us? The following represents my analysis of the literature on professional identity that has aided my understanding of the meanings attached to the construct and its collective form. The next section will also explore the various theoretical approaches that have been applied to its analysis. The section starts with a general consideration of the term 'identity' before considering its collective derivations. It is hoped that this discussion will provide a context for, and enhanced understanding of, the notion of professional identity.

The nature of identity
A review of wide-ranging published literature demonstrates that 'identity' is a potent and pervasive term, about which in recent years there has been a "veritable discursive explosion" (Hall, 1996, p. 2). The differentiation and delineation of identity includes the semantics of many descriptive entities and embodiments. The predominant prefixes are 'self'; 'personal'; 'collective'; 'shifting'; 'multicultural'; 'overlapping'; 'multiple'; 'sexual'; 'gender'; 'theft'; 'female/male'; 'mistaken'; 'negative'; 'minority'; 'transformational'; 'professional'. Overall the tone that emerges reflects one of concern and struggle; of complexity and anxiety. Words such as crisis, mistaken, dilemma, security, contest, diaspora feature often. Perhaps, as Bauman suggests, "one thinks of identity whenever one is not sure of where one belongs" (1996, p. 19).

For Epstein (1978) identity is essentially a concept of synthesis, integration and action. For him and others identity must be forever re-established and negotiated

(Sachs, 2001) for "contemporary life poses apparently boundless options for what we could be" (Gubrium and Holstein, 2001, p. 1).

Since the early 1980s identity has received considerable attention from post-modern and post-structuralist perspectives (e.g. Judith Butler, 1990). As Ferguson (2007) explains, such identity is meaningful not because it is grounded in an essence, but because it is implicated in complex, interrelated practices that are part of a larger world view. From a social constructionist's perspective 'identity' is a frequently used concept that has more to do with conferred purposes rather than the nature of the thing itself (Burr, 2003). From such a philosophy, identity of the personal does not originate from inside the person but from,

> …the social realm, where people swim in a sea of language and other signs, a sea that is invisible to us because it is the very medium of our existence as social being. (Burr, 2003, p. 109)

Such thoughts will engender later in this chapter a consideration of the notion of 'collective' identity – but first, what of the term 'professional' that has been selected to accompany the term 'identity' for this study?

Professional/ism/isation
The concept 'profession' can be traced to the Latin *profiteri* – a public pronouncement on certain principles and intentions by an individual, as well as devotion to a particular way of life (Searle, 1987). The term 'professionalism' is often allied to certain criteria identified as essential to a profession – an organisation, an ethical code and standards of practice, a regulatory body to prescribe principles and proficiencies of practice and therefore curricula to sanction preparation programmes, a regulatory body that licences and is accountable for practice. All of these pertain to health visiting.

For some authors professionalism represents the characteristics of a 'calling' (Gustafson, 1982). For others such as Olesen (2001), professionalisation represents the trinity of expert status, knowledge and subjectivity - where individual subjectivity is more or less integrated into a professional identity and is shaped by "ways of being" in a certain world (p. 290). For some it is a world shaped by use of language, ways of acting, interacting, feeling, believing, valuing and using various sorts of objects, symbols, tool and technologies …"a given "form of life" or Discourse" (Gee, 2005, p.7). Hence discourse shapes subjectivities and renders it difficult for people to think outside them – the subjects have consented, or been persuaded or seduced, or have

(re)negotiated their subjectivities, and therefore have bought into many of the roles, behaviours, values, etc., offered by a discourse.

During her consideration of professional identity politics Caughie quotes the definition of professionalism provided by Fish (1995):

> It is a form of organization in which membership is acquired by a course of special training whose end is the production of persons who recognize one another …because they perform the same 'moves' in the same 'game'. (2003, p. 424)

Collective identity

Hardy, Lawrence and Grant (2005) assert that the idea of collective identity is grounded in a variety of traditional sociological concepts, ranging from "Durkheim's 'collective conscious' to Marx's 'class consciousness'" (p.61). They endorse Cerulo's argument that collective identity "addresses the we-ness of a group, stressing the similarities or shared attributes around which group members coalesce" (1997, p.386). Of particular relevance to my field of inquiry are their thoughts on how a collective identity 'names' the group, giving it an identity when,

> …members collectively engage in the discursive practices that produce and reproduce it over time. (Hardy, Lawrence and Grant, 2005, p. 62)

For Poletta and Jasper (2001) the definition of collective identity revolves around its potential for solidarity and belonging. Yet can 'belonging' and 'shared status' be a constant? Hall (1990), during his social constructionist work on racism, suggests that identity is always in a cultural sense 'in production'. His comments raise considerable resonance with the current context of health visiting:

> Identity …is a matter of 'becoming' as well as 'being' …It is not something which already exists, transcending place, time, history and culture …they undergo constant transformation …identities are the names we give to the different ways we are positioned by, and position ourselves within, the narratives of the past. (p. 225)

Yet how far does this assist in understanding or confirming the (in)coherence of the collective identity? Zerilli (1998) and Ferguson (2007) suggest that to ground collective identity in only knowable, shared characteristics and commonality is a misconception. Ferguson (2007) develops an alternative account of collective identity as one that can emerge from multiple, overlapping and discontinuous social practices. From her perspective, seeing identity as a matter merely of classification renders that

identification passive and objectified. For her identity is produced through doing, through practices that give the identity meaning to the participants, and since identity is produced through practices, these practices must be sustained in order for the identity to continue to have meaning (p. 38).

Holland, Fox and Daro (2008) view collective identity as a multi-faceted and dynamic cultural production which forms and reforms in local and sociohistoric time/space (p.97). For them collective identity formation is fundamentally dialogic involving processes of 'orchestrating' multiple discourses and versions of self. This perspective has considerable reverberation with this study, as do the thoughts of Gubrium and Holstein (2001). They suggest that our notions of the 'self' do not amount to much at all anymore as it has relocated itself in a "vast landscape of self-construction processes and potential identities" (Preface) – offering countless opportunities for presentation and direction. Even though 'opportunities' for self-construction are now greater than ever, they are still disciplined by the practical conditions under which it unfolds – the institutional panorama in which we live our everyday lives.

So where does this lead us? What does 'professional identity' mean? It has been termed a concept, a metaphor, a discursive construct and even as a psychological resource. Are the aspiration and maintenance of an identified (titled) professional identity a means of retaining power and status through ownership over specific knowledge and expertise? For Johnson (1995) this may well be the case, and may be vital to professional groups carving out a boundary around knowledge – that is, protecting their position from encroachment. Perhaps one distinctive historical aspect of health visiting has been its tenacious determination to maintain its title and uniqueness (other) within nursing.

General review of occupational interest in professional identity
The literature interested in this notion appears mainly in the form of journal articles from specialist, professional journals predominantly contributing to the discourse of their specialist field and a few academic theses. The literature shows that certain professional groups have an enduring interest and concern with their professional identity (social work, teaching, nursing), and conversely some professions appear new to the debate and discourse (counsellors, psychologists, other therapists). Those occupations with a keen and ongoing interest in professional identity often associate their discourse with a search, 'quest' or affirmation, of and for, a professional position and status. As Katz suggests, few professionals talk as much about being

professionals as those whose professional stature is in doubt (in Etzioni 1969, cited by Stronach *et al*, 2002).

Many authors, from varied occupational groups, talk of the redefining and redirection of their professional identity and how this represents a fundamental challenge to the definition of that identity (e.g. McCollum, 2000; Mrdjenovich and Moore, 2004; Lewis and Hatch, 2008; Benshoff *et al,* 2008; Liebig, 1995; Van Hesteren and Ivey, 1990; Gale and Austin, 2003). Often the challenge that change represents is described by authors as that created by external forces, such as change associated with the need to learn new skills, terminology, interpersonal styles and models of care (Mrdjenovich and Moore, 2004; Byrnes, 2000) or change in government policy and organisation (Sachs, 2001). For such authors professional identity is defined as the set of externally ascribed, shared attributes and values that are used to differentiate one group from another (Sachs, 2001). Whether professional identity is externally, internally, and/or subjectively ascribed, and constitutes a process not just of identification but alignment, is considered by a significant number of authors.

One of the few books to examine the nature, development and application of professional identity is Jeff Solomon's *Metaphors at Work: Making Professional identity* (2008) which scrutinises professional identity through a 'cognitive science lens' – that is work illuminated and underpinned by cognitive processes. Solomon's study of over 1200 professionals in the US (doctors, lawyers, journalists, geneticists and business people) found professional identity to be a key psychological resource that enabled workers to sustain motivation and to make work meaningful while untoward changes are affecting their occupational domains.

The issue of the professional visibility and centrality of an occupation within and outside its particular firmament is another key topic within the literature. Patterson (2009) and Stebnicki (2009) both express concern at the lack of visibility and centrality of their particular occupation (rehabilitation counselling), as well as its marginalisation to that of a minor planet among a constellation of many other counselling professions. This theme of 'marginality' has been raised and explored by Hendry as far back as 1975. He considered how those in marginal roles within their organisations (those peripheral to the main functions of the institution) were required to develop various 'survival' processes in order to resolve, and reduce, 'role strain' within their organisations. This theme has interesting parallels with health visiting and nursing.

Several writers regard the issues of specificity and uniqueness of their individual professions to be of particular importance to their professional identity. For them, such attributes are viewed as essential for securing their profession's role in the eyes of others (professionals and the general public) e.g. Swickert (1997), Pistole and Roberts (2002). However others sound a note of caution, that the idea of uniqueness often synonymous with 'specialisation', can be narrow and constrictive and to the detriment of that profession.

One of the most recent themes to emerge on the notion of professional identity is that of the conception of occupational boundaries. Norris (2001, a health researcher in New Zealand) examines the rhetorical strategies used by individual practitioners to establish and maintain occupational boundaries, to distinguish their occupation from others, to create a sense of professional identity and to enable claims of jurisdiction over an area of work. For Norris, practitioners construct boundaries by adopting differing professional ideologies in order to distinguish themselves from others - the goal being occupational control. The differences of the practitioners are not, she claims, *real* differences, but manufactured and constructed by them within their talk and expressions using rhetorical strategies and devices.

The uncertain politics of nursing professionalism
Examining the literature of nursing in respect of 'professional identity' it is easy to recognise the enduring discourse of concern in relation to its definition and defence of a 'professional' identity. Nursing often perceives its assigned status as that of one of a group of "semi-professions" (e.g. Etizioni and colleagues, 1969, Simpson and Simpson, 1969). According to Etizioni (1969), an occupation such as nursing does not qualify for professional status on the grounds that its knowledge base, theories, and length of training are insufficiently robust and unique, and their work is more 'supervised' and 'applied' than the more theoretically informed and autonomous work of other professions (Abbott and Wallace, 1990).

Stronach and his fellow researchers (2002) considered the uncertain politics of professionalism with respect to nursing, whose professional self and status they describe as 'inherently problematic'. They explore the epistemological, methodological and narrative strategies whereby 'professionalism' for this occupational group is conceptualised. For them the term 'professional' is a construct born of methodological reduction, rhetorical inflation and universalist excess and is an indefensible unitary construct. In this sense the notion of 'nurse' is already too much of a generalisation to

constitute such a construct. This 'construct' they believe to be an expression of the zeitgeist – sometimes a hero/heroine, often a victim, less and less a planner of his/her own destiny but usually as an agent for good in society:

> Whether cast as a poetic, philosophical or political figure, the professional [nurse] is constructed emblematically, as standing for much more than the 'semi-professional' that Etzioni prosaically identified. (2002, p. 111)

Emanating from the nursing literature is a considerable and enduring interest with achieving 'professionalisation'. Thupayagale and Dithole (2005) represent other authors when they assert that for many years nursing (unlike medicine, pharmacy, psychology) has struggled "with an inner hunger; a deep need for professional congruency and effectiveness" (p.142). Tschudin (1999) proclaims "nursing needs a voice and an identity more urgently than ever before" (p. x). She suggests that nurses need to adopt a 'proper selfishness' – a proper concern with themselves that searches for the reality that they are (from Handy, 1997).

Yet even the most cursory look at recent nursing literature shows that the quest for professional status continues. Chua and Clegg (1990) propose that this quest for 'professionalism' can be defined by discursive complexity and contradiction that has not been resolved by state intervention or enhanced regulation. Of interest to this study is their opinion that the historical pursuit of nursing professionalism reveals the centrality of both inter-and intra-occupational contest, which displays "neither functional specificity nor universalistic impersonality. It has not been characterized by shared norms and values" (p. 164).

Hallam's analysis of nursing's identity (2000) starts with the statement, "Since Nightingale's day, nursing and female identity have been difficult to prise apart" (p.10). This connection between nursing and the feminine condition, position and societal roles is a recurring theme within the nursing identity discourse. Davies (1995) also suggests that 'nursing' has always been a much conflicted metaphor in our culture due to the ambivalence, devaluation and marginalisation of womanhood and the gendering of social institutions. For Janet Muff (1988) central to the problems that have traditionally faced nursing is the fact that nursing "is a traditionally 'woman's job' in a traditionally 'man's world'" (p. 197). As a consequence, she argues, the role and identity of nursing has altered in response to the needs of others "without conscious decisions by nurses to make those changes" (p. 202).

The literature also shows significant interest in the subjection of nursing to a 'subservient' occupational position acquiescing to medical dominance and gendered divisions of labour (Kelly and Symonds, 2003).

Professional identity and nursing

From my investigations the phrase 'professional identity' appears rarely investigated in an empirical sense in the health and social care arena. The discursive 'voices' that have explored this area are mainly confined to academic members of universities who appear to speak on behalf of their particular interest and 'practice community'. 'Professional identity' within the nursing literature is mainly addressed in terms of a deconstruction of its related concepts and parts yet a recurring theme is that the 'identity' of the nurse within her profession is foundational to the assumption of various nursing roles. However as Borsay suggests such identity can seem in perpetual motion, for,

> …nurses are no longer ascribed a single identity …rather, they are forced to construct their own identities on an ongoing basis by thrashing out the multiple meanings of their changing roles. (2009 p. 21)

The strongest consideration of the actual phrase/notion of 'professional identity' to be found within the nursing literature focuses on two main themes – a) aspects of socialisation to nursing and b) issues arising from the reality of nurses working in more interdisciplinary and interprofessional ways.

The political imperative since the 1990s for integrated, interprofessional working has prompted an interest in the boundaries and identities of professionals involved in learning and working together (Davies, 2002a). The expansion and 'reassessment' of nursing roles has also prompted calls for nursing to reassess and modernise its identity (Gough, 2001). Others warn that such a reassessment should be a 'reconceptualisation' and not a dissolving of professional role identity (Howkins, 2002, Ewens, 2003).

Theoretical perspectives

Within the nursing literature three main theoretical and discursive approaches are adopted to explore professional identity and its component parts: a) the socio-historical, b) the psycho-social and developmental and c) the sociological/symbolic interactionisitic and their various combinations or permutations as hybrid models are recommended by Öhlén and Segesten (1998).

A socio-historical perspective

Nursing authors adopting this perspective are concerned with how and why nurses have been socially, politically and culturally positioned within particular ideologies, ontologies and historical periods.

Borsay (2009) reflects many other voices within nursing (Abel-Smith, 1960; Davies 1980; Dingwall *et al,* 1988; Baly, 1995; Hallam, 2000; Kelly and Symonds, 2003; Robinson, 2005; Wood, 2005) when she traces the threads of its historical origins, thus enhancing understanding of the present. By thinking in terms of professional identity she suggests we are better able to comprehend the complexities of nursing knowledge, practice, regulation and caring (quoting Celia Davies from her 2005 Monica Baly Lecture). For such a discipline "which is unique, complex and at times confusing, for some, insights into its history and evolutionary processes can and do assist in clearing these 'murky waters' " [of identity] (Leishman 2005, p. 1157).

Psycho-social and developmental perspectives

Some nursing scholars have found the adoption of a psychosocial and developmental perspective useful. For Cook *et al* (2003) identity in nursing is linked to the development within nurses of an internal representation of people-environment interactions and their responses to actual or potential health problems. Du Toit (1995) also supports the view that a nursing identity is formed partly by interaction with people (clients – the cared for) and partly by interaction with peers and role models (the carer).

The sociological and symbolic-interactionistic perspective

The symbolic-interactionistic approach to the professional identity of nursing emphasises the interactions between nurses and the individual internalisation of the knowledge, skills, norms, values and culture of the profession. For this mode the 'self' is the major unit of analysis and the main process through which social interaction develops with and between others (Blumer, 1969).

One of the main studies is that by Norwegian nursing academic, May Fagermoen (1995, 1997). Her descriptive studies of nurses, with one, five and ten years of experience suggests that professional identity evolves from a general altruistic motivation to a set of values which are specific and differentiated, namely - altruism, security, integrity, personhood, autonomy, privacy, reciprocal trust and hope. From this perspective professional identity emerges through a process of self-formation in

which social interaction and self-reflection are basic processes within which the internalisation of values is an integral part.

From nursing scholars who adopt a more sociological perspective there is emphasis on the processes of learning for the nursing role, rather than on defining its identity. Du Toit (1995) and other nursing scholars (e.g. Cohen, 1981, Melia, 1987, MacIntosh, 2002) have studied this process of 'professional socialisation'. Cohen's (1981) research into this concept defines professional socialisation as:

> The complex process by which a person acquires the knowledge, skills, and sense of occupational identity that are characteristics of a member of that profession. It involves the internalisation of the values and norms of the group into the person's own behaviour and self conception. (p. 14)

Other nursing authors perceive professional identity as one construct of social identity that develops over time, and involves gaining insight into professional practices, talents and values, and how people compare and differentiate themselves from other professional groups (Adams *et al*, 2006), such authors have been influenced by Social Identity Theory (Turner, 1999). From the use of such a theory it is useful to consider that whilst several identities may co-exist simultaneously in an individual, one may be more salient than another at any one time, depending on the context (Adams *et al*, 2006).

In summary, it has been clear from my studies that, as Caughie states, "professional identity runs deep" (2003, p. 423) and matters. Professional identity appears a particularly important notion during any time and state of occupational transition as it allows the valuing and honouring of past professional lineage, whilst cultivating and responding to new occupational challenges and changes. From other published voices there is a plea for more pluralistic approaches to professional identity - "to grow unencumbered by tradition and ideology" (Mackey, 2007, p. 96).

The discursive reality is that many occupations appear to be seeking a professional identity that is clear, definable, legitimised, fully recognised and acknowledged as 'professional'. Yet many authors seem to centre their debate on whether or not their occupation has reached the elusive status of being a 'profession', rather than exploring, explaining and strengthening their own distinct identity. From the personal experience of conducting this literature review it is clear to see the complexities, confusions, inconsistencies and contradictions that abound when attempting to define 'nursing'.

Many definitions are provided for 'professional identity' within the literature. The two that strike a resonance with this study are joined by their recognition of the importance of self-conceptualisation – yet in other ways they are dissimilar. Brott and Myers (1999) define professional identity as a frame of reference (a meaning-making framework) from which one carries out a professional role, makes significant professional decisions and develops as a professional, that is self-conceptualisation (p.339). Adams *et al* (2006) provide a definition of professional identity that relates to how people compare and differentiate themselves from other professional groups:

> It can be described as the attitudes, values, knowledge, beliefs and skills
> that are shared with others within a professional group and relates to the
> professional role being undertaken by the individual, and thus is a matter
> of the subjective self-conceptualisation associated with the work role
> adopted. (p. 56)

Despite the efforts of many authors the general conclusion appears to be that certain professional identities remain as elusive as ever – none more so than nursing and health visiting - which is why the selection of certain supporting theorists for this enquiry is of importance.

Supporting theorists employed for this study

From my studies I came to appreciate the issues of key importance to the questions I was asking and the answers I was seeking. Such issues related not only to exploring a specific type of identity - health visiting, but also the specific context, reality, and discourses shaping that identity, and the impact (power) that discourses could have on its professional identity. This led me to consider the work of Foucault for whom a discourse is a construct of *power* and *knowledge.* For Foucault *power* and *knowledge* are bound up together and interdependent with *meaning* produced by their configuration (my italics). He asks – what is knowledge? How do we know what we believe to be the 'truth'. From his perspective, knowledge has *roots*, which can be uncovered and understood (Foucault, 1972). His theory of discourse, therefore, is an "attempt to uncover the meaning of a body of knowledge" (Kelly and Symonds, 2003, p. 4).

Within such a Foucauldian approach, discourses are inextricably linked to 'institutions' and to the 'disciplines' that regularise and normalise the conduct of those within the institution – and establish what kind of person one is entitled/obliged to 'be'. Thus, as Foucault suggests, the individual is "fabricated" into that social order (1979, p. 217),

and we discover our identity by deconstructing the formalities through which we endlessly examine, evaluate and classify our experiences.

Further reading around 'discourse' and 'identity' led me to the work of James Gee (1999, 2005) and his integrated theory and method for studying how language gets recruited "on site" to enact specific social activities and social identities. Gee defines "identities" to mean the different ways of participating in different sorts of social groups, cultures and institutions (2005, p. 1). For him social identities are shaped, along with social activities, by cultures, social groups and institutions. In common with Foucault, he makes the point that groups and institutions render certain sorts of identities and certain sorts of activities meaningful, and constitute the nature and existence of specific social groups and institutions (2005). Further consideration of how discourses can affect the identity of health visitors are considered in Chapter 3.

Conclusion

In conclusion, the literature review has shown that nurses and others (as well as health visitors) have enduringly debated their role, identity and position within society and with other allied professionals. They have sought to describe their 'uniqueness' and specificity and to distinguish their occupation from others. Nursing in particular has pursued the recognition and acceptance of a professional status. It seems a paradox, therefore, that the construct of 'professional identity' appears rarely investigated in any empirical sense in the fields of health and social care, yet obviously runs deep and matters to its members.

The synthesis of 'identity' in relation to health visiting's occupational role, position, practice, culture, title and status will be considered in depth in Chapter 5, as will the main theoretical and discursive approaches raised in this chapter. The key issues of specialisation, visibility, marginalisation, occupational complexity and change related to professional identity will form part of that synthesis.

The next chapter will focus on the contemporary discourses contributing to, and creating, the recent debate concerning the role and identity of health visiting. The significance and meaning of these discourses provide an important empirical context as well as data for this study.

CHAPTER 3

CONTEXTUAL DISCURSIVE THEMES

This chapter considers the context and contemporary discourses that have significance and meaning for the recent debate concerning the professional identity of health visiting. Whilst accepting that exploring the important discourses influencing health visiting is a necessary and logical step for this study, it has proved a challenge. As Mischler suggests "confronting the problems of context is like opening up Pandora's box" (1979, p.17). The constant shifting, shaping interplay and renegotiation of discourses and the continual positioning and repositioning as contexts and discourses evolve, emerge, and are responded to, have proved testing.

The aim of this chapter is to try and capture the complexity and uncertainty of professional, governmental, political and social activity, and gain some sense of how these activities may be creating and influencing a changing professional identity for health visiting. One of the major strengths of qualitative research, it can be argued, is the necessary emphasis on understanding the phenomenon of interest holistically (Murphy *et al*, 1998, p. 5). This requires a comprehensive exploration and consideration of its context. The use of Gee's method of discourse ('d' and 'D', 2005 see Chapter 4) is used as a framework for exploring all the associated, complex, multiplicity of discourses that provide the context for this study.

The design for this study began by exploring the nature of the relevant discourses and developing the questions that needed to be asked:
Which are the dominant discourses influencing health visiting?
What is the nature and degree of their influence on the professional identity of health visiting?
Which discourses are complementary? Which are competing? Alternative? Contradictory? Intersecting? Antagonistic?
How will I demonstrate how these discursive views (positions) are influencing the professional identity, and hence meaning, of health visiting?

The outcome of exploring these questions informed the methodological decisions for this study and also demonstrated the multilayered and multivoiced nature of the discourses surrounding health visiting - at policy, professional and public level. The difficulties of defining and interpreting discourse are considered later in this thesis, for it is a term as vague as it is fashionable - "discourse is something everybody is talking

about but without knowing with any certainty just what it is: in vogue and vague" (Widdowson, 1995, p. 158). For this study, 'discourse' represents the reality as constructed through language, texts, communication narratives, actions and symbols. This approach draws on Foucauldian concepts of discourse where discourse means a group of statements which provide "a language for talking about – a way of representing the knowledge about – a particular topic at a particular historical moment" (Hall, 2001, p. 72).

This study is also interested in discourse as an instrument of power and control and as a way of representing social practice(s) as a form of knowledge. My application of the notion of 'discourse' therefore also encompasses a broader sociocultural conceptualisation that includes the practices producing the meaning, form, construction, regulation, and meaning of health visiting at this particular point in time. Such a post-structuralist position acknowledges that truths are always partial and knowledge is always situated, "that is – produced by and for particular interests, in particular circumstances, at particular times" (MacLure, 2003, p. 175). As power and control are of central ideas to this study, then the contemporary governmental and political aspects influencing them will be considered first.

Governmental discourses

Reviewing the contemporary discourses emanating from recent political rhetoric and policy related to health care, the themes of modernisation, performance and regulation abound. The text of the government in its first manifesto (*New Labour because Britain deserves better,* 1997) heralded for health care a change in ideology, values and emphasis. Such political changes appeared not to be based on theoretical models of care but on reports commissioned by government that resulted in far-reaching consequences for nursing and particularly health visiting.

As policies emerged from this new Labour government, certain 'ways forward' for health care were clearly identified, supported and encouraged. Some of the key foci centred on challenging traditional working practices and professional role boundaries (*The NHS Plan: A Plan for Investment, A Plan for Reform,* DoH, 2000), which increasingly contested the structures, systems of authority, accountability, regulation, and autonomy related to health care practitioners.

The modern health care worker was to be a flexible, reflective practitioner, a team worker, and a life long-learner, market-orientated, managerial and entrepreneurial (Mackey, 2007; *A First Class Service: Quality in the New NHS*, DoH, 1998b; *Shifting*

the Balance of Power within the NHS: Securing Delivery, DoH, 2001c; *Liberating the Talents: Helping Primary Care Trusts and Nurses to deliver the NHS Plan,* DoH, 2002). Allied to this discourse of health care modernisation the government promoted the perspective and voice of the consumer (user), so they could also challenge, where <u>they</u> saw fit, health care professionals' ways of working, knowledge and autonomy.

The discourse of 'public health'

The new Labour government with its raft of health-related policies represented a renaissance for the discourse of public health, a discourse usually positioned at the margins of political health care interest and importance. The first Minister for Public Health was appointed and set in motion a series of projects and events designed to develop and enhance the public health function and capacity of the NHS, demonstrating also the government's commitment to tackling inequalities in health.

The research undertaken by Sir Donald Acheson (commissioned by the government) into the inequalities in health in Britain (DoH, 1998c) fostered and influenced a raft of public health policy intent on improving the health of the nation. The context for public health practice was clearly presented in the various governmental strategies that followed within *Saving Lives: Our Healthier Nation* (DoH, 1999a), *Tackling Health Inequalities: A Programme for Action* (DoH, 2003b), *Choosing Health: Making Healthier Choices Easier* (DoH, 2004a), *Our health, our care, our say: A new direction for community services*, (DoH, 2006b).

The government ideology, shaping its underlying discourse on public health, appeared predicated on the importance of partnership between individuals, communities and the state. It acknowledged the links between health and poverty, socio-economic circumstances, lifestyle, environmental factors and public services - a model of health (not disease) very close to the 'new public health' approach pioneered by Lalonde (1974).

Under the auspices of the Chief Medical Officer (CMO) a series of government backed enquiries and projects were undertaken to redefine and strengthen the public health function of Local Authority and NHS staff (DoH, 1998a). Within the CMO report health visitors were identified as 'hands-on' public health practitioners and recognised as a group of practitioners whose "title always signifies a priority focus upon public health and prevention" (Cowley 2002, p. 12). For such practitioners the future looked promising, validating and signalling of a time for re-energisation.

The discourse of regulation

From its beginning the Labour government signalled their intent to 'rebuild public confidence' in health care services and practitioners by guaranteeing acceptable standards of health care provision. In 1997 the government ordered a review of all existing statutory regulatory bodies for health practitioners with the requirement for them to become more robust, proactive, publicly open and accountable.

For nursing, the review centred upon the regulatory processes and procedures of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC), a body created in 1983 to amalgamate the many strands of nursing into one regulatory body. From within the UKCC it was decided that the profession of nursing required a new, more robust regulatory body. As a consequence the UKCC was dissolved and a new regulatory body for all nurses was created, entitled – The Nursing and Midwifery Council (NMC). In April 2002 the NMC came into being (through The Nursing and Midwifery Order, 2001), its first priority being to create a new regulatory register to support and underpin a more rigorous, simplified and publicly accountable model of regulation.

Within the register of the UKCC, health visitors had historically held their own dedicated part of the register (Part 11, – of a 15 Part register) and with it the legal and 'protected' title of health visitor. This title defined a body of practitioners recognised by and for their specialist knowledge and practice (particularly in relation to public health), and distinct and separate academic preparation. This title, until 2001, had always been contained within the name of the prevailing nursing regulatory body.

The new nursing register was launched by the NMC on August 1st 2004 (for its 650,000 nursing practitioners). It finally consisted of three parts. One part for Nurses (Part 1) and Midwives (Part 2) and a new category (Part 3) for a new type of nurse to be known as a 'Specialist Community Public Health Nurse' (SCPHN). Included within this part of the NMC register and its title (SCPHN) were the 'practitioner pathways' of health visitor, school nurse and occupational health nurse. All existing health visitors were transferred to this part of the NMC register and recorded as Specialist Community Public Health Nurses (SCPHNs) with the *annotation* of health visitor.

In June 2004 the NMC approved and published *Standards of proficiency for Specialist Community Public Health Nurses* (NMC, 2004b) – the standards of proficiency and education required to become a SCPHN. This document states that the reason for

establishing this part of the register is "that this form of practice has distinct characteristics that require public protection" (p. 4).

One of the aims of this study is to explore the impact of these regulatory changes on the professional identity of health visiting, which was prompted by the thoughts of Schwandt (2003) who suggests that the world of the new SCPHN and the subsequent impact on the health visiting community are emerging as people talk, write, read and argue about them. As Schwandt purports, in time the health visiting community will judge what the 'reality' is for them.

The parenting and safeguarding of children

The issue of child abuse, and particularly sexual abuse of children, emerged as one of the most publicised discourses of concern in the 1980s (e.g. The Cleveland Inquiry, DHSS, 1987). What some described as a 'moral panic' over the incidence of child abuse dominated the press at this time, activating a new discourse on the rights of children (including the right to be heard) and greater government emphasis upon interagency provision.

The events in Cleveland in the summer of 1987 (social work claims of sexual abuse by family members, grievances of families whose children had been removed, actions of paediatricians, and the crisis of family life) prompted a full government and judicial inquiry and led to the *Children Act* of 1989. This Act focused upon the primacy of the 'interest of the child' and signalled a shift in service provision to one of being needs-led – with distinction made between 'a child in need' (Section 17) and 'a child in need of protection' (Section 47). Social services became the lead agency in this new era of child protection although, historically and traditionally, this had always been one of the prime components of health visiting practice.

The new Labour government brought a new approach, policy direction and ideology in respect of families, children and parenting. This approach embodied a belief in community as a value and a site (Kelly and Symonds, 2003). The rights of individuals as parents and workers were to be strengthened along with their responsibility. Many projects were initiated to tackle poverty and social exclusion, such as Sure Start and Children's Trusts. Childcare was brought firmly into the public gaze and a new childcare strategy and raft of family policies emerged from 1997.

The context for the safeguarding and protection of children also witnessed a distinct conceptual shift, as the terms and principles changed and were applied at

interprofessional, professional, inter-organisational and national levels (Lupton and Khan, 1998). Since the publication of *Child Protection Messages from research* (DoH, 1995) it had been widely accepted that child protection should be viewed within the broader spectrum and concept of 'safeguarding', a concept representing a broader, more proactive, and positive notion encompassing,

> …the prevention of impairment of children's health and development, the maximisation of children's potential through stimulation, play and education, protection from disease through immunisation, prevention of harm from accidents, through to protection from child abuse and maltreatment. (Appleton and Clemerson-Trew, 2008, p. 258)

The physical, mental abuse, neglect and death of Victoria Climbié in 2000, at the age of 8 years and 3 months, by her great aunt Marie-Therese Kouao and her partner Carl Manning, proved a catalyst for the enhancement of the concept of safeguarding children. The subsequent inquiry by Lord Laming in 2003 was pivotal to the production of new guidance and legislation, not only to seek better protection of children, but also to introduce and develop wider policies to improve the outcomes for all children and young people, particularly the most disadvantaged (Powell, 2007).

The Laming Inquiry recommendations (108 in number) led to government actions that significantly changed the structural and organisational efforts of societal, governmental, and professional sectors involved in the care and protection of children. 'Safeguarding and promoting the welfare of children' was to become the watchword for all such professionals. The term safeguarding received statutory status under section 11 of the Children Act 2004, with "child protection" now described as "a part of safeguarding and promoting welfare" (*Working together to safeguard children. A guide to interagency working to safeguard and promote the welfare of children,* 2006a, DoH, p. 5).

A whole-system, whole-population reorganisation of policies, guidance and procedures (enshrined in legislation) followed in order that vulnerable children in need (and their families) would be identified and offered services i.e. *Every Child Matters: Change for Children programme* (Department for Education and Skills, 2003); *National Service Framework for Children, Young People and Maternity Services* (DoH, 2004c); *Children Act* (DoH, 2004b). A requirement for more effective inter-agency working and integrated service planning and delivery, along with partnership working with both children and parents, became enshrined within the Children Act of 2004.

The vision for change was "a shift to prevention whilst strengthening protection" of children and young people (Margaret Hodge, Minister of Children, Department for Education and Skills, 2004). One major impact of this most far-reaching reform of children's services for 30 years was the reconfiguration of the relationship between the state, professionals, parents and children and the generation of new and wide-ranging systems of surveillance (Parton, 2006). These changes posed particular challenges for all professionals concerned with child care services, not least for the health visitor and health visiting.

Modernising the NHS workforce

The NHS modernisation agenda of the Labour government paid particular attention to nursing. Their agenda sought to strengthen the nursing contribution to health care by developing new ways for nurses to work and to be, by encouraging the creation of innovative nursing roles, and greater multidisciplinary working and multi professional, integrated approaches to care (*The New NHS: Modern, Dependable,* DoH, 1997; *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare,* DoH, 1999b).

For health visiting the omens were very positive with finally a new impetus and commitment to preventative, public health services within the National Health Service. Community nurses were identified as being in a position to assume a 'prime' public health role in this 'new' primary health care, public health-led NHS and "be in the driving seat in shaping local services in the future" (DoH, 1997, section 5.1).

A new political orientation towards the importance of community and parental responsibility designated a pivotal and specific role for health visitors. A White Paper, *Supporting Families: A Consultation Document* (Home Office, 1998), set out the government intention for a new enhanced role for health visitors, to respond to government initiatives to encourage responsible parenting (not just motherhood), to target vulnerable groups and individuals, to reduce health inequalities and be a supportive mechanism in the reconstruction of family and community networks.

The Acheson Report (DoH, 1998c) specifically recommended that health visitors should further develop their role in providing social and emotional support for parents and children in disadvantaged communities. In the key government public health policy *Saving Lives: Our Healthier Nation* (DoH, 1999a) health visitors were identified as pivotal to the achievement of a healthier nation. Health visitors were encouraged to develop,

…a family-centred public health role, working with individuals, families and communities to improve health and tackle health inequality. (p. 132)

A new modernised role for health visitors was also outlined in various key publications - the ten-year nursing strategy *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare* (DoH, 1999b); *Health Visitor Practice Development Resource Pack* (DoH, 2001d). The *Making a Difference* document proclaimed the need for health visitors to work in new ways and take forward the public health agenda, yet it offered no clear suggestions as to how this was to be done (Smith, 2004). For Carr (2005) this vision of the 'new look' health visitor was beset and blurred by problems from the very beginning:

Health visitor problems of identity are emphasized by their medical/nursing background, the ambiguity of their role in relation to social workers, their domination by medical men and their aspirations to professional status. (p. 121)

In November 2006 the Department of Health commissioned a review of the future role and practice of health visiting – the first since The Jameson Report in 1956. The scope of the review was described as being to define and describe a 'renewed' future role for health visitors as part of the *Modernising Nursing careers – setting the direction* initiative (DoH, 2006c). The commissioning of the review arose from concerns in government, nursing and health visiting that the lack of focus (or too many foci), clarity and appreciation about the role of health visitors was threatening to "undermine the profession and the important preventative services that they provide" (DoH, 2007b, p. 5).

The function of the Review Working Group was to gain a national response to the questions, 'Where is health visiting now? and where should it be in the future?' In June 2007 the resulting report *Facing the future: a review of the role of health visitors* (DoH, 2007a) was presented to the government and in October 2007 came *The government response* to *Facing the Future: a review of the role of health visitors* (DoH, 2007b). Both documents are considered in greater depth within the findings in Chapter 5.

By adopting the role of commissioner of the health visiting review the government purported to expose the 'inadequacies' of the present health visitor role – however it failed to provide details of these inadequacies or consider the context of how these 'inadequacies' arose in the first place.

The NHS commissioning context and discourse

In keeping with the Labour government's required NHS ideology of devolved responsibility and local decision-making, the discursive theme of the need for change and modernisation in the management and commissioning of health care services regularly occurred. The government 'commissioning' (see Glossary) agenda was clearly at the forefront of their intent to modernise and reform the NHS in order to develop a patient-led NHS that used available resources as effectively and fairly as possible to promote health, reduce health inequalities and deliver the best and safest healthcare.

During the time leading up to, and the undertaking of, Stage 3 of the study (i.e. 2007 - 2008) the responsibility for the commissioning of NHS services was subject to significant change. Primary Care Trusts (PCTs) were now required to divide their functions into commissioning organisations (PCTs) and provider organisations (Primary Care Organisation, PCOs) with a determinedly more detached relationship, differing titles and significantly different roles. Both organisations were now to be overseen by smaller, more overtly tactical Strategic Health Authorities (SHAs).

During this period of 'reconfiguration' all NHS bodies were required to 'balance their books' by removing financial deficits, facilitating competition, stepping up the amount of services being provided by voluntary, community organisations and social enterprise, and moving towards Payment by Results. The results of such financial and commissioning imperatives led many to fear the withering consequences for health visitors and health visiting.

Wither health visiting?

The impact of this 're-configuration' and reduction in financial deficits on the provision of health visitors and their service wrought significant disinvestment and reduction in their work force. Evidence of this was identified by the Family and Parenting Institute (FPI) in a study undertaken by them in 2007 in which Freedom of Information requests were submitted to the 151 'newly' formed/reconfigured PCTs in England asking how many health visitors they employed (research conducted Jan-March 2007). The FPI also commissioned YouGov to ask 5,000 parents what they thought of health visitors. The results of their studies was published in April 2007 and entitled *Health Visitors – an endangered species* (Gimson, 2007). The title contains no question mark. The title page contains the words "we have found that health visitor numbers are in **freefall"** (their emphasis in bold). In this twenty-two page, widely circulated publication the FPI comments on the results of the study:

Our results were dramatic. Parents love health visitors. They overwhelmingly want parenting and health advice from them. Yet when we asked trusts for numbers we found huge variations up and down the country with health visitors vulnerable to savings costs.

This is not because anyone in Whitehall has yet made an explicit decision to get rid of them – quite the reverse, they are cited as an essential preventative service, yet their service hasn't been cherished.

There is general uncertainty about health visitors' role, they and their work do not figure in any government targets, and they are expensive to employ. They find themselves squeezed by and subject to the decisions of individual Primary Care Trust Managers. Where you live in the country increasingly determines how or even whether you see a health visitor. (2007, p. 2)

Other studies, by another independent parenting organisation, Netmums (see Glossary), also highlighted a significant reduction in health visiting services:

‒ 25.11.2005 Letter and petition to Secretary of State, Patricia Hewitt – from Director of Netmums (Sally Russell) to express "Our concern over the poor community support available for mothers with postnatal depression and, in particular, the on-going and currently devastating reduction in health visiting services";

‒ 18.09.2008 Daily Telegraph feature on 'Mothers failing to see health visitors' – the result of a poll and research undertaken by Netmums 'Left Fending for Ourselves – a Report on the Health Visiting Service as experienced by mums' – "Respondents call for the government to increase numbers"; "Founder of Netmums said "Health Visitors have been at the heart of family health care since Victorian times".

Other data and statistical information emerged from more official circles, all demonstrating the prevailing decline and disinvestment in the health visiting workforce and providing a discursive model of one particular truth (See Appendix XIV).

In conclusion

The intent of this chapter has been to demonstrate the multilayered and multifaceted nature of the discourses surrounding health visiting - at governmental, policy, professional and public level. It has acknowledged and considered the significant discursive themes of modernisation, performance, public health, regulation, and their significant impact upon health visiting. The Labour government's requirement for a

review of the functioning and effectiveness of health regulatory bodies proved momentous for health visiting. It has also been instrumental in sowing the seeds for this study. The actions and events discussed in this chapter have prompted and informed the initiation, undertaking and findings of this study and have informed and influenced its methodological deliberations, which are described and debated in the following chapter.

CHAPTER 4

METHODOLOGICAL CONSIDERATIONS

The methodological approach for this study, that of discourse analysis, has materialised from considerations of how best to respond to the key research questions and the emerging, changing, discursive landscape surrounding my area of study. Within this chapter, I consider issues of my role complexity, reflexivity, the notion of 'discourse' and its analysis, and the design, organisation and undertaking of the study.

Issues of researcher role complexity

As a researcher I am positioned through (at least) my age, gender, race, occupation and geography/location. My personal experiences in the occupational field as a nurse, health visitor, educator and now researcher have all required specific public presentations of my 'self' and yet all are entwined within my current 'self' – a 'self' that represents the sum of all the socially and historically constituted subjectivities, meanings, power asymmetries, that I have experienced.

During this exploration on my 'self' as researcher I have been interested in the ideas of Michelle Fine (1992). From her own declared perspective as that of a feminist psychologist, researcher and 'activist' (p. vii), she tries to 'resurface' those contradictions within women's lives which she believes have been suffocated by "structured social silences" (p. viii). She attempts to show what she describes as the tensions and 'wedges' between the layers of the lives of women - to hear what has been hidden, swallowed, suffocated, and treasured by, for, and despite women (p. xii).

I have very much felt the tensions of my insider/outsider status with health visiting during this research and wondered at its possible impact on the study processes and outcomes. I have come to acknowledge the difficulties of operating at the 'hyphen' (Fine, 1992) of being a nurse, health visitor, educator AND researcher. It is therefore unrealistic to believe that I can present myself as a neutral, objective, disinterested observer. As Kreiger states:

> We ought to acknowledge, more honestly than we do, the extent to which our studies are reflections of our inner lives. (1991, p. 1 quoted in Hallam 2000, p. 1)

Within most research activity associated with health care, there often appears a prevailing value attached to the 'scientific' quest for detached, objective, reductionist

and impersonal research approaches. This traditional approach appears to have generated the apparent conceptual distinction between the 'research' role of the 'outsider' and the 'research' role of the 'insider' (Elliot, 1991). Such distinction provides a complex position for those of us recognised as 'clinicians' and 'educators' who also seek to become 'researchers' and who attempt to embrace all three identities. This 'problem' has long been acknowledged within health care and is aptly demonstrated by Phyllis Silverman's quote – "Therapists are from Venus and Researchers from Mars" (2000, p. 469). She suggests that these activities and positions represent two cultures that in many ways cannot exist without each other, although each has different ways of generating knowledge and seeking answers and neither are comfortable advocating a way of knowing that makes their own personal experience public and a conscious part of what they do.

For myself, the challenge is further complicated by not only being recognised and qualified as a health visitor (a clinician and therefore an insider) but also as an educator who educates and trains future health visitors (outsider **and** insider), who also aspires to become a researcher (outsider). This presents for me an interesting and complex insider/outsider, 'looker and looked at' researcher perspective. I am unclear of and uneasy with my inside/outside demarcations and boundaries. Perhaps I am uncomfortable with research styles and outcomes imposed by "clever, out-of-touch outsiders" (Lewis 1992, p. 1) but feel more at ease with research negotiated through members of my own community of health visitors and within my own policy and professional field. As a researcher I do not wish to be consigned to a separate, unreal world, in opposition to practitioners. I feel that in my years of contact with differing clinical and educative roles in health care I no longer have an absolute point from which to triangulate my identities (Ronai, 1998) and 'settle' on a version of myself. All my roles have become intermingled.

The impossibility of being an 'impartial spectator' (Rorty, 1999) is because I cannot deny my own subjectivities and 'connected' position to and with health visiting. When writing about health visitors and health visiting, I naturally adopt the style of 'we' and 'us'. Am I too close? Or is it acceptable to view myself as a 'passionate participant' - as a facilitator of the many voices within health visiting and nursing, as well as an interpreter of the wider policy and professional voices (Denzin and Lincoln, 2003a)? I have conspicuously and determinedly listened to the various voices that I have heard and have tried to remain intra-subjective and reflexive in each part of the process.

In reality do I need to be only a distant observer - disengaged from the phenomena under study? I do not feel the need to be 'a disembodied seeker of the truth' (Greenwood and Levin, 1998, p. 68). The 'insider' researcher **can** use his/her special position to create knowledge that might otherwise not be produced. Arguably, insiders could also use their position to create better rapport, and a climate of trust, openness and understanding.

The community of health visitors has a cultural identity that allows what they do (their actions, language and practices) to be seen as a "form of life" (Wittgenstein, 1953, p.11.226). I am part of this clearly bounded community with its own specific culture and position within the wider world of nursing, a community that is almost "immediately present to itself, without difference, a community of speech where all the members are within earshot" (Derrida, 1976, p. 136, in MacLure 2003, p. 101).

As a collection of unique practitioners, health visitors have often been viewed as a closed and defensive group – my status as an 'insider' in this group has been positively influential in gaining access, approval and co-operation with the various participants, as well as appreciating the wider political and professional influences within which they operate. As suggested by Platzer and James, 'insider' status can considerably reduce the difficulties in research in terms of access and rapport with participants (1997; cited in Pugh *et al*, 2000).

My 'insider' status has also aided the understanding and interpretation of professional jargon, etiquette, processes, pressures, structure and ways of knowing and being. Being viewed as a 'friendly face' (Pugh *et al,* 2000) has appeared to allay inhibitions and concerns from participants about confidentiality and the use of these research findings. The shared base-line knowledge on health visiting between researcher and participants has provided an informed basis from which to launch the research activities.

There are, however, potential problems to my being viewed as an insider. Some participants could have found it difficult to divorce my position as a researcher from that of a health visitor educator. Some may make the accusation of my 'going native'. Such a charge invites a suspicion and suggestion of bias. Yet how 'inside' can I truly be in respect of the day-to-day life experience of the participants? A shared knowledge base, culture and interest does not necessarily incur bias. A clearly defined research role, purpose, processes and outcomes have been generated to mitigate this suspicion.

Consciously adopting the role of 'friendly outsider' (Greenwood and Levin, 1998, p. 3) was one possible position for me. This would recognise my expert power and substantive appreciation of the particular issues involved as a strength rather than as a weakness. Being a 'friendly outsider' does not mean that a systematic approach cannot be applied or that questions and explanations cannot be probed for deeper understanding and meaning. This approach allows critical questioning to be experienced as supportive rather than as negative discussion – it opens the possibilities of exploring different perspectives.

Adopting a reflexive approach

Being initially unsure just exactly what it meant to adopt a reflexive approach, I searched the literature for meaning and understanding. Being essentially reserved in nature and inculcated occupationally to minimise the subjective and to manage the emotional, the idea of reflexivity and periods of intense reflection did not feel appealing or comfortable to me. And defining reflexivity seems anything but straightforward. Lynch (2000) considers "being reflexive" as a source of superior insight, perspicacity or awareness (p. 26). For Davies, "reflexivity, broadly defined, means a turning back on oneself, a process of self-reference" (1999, cited in Pillow, 2003, p. 178).

Such reading around the subject prompted me to examine how much time and investigation of 'self' was considered *enough* to be reflexive? When is it too much, too confessional, indulgent or narcissistic for anything or anyone to benefit? Is Patai (1994) right in suggesting that reflexivity is an academic fad, encouraging academics to spend too much time wading in the morass of their own positionings? Her question, "does all this self-reflexivity produce better research?" (p. 69), echoed my own thoughts.

But my attempts to adopt a more reflexive approach encouraged me to adopt a more questioning, critical, and self-scrutinising stance towards my comfort zones, beliefs and interpretations. Throughout this research exercise I have kept a reflective journal to encourage and record a more questioning and ongoing voice, awareness and conversation of self-analysis. The following represents one example from the early stages of the reflective journal related to a moment of critical perception when I first began to acknowledge my emotional attachment and connection to health visiting:

"I've come across something today that has really surprised me about myself – I was reading Verena Tschudin's (Nurse, teacher, counsellor, prolific writer on nursing ethics) book Nurses Matter (1999) and came across a quote from a chapter entitled

''Reclaiming our professional identity'. She wrote the book, as she says, to give a voice and substance to why nursing's vision, message and role are indispensable to our society (p.x). She writes:

> *"What we do matters; what we contribute matters; what we say matters; what we believe matters; what we think and feel matters; what we are matters; and it matters that our voice is heard and considered" (p. 1).*

I found myself having connections between these words and what I felt about health visiting – I did not realise that I had this degree of emotional attachment and concern in relationship to health visiting – will need to watch and be aware of this.

From this experience I started to appreciate that perhaps for me the value of reflexivity lies in being able to render the 'hows', 'whats' and 'whys' of my topic area more visible and meaningful. I have come to recognise the value of understanding *how* knowledge is acquired, organised and interpreted and the relevance to *what* claims are then made (Altheide and Johnson, 1994), as well as reflecting on *what* I know and *how/why* I know it. Being reflexive has proved to be a useful tool and process. It has helped me grasp that the 'I' within this document is the sum of the many selves and many ways of knowing that I represent and a means of encouraging critical recognition of issues of self - location, positions, truth, self-questioning, conflicts, tensions and interests within this research exercise.

Methodological selection and implications

Methodologies or 'ways of knowing' tend to be described by way of different and oppositional use of terms, alignments and positions, each, as Oakley purports, "flogging whole sets of associations" (2000, p. 5). The use of the word 'methodology' for this study will be used to denote principles, ways of working, as well as specific methods and techniques.

For me there is a strong attraction to undertaking research that locates the observer in a world and the interpretive, participatory, material practices that make that world visible (Denzin and Lincoln 2003a, p.4), even though as Denzin and Lincoln admit, such an approach is still defined primarily by tensions, contradictions and hesitations (2003b, p.vii). On closer examination the ideas of qualitative, postmodern, postpositivist methodologies appeared increasingly instructive and relevant. They helped make sense of the trend for practitioner roles to be structurally and operationally increasing in complexity and specialisation, and the move away from the traditional occupational model of prescribed and delineated modes (positions) of action and practice to models of fluidity and uncertainty. Adopting a qualitative,

interpretive, participatory method, through the adoption of a discourse analysis approach, offered the demonstrable advantage of allowing the flexibility to research a situation where there is little pre-existing knowledge, and where the issues are sensitive and/or complex (Bowling, 1997).

A Community approach

The selection of a methodological approach required a tactic that would suit the exploration and investigation of a situation based in day-to-day reality and the meaning of this situation for certain key stakeholders (the participants of this study), who have been of central significance in formulating the principles and design aspects of the study. Rorty's idea that one of the principal ways in which reflective human beings try to give sense to their lives by telling of their contribution to their community struck a chord (1991, p. 21). The requirement of the objectivist tradition that we should step outside our community long enough to examine "it in the light of something which transcends it" (p. 22) did not seem a realistic or possible option. This study seeks the path of 'doing' research 'with' the participants, not 'on' them. As Rorty suggests, we can still make admirable sense of our lives and situations, even if we cease to have "an ambition of transcendence" (1991, p. 12, after Nagel 1986).

Methodological selection

The selection of a methodological approach was influenced by two main factors: firstly the concepts/phenomena (and associated constructs) under investigation - that of 'professional identity' and its association with 'health visiting' and secondly, the related and relevant discourses associated with this situation. The existence of a very limited body of knowledge on the influences on health visiting required me not only to pose questions through primary research activities but also to generate further empirical data by exploring the variety of associated contextual discourses – professional, governmental, political, managerial, organisational, national, public and individual.

Discourse and discourse analysis

The consideration and analysis of 'discourse' appears an influential presence in the social sciences, yet Meinhof suggests that 'discourse' has become one of the most widely and often confusingly used terms "without a clearly definable single unifying concept" (1993, p. 161 cited in Morrow, 1994). 'Discourse' appears open to many interpretations. For Lupton it represents "a group of ideas or patterned way of thinking which can both be identified in textual and verbal communications and located in wider social structures" (1992, p. 145). Reisigl and Wodak (2001), in their attempts to establish a theory of discourse, believe discourse can be best understood as:

A complex bundle of simultaneous and sequential interrelated linguistic acts, which manifest themselves within and across the social fields of action as thematically interrelated semiotic, oral or written tokens, very often as 'texts', that belong to specific semiotic types, i.e. genres. (p. 66)

Usually, discourse analysis purports to examine all forms of verbal and textual materials in order to glimpse or grasp the quite elusive discursive nature of social realities (MacLure, 2003). For Luke (1995) the life of the twenty-first century citizen represents a "text saturated" condition through which human subjects are socially constructed and contested identity is made and remade, and it is through these texts that "one learns how to recognise, represent, and 'be'" (p. 14). For Luke one of the main tasks of discourse analysis is to 'disarticulate' the texts of everyday life as a way of 'disrupting common sense' about the naturalness or inevitability of identities, values and concepts, thus showing the workings of power and material interests in the most seemingly innocent of texts and "taking that which offers itself as common-sensical, obvious, natural, given or unquestionable, and trying to unravel it a bit – to *open it up* to further questioning" (1995, p. 20, cited in Maclure, 2003, p. 9). Of particular interest to this study is how language and texts "involve how one is being named, positioned, desired and described and in which language, texts and terms of reference" (Luke, 1995, p. 5, cited in MacLure, 2003, p. 5).

Crowe (2005) suggests that discourse analysis is "a useful methodology for conducting nursing research" (p. 55). She reasons that just as qualitative research is generally concerned with discovering knowledge through "grasping an individual's subjective experience" (p. 62), discourse analysis is concerned with discovering how individuals or groups construct particular understanding in and through text which contributes to their understanding of how processes of social relations, identities knowledge and power are constructed.

Discourse analysis does not attempt to isolate data from the context within which it is collected. It is an analytical method that recognises that language cannot be viewed as a "merely neutral medium for the transmission of information, values and beliefs about the world 'out there'" (Gilbert, 1993, p. 289). Siegfried Jäger's epistemological position (from Laclau's social constructivism, 1981) denies any societal reality that is determined outside of the discursive - "If the discourse changes, the object not only changes its meaning, but it becomes a different object, it loses its previous identity" (Jäger p. 43, in Wodak and Meyer, 2001).

Overall, discourse analysis as a methodology allows me to play to my strengths as an insider with knowledge <u>in</u> and <u>of</u> the professional worlds of nursing, health visiting and nurse education. For as MacLure (2003) suggests, words accumulate different resonances according to the institutions and discourses from which they emanate and the institutional and social location of those who are making or critiquing them.

I investigated several different schools of thought on the nature of discourse as well as types of discourse analysis when considering the methodological structuring of this study. The following presents the two main theorists chosen to support the structure, approach and outcomes for this study – namely Michel Foucault and James Paul Gee.

Foucault and discourse

Exploring the notions of discourse, knowledge and power led to the positive consideration of the Foucauldian (1978) concept of discourse and how discourse can be both an instrument and an effect of power. For Foucault (1972), discourses are practices that systematically form the objects of which they speak. Of interest to this study is Foucault's (1979) suggestion that discourses are inextricably linked to *institutions,* particularly those that regularise and normalise the conduct of those who are brought within the ambit of those institutions.

In *The Archaeology of Knowledge* (1972) Foucault asserts that discourse determines the reality we perceive, not only all utterances and statements which have meaning and have some effect but also the unwritten rules and structures (p. 80). For him discourse can be something that can constrain our perceptions, fix our norms and set limits. His envisioning of power and discourse theorised power as being inextricably linked to discourse, not as negative or repressive but as a complementary, supportive structure, it is through that power-positioning that our place in the world is secured, or identity and image to others portrayed. Critical to the construction of discourse, in Foucault's opinion, are the sites at which power and knowledge intersect to form a 'truth'. Foucault (1980) also argues that although discourse transmits power, it also makes it possible to undermine and expose it.

Foucault's thoughts on a discourse of silence, and what is held silent within a discourse, create resonance with aspects of this study. Foucault defines the discourse of silence to represent,

> …silence itself – the things one declines to say, or is forbidden to name,
> the discretion that is required between different speakers …there are not

one but many silences, and they are an integral part of the strategies that underlie and permeate discourse. (1998, p. 27)

Foucault's ideas on discourse analysis have provided a useful conceptual position for this study, as their focus would appear to be on how social relations, identities, knowledge and power (particularly from institutions) are constructed in spoken and written texts (Crowe, 2005) and what remains unspoken and silent. Their possibilities also lie in placing the social and historical context centrally to the inquiry process, emphasising the contextual aspects (historical, recent, current, emerging) as an important source of empirical data. Foucault's thoughts on discourse offer a method of deconstructing, and constructing, the differing constructs of thought and opinion around professional identity and health visiting.

Language-in-use

From the many approaches to discourse analysis available, the ideas offered by James Paul Gee, that of the analysis of language–in-use, were selected to help unpick, deconstruct and analyse the varied and different discourses being explored for this study. As Gee points out there is no one uniquely "right" approach to discourse analysis: "different approaches fit different issues and questions better or worse than others" (2005, p. 5). The attraction of this method was that Gee viewed his approach as representing a 'tool of enquiry' and 'thinking device', to describe and explain what the researcher believes to exist and be important (2005, p. 6).

He views the two closely related functions of language to be a) to support the performance of social activities and social identities and b) to support human affiliation within cultures, social groups, and institutions. For him language–in-use is everywhere and always 'political'. Politics for him has the meaning of,

> …how *social goods* are thought about, argued over, and distributed in
> society. "Social goods" are anything that a group of people believes to be
> a source of power, status, value or worth. (2005, p. 2)

The key to discourse for Gee is 'recognition' – recognition of all relevant features of discourse - language, action, interaction, values, beliefs, symbols, tools and places (1999, p. 18). If these are recognised you are 'in' a discourse. Gee's approach views discourse analysis as containing both "little d" and "big D" elements (D/discourse). "Little d" is interested in how language is used "on site" to enact identities and activities (language-in-use), "yet activities and identities are rarely ever enacted through language alone" (2005, p.7). "Big D" represents the "other stuff" – ways of

acting, gestures, interactions, feelings, beliefs, values and using various sorts of objects, symbols, tools and technologies,

> …to recognise yourself and others as meaning and meaningful in certain ways. In turn you produce, reproduce, sustain and transform a given "form of life" or Discourse. (2005, p. 7)

When "little d" discourse (language-in-use) is melded integrally with non-language "stuff" to enact specific identities and activities then "big D" discourses are involved. This approach provided a useful framework to explore the "form of life" known as health visiting with all its patchwork of words, events, actions, and interactions. The phrase 'discourse analysis' will be used from now on to represent the integration of the little and big d/D elements. How Gee's approach to discourse analysis enabled and provided the tool for analysis of the texts used and generated by this study will be considered in more detail later in this chapter (see page 72).

Adopting a staged approach

Researching a situation as it happens around you presents many difficulties for the researcher. The way forward seems unclear, uncertain and confusing as different events and responses occur, and create different and varied responses in their own wake. Therefore a staged approach was adopted for the primary research activities to edge the study forward, whilst leaving open decisions about the next stage until a better view of the prevailing reality presented itself.

Research design

The overall research design for the study, although responsive to the changing reality in which I found myself, endeavoured to maintain a clear focus on the underpinning research questions and the overall purpose and aims of the study – to explore and investigate the changes impacting upon the professional identity of health visiting. Each of the three stages of primary research activities undertaken for this study were designed to encompass strategies to answer specific aspects of the research aims, as will be discussed shortly. As an introduction to the different stages:

- Stage 1 involved face-to-face interviews with three senior health visitors and the formulation of the key aims and research questions for the study;
- Stage 2 consisted of a scoping exercise by means of a questionnaire sent to all members of the United Kingdom Standing Committee for Health Visiting (UKSC), in order to advertise my study and generate participants for its main element, Stage 3;

- Stage 3 involved the development and despatching of a questionnaire to health visitor educators (HVEs) and its returned completion.

The analysis of the data generated by the stages is further considered later in this chapter. Certain key documents pertinent to health visiting were also explored and analysed for this study (see Chapter 5), as were the contemporary contextual policy perspectives (see Chapter 3). A more detailed description of what was done for this study and why are provided in a table (see Appendix II), which demonstrates how the main research activities relate to the main research questions.

Stage 1

The first stage (2005 – 2006; interviews conducted February 2006)

The first stage of the study clarified the purpose of my investigation by describing the *why* and the *what* of the investigation before going on to consider the *how.* This exercise led to a clearer formulation of the key research questions and aims. My attention then turned to thoughts of *how* to pose and explore the questions I had raised as well as extending my understanding of the research field.

Designing the research study

The design of the first stage of the study was generated from the question: *How am I to obtain the knowledge and insight I wish to gain in relation to my research aims and field of study?* The selection of an appropriate and useful research method for the primary aspects of the study emerged from my considerations of who could provide some understanding and insight into the area I was investigating – namely the actual/potential impact on health visiting of the recent Nursing and Midwifery Council (NMC) professional and regulatory changes. Reviewing the literature demonstrated a paucity of published discussion on this subject area so the selection of the participants centred on the questions, *Who is aware of the recent changes to the NMC register*? And, *who would be likely to have an understanding of the implications of this for health visiting*?

This led me to three senior health visitors well known nationally through their publications and/or professional positions and for their involvement/interest in the creation of the Specialist Community Public Health Nursing (SCPHN) part of the NMC register. The participants were chosen for their specialist knowledge and insight into the research area. All three participants held the qualification of health visitor and had practised at some time as a health visitor. The smallness of the selected sample concerned me and I wondered what size of sample could be considered enough. From the literature the message appeared to be,

> …interview as many subjects as necessary to find out what you need to know. (Kvale, 1996, p. 101)

The potential population of health visitors from which to choose was very small and specialist, therefore access to three of this unique group did provide, in my opinion, a sample large enough to gain insight and knowledge into my area of interest (Hart, 2001). Although the sample appears homogeneous (in respect of their links to health visiting), their professional interests, published writings, comments, perspectives and positions render them relatively heterogeneous. With so little known by so few about the topic being studied, it seemed useful and appropriate to select the method of individual, face-to-face interviews with these key health visiting personnel.

I intended Initially to select a preliminary number of key subjects and then by adopting a non-random snowballing technique to draw in more people into the research as it progressed. This, however, did not happen as I had underestimated how much time it would take me to make informal contact with each of them, explain my research area and purpose, confirm my credentials, gain their willingness to participate as well as arrange and conduct the interviews. All three individuals were based at notable distances from me so a considerable amount of time was spent travelling to each location in order to interview them.

<u>Interviews</u>

Why interview? The value of the interview technique for my field of inquiry lay in the possibilities of accessing the differing philosophical modes of understanding ('mirrors of reality' Kvale, 1996, p.41) available through this qualitative approach. The desire to engage in a multiple, socially constructed 'lived experience', that is interactive and participative was important to me. Engaging in face-to-face interviews allowed me to focus in on 'the life world' of my subjects and be open to their experiences. Thus gaining a sense of **their** understanding and **their** own perspectives on the topic in hand and rendering the invisible slightly more visible, thus gaining a greater understanding of the phenomenon being studied (Wilson and Hutchinson, 1991). I acknowledge that such an approach "must necessarily implicate the researcher's own view of the world as well as the nature of the interaction between researcher and participant" (Willig, 2008, p.53), yet it is useful in grasping how we come to interpret our own and others' actions as meaningful (Schwandt, 2003, in Denzin and Lincoln, 2003a).

Individually interviewing each participant held out the promise of mutual listening (Oakley, 2000) and allowing them to tell their own stories in their own words – as individuals, not objects of research. As Kvale states, "conversation is a basic mode of human interaction" and the research interview is a "professional conversation" (1996, p. 5). It offered the possibility for openness and flexibility. It held the advantage of allowing such a complex topic to be explored, probed, prompted, clarified, investigated and elaborated upon, hopefully leading to the generation of more in-depth and sensitive data.

The idea of any interview can initially seem deceptively simple and straightforward yet selecting this method required my personal involvement and participation to be the main instrument and vehicle for obtaining this precious data. How was I to manage something so unstructured and indeterminate? Kvale's (1996) logical, linear, seven stage process to undertaking research through the method of interviewing (thematising, designing, interviewing, transcribing, analysing, verifying, and reporting) provided a useful framework. Although in actuality the process presented many surprises and reformulations of thoughts and ideas, the stages did provide a valuable framework and a clear, systematic, sequential approach for me.

Adopting a semi-structured face-to-face interview method

From an exploration of a range of interview techniques spanning the unstructured to the highly structured, Loffland and Loffland's (1995) ideas of 'guided conversations' appealed. To facilitate the face-to-face interview process a semi-structured design was adopted and supported by an interview guide of predefined questions. It was hoped that this method would provide more consistency, focus and structure to the conversations, as well as providing some framework for analysis of the data.

The interview guide consisted of specific, open-ended questions to be asked of all participants, plus a few additional points and topics to guide the conversations (see Appendix III). The guide questions were composed from the key themes that had emerged from my thinking and reading around my topic area and included:
– Personal familiarity with the recent changes to the NMC register
– Personal perspectives on the intention, purpose of the changes
– Actual/potential impact of changes on Health visiting
– The future of/for health visiting
– How to explore the impact on health visiting of the NMC creation of the SCPHN.

The guide worked well in practice and did not appear to inhibit responses or interactions and it facilitated the extending of questioning to follow up on new angles, and/or knowledge on the situation.

<u>Strengths and weaknesses of using a face-to-face interview technique</u>
Using a face-to-face interview technique illustrated clearly for me some of the possible weaknesses associated with this method, such as the costs associated with time and travel as well as the skills required for undertaking and recording the event, transcribing and analysing the data, and the more subtle concerns of gaining validity for the data generated.

It is a research method concerned intrinsically with inherent human interaction – considered by some to be value-laden, biased, based on personal impressions and always partial. Its weaknesses are often described in relation to what it cannot achieve: be systematic, objective, methodical, reproducible and deductive and produce facts and truths. Yet is this not a limited interpretation? Kvale reminds us that objectivity is itself rather a subjective notion (1996), arguing that the qualitative research interview is neither an objective nor a subjective method but in essence an "intersubjective interaction" (p. 66).

From my personal experience I learnt that the ability to interview requires commitment and perseverance. The skills needed by the interviewer include establishing rapport, putting people at their ease; maintaining the respondent's interest and motivation throughout; speaking and acting in a neutral, non-judgemental manner; asking questions in a non-biasing and non-leading way; bringing respondents back on track and reducing rambling; exercising tact, whilst being sensitive to the needs of participants.

As a novice interviewer, I became acutely aware that interviewing effectively is a craft to be learnt and that the data generated is largely dependent on the instrument used - me. This method removes the objectifying distance of more detached means of data-generation. As a consequence, the successful collection of interview data is strongly dependent on the interpersonal skills of the interviewer and a satisfactory relationship being established between interviewer and respondent (Polit and Hungler, 1989).

The interview events proved to be lively, stimulating, engaging and useful. The capturing of the interview data did present challenges – mastering the setting up and use of equipment whilst trying to place the participant at ease; handwriting/recording

verbatim quotes; recording the (nature of) replies (e.g. sceptical, cynical, abrupt, etc.) plus the noting of silences, sighs, and relevant body gestures. Two of the interviews were conducted in busy offices and. although the participants tried to ensure privacy and focus, distractions, disruptions and interruptions needed to be managed as the interviews were unique, one-off opportunities that had taken considerable planning.

Analysis and findings of interview data

As Parahoo (1993) suggests, the management and analysis of qualitative data generated by research interviews may be problematic and lengthy. Burnard also notes, "the issue of how to analyse qualitative data remains a thorny one" (1991, p.465). How to analyse the data from Stage 1 was considered from the very beginning of the study as I asked myself *'how can the interviews be conducted and recorded so they can be analysed in a coherent and creative way?'*

The interview guide was developed around the five themes previously described on Page 58 and these themes provided the framework for a thematic content analysis (after Glaser and Strauss, 1967; Burnard, 1991) of the texts - transcripts, interview notes and visual observations.

As well as applying the predetermined themes, the text was also critically examined for other meanings, categories or themes emerging. These I then attempted to identify, describe and then relate, not just to each other, but also to the whole of the data. The texts were treated as a window into human experience, rather than just as an object of analysis itself (Ryan and Bernard, 2003, citing Tesch, 1990).

Preparing the interview material for analysis by transcribing the interview oral speech (by way of tapes) to written text, typing up my notes and observations of the events, writing comments in my reflective journal, took far more time than anticipated. These activities were time-consuming, demanding and anything but straightforward. I undertook this manually rather than through the use of software packages, which might have saved time and some of the drudgery, but this allowed me to maintain some of the textual nuances and contextual variables of the lived conversations.

Each tape was listened to three times. As I typed, listened, re-listened and adjusted the written text for accuracy, the transcripts emerged - feeling somewhat like artificial constructions, frozen in time, requiring a series of judgements and decisions e.g. how long is it before a silence becomes a 'pause'? It was heartening to discover that there

appears to be few standard rules for the technical and interpretational issues of transcription, but rather a series of choices to be made (Kvale, 1996).

I tried for detailed, reliable transcriptions with noted inclinations of voice, laughter, silences, expressed emotion, remembered facial gestures, etc., and "to hear meanings that had previously gone unattended" (Belenky *et al.*, 1986, p. 7). Transcribing and writing up the data was not just a clerical task but also an interpretative and constructive process. I felt very much a co-author and co-creator of the interviewees' statements (Kvale, 1996). I tried to be aware of my own presuppositions and possible modes of influence, taking them into account during the interpretation of the text. Yet I accept that the texts created represent an incomplete account of the wealth of meanings expressed in the interview situation.

Listening to the tapes tended to provide a decontextualised and rather detached version of the events. I valued and used my subjective memory - remembering my thoughts at the time, feelings, social atmosphere and personal dynamics as the interviews progressed. The exercise prompted me to consider '*Does to transcribe mean to transform*'? Turning the interview events into static written words felt quite reductionist, yet conversely quite creative at the same time. I can now appreciate that 'ways of knowing' are best located in the conditions of their emergence (i.e. through language and discourse) for as Wetherall and Maybin state:

> Language is not a transparent medium for conveying thought, but actually constructs the world and the self through the course of its use. (1996, p.22)

Findings and context of Stage 1

It became clear from all three participants that health visiting was at the centre of an evolving national situation, with its role, purpose and future significantly influenced by the changes to the NMC register. Yet they clearly expressed that a) few health visitors seemed aware of the implications of these changes for health visiting and b) other important influences were also affecting the present and future meaning of health visiting.

From the perspectives of two of the participants, there was only one place to look for some measure or indication of the impact on health visiting of the professional and regulatory NMC changes, and that was with health visitor educators (HVE). For in their view HVEs would now be required to respond to the NMC regulatory changes by developing new curricula and educational programmes that reflected the change in

professional emphasis, title, role and underpinning practice principles for health visitors.

This helped crystallise my thoughts for Stage 2 of the primary research activities. As a HVE myself I realised that we were at the forefront of making the NMC changes for health visiting a reality, and also had knowledge of many differing aspects of health visiting – the educational, professional, strategic, managerial and practical. Such a group, however, would not be easily accessible. HVEs represent a small and specialised group of health visitors who have progressed into education and are employed in Higher Educational Institutions all over the United Kingdom.

Undertaking Stage 1 proved a valuable exercise, providing greater clarity and focus for the study and suggesting a way forward. It introduced me to a concept as diffuse and multifaceted as 'identity' applied to something as complex, dynamic and evolving as health visiting. It also led to finalisation of the key research questions:

- What is the current state of the professional identity of health visiting?
- What is the historical context and meaning associated with health visiting?
- What is the nature and degree of influence of the discourses currently debating the role and identity of health visiting?
- What changes are these discourses having on the professional identity of health visiting?

Stage 2 and the context changes (2007- 2008; Scoping exercise May – July 2008)

Stage 2 of the research exercise evolved from stage 1 but was also influenced by the changing national and professional contexts associated with health visiting. As 2007 progressed it became evident that the interest and discourses talking about and discussing the role, practice and purpose of health visiting were growing in number and influence. These influences had widened from being a mainly internal professional discourse, focussed around the NMC regulatory changes, to a more national and public debate that included significant contributions from a range of statutory and voluntary sources, all of which contributed to a growing national debate on the present and future professional identity of health visiting.

Having decided on the proposed sample for Stage 2 – HVEs, I considered how such a small, specialist group of health visitors could be accessed. My personal knowledge led me to the United Kingdom Standing Committee for Health Visiting (UKSC), a body representing all health visitor education and training centres in the United Kingdom

and a forum for discussion and exchange of information and ideas. With its permission I advertised my research study at one of their meetings and detailed the forthcoming contact exercise. Generating interest and participation from this small, busy population I knew would be a challenge so to increase the likelihood of their participation I undertook a scoping exercise (as stage 2 of the study) of all UKSC members.

The UKSC membership crossed the United Kingdom yet devolutionary changes in Wales, Scotland and Northern Ireland had recently altered the role and function of health visitors within the different countries. I therefore chose to select only HVEs working within England. With the permission of UKSC, I utilised its database of contact details to e-mail its members explaining the aims and purpose of my study. Attached to the e-mail was an introductory letter providing further information about my research and a small questionnaire to be completed and returned to me if members were willing to be part of it (see Appendices IV and V).

This scoping exercise was conducted against a growing backdrop of national disinvestment – financial, political and strategic – in the employment and training of health visitors. As I designed and developed my scoping questionnaire, more and more HEIs across the United Kingdom, particularly in England, ceased training health visitors and dispensed with the services of their HVEs. The number of HEIs and HVEs that I might eventually include in my study was difficult to gauge with any certainty. The only certainty appeared to be a diminishing of numbers. At the time of despatching the scoping questionnaire I counted approximately thirty HEIs still providing health visitor training in England but this number continued to reduce rapidly. Fifteen HVEs – 2 males and 13 females – located in HEIs across England, responded by returning a completed questionnaire and agreeing to be part of the final stage of the study.

Stage 3 (2008 – 2009; Final Questionnaire despatched September 2008 and returned by end of January 2009)

Stage 3 (the final stage) of the research exercise was designed to be an effective means for exploring the perspectives and opinions of my chosen, and precious, participants in respect of the main four aims of the study. The HVEs that had offered to be part of this study were spread widely throughout England and my previous experience of undertaking face-to-face interviews gave me some insight into the degree of time and travel any such meeting might incur. Being employed full-time limited considerably the time available to me during the working week. Yet I still hoped

to gain a personal level of contact with each potential participant in order to promote a good level of response and attention. Gathering data at a distance became a logistical necessity for me, but how was I to do this and still constitute good social science research practice?

<u>Adopting a Survey approach</u>

The suggested 'golden rule' for the selection and application of any research method is allied to its suitability for the issue being investigated (Watson *et al*, 2008). At first glance the selection and use of a survey approach may not fit comfortably within the qualitative paradigm. Yet many sociologists regard surveys as an invaluable source of data about beliefs, personal experiences, attitudes and values (Gilbert, 1993). Such an approach is also recognised for gaining an overview of a specific phenomenon or situation directly from those concerned (Polit and Hungler, 1999). As such, the term survey is used here to represent both the design of this stage of the research exercise, as well as the means of collecting primary data through a self-reporting exercise, undertaken by the participants in response to a questionnaire. The questionnaire was developed and designed to elicit responses in a systematic, standardised format that would be common to all participants and yet generate individual, unique and open responses (Appendix VII). Adopting such a survey approach enabled me to reach my participants relatively easily, as they were geographically scattered throughout England.

<u>Questionnaire design and development</u>

Designing the research instrument for stage 3 proved to be a time-consuming, laborious, lonely and testing exercise. The challenge was how to develop and select questions that would obtain the most valuable information. The aim was for clarity, realism and feasibility and a keen appreciation of the ultimate 'audience' for the questionnaire. The structure, layout, question wording, format, accompanying instructions, etc., were all carefully crafted to try and achieve this aim. The question wording was derived from, and led by, the key research topic and questions. The plan was to achieve wording that was user-friendly, unambiguous and understandable and that did not lead or confuse. These principles were also applied to the wording of the instructions for administration, completion and return.

The use of open questions was employed to encourage and allow participants to respond in any way they wished. Such questions require more thought and consideration than closed questions but they are valuable "where the issue is

complex, where the relevant dimensions are not known, and where the process is being explored" (Stacey 1969, p.80, in Gilbert, 1993, p.103).

Piloting of questionnaires

To test the wording, use, length and ease of completion, the questionnaire was piloted (following informed consent) by two HVEs. They found the questionnaire structure, lay-out and wording to be clear and understandable. They did not detect any opportunities for confusion and ambiguity. Completion of the questionnaire did, however, take one participant 40 minutes and the other 60 minutes. This made me question the extensiveness and time-consuming nature of the instrument, as the length of completion was an important aspect for the intended participants were known to be busy people. I worried that the response rate would be negatively affected if they were to tire and disconnect from the study due to the completion of the questionnaire being too burdensome. By re-examining the questions I found ways to reduce the number of questions without adversely affecting the desired outcome. The two tables considering a) the possible factors influencing health visiting and b) their degree of influence, were combined into one table to reduce completion time.

The pilot exercise also provided a useful completed 'text' by which the main methods for analysis could be tried out and tested for usability, understanding and usefulness. It also provided an opportunity to test the internal validity of the tool and the extent to which the questions and answers addressed the key research questions. The edited questionnaire was then subjected to peer review by nursing educators with research experience to comment on the extent to which the questionnaire could generate data in respect of the key research questions.

Final questionnaire

The working definition of professional identity used for this study was provided at the beginning of the questionnaire so that there could be some commonality and shared understanding of the key research issue and focus. The questionnaire was divided into three parts (See Appendix VII):

Part 1 – Factors influencing health visiting and their degree of influence.
This focussed on the participants' view of the present professional identity of health visiting and the factors currently influencing it. A table of possible factors influencing health visiting was provided. These factors ranged from micro to macro elements, individual, public, professional, economic, strategic, managerial, regulatory and

governmental. Fourteen factors were listed for consideration. There was also the opportunity for respondents to add their own.

The purpose of this table was to provide a broad context and range of potential factors possibly influencing health visiting, with the hope that this would stimulate a wide consideration of the factors. The table also requested the participants to apportion a degree of influence for each factor by allocating a number between 1 and 10, 1 being a factor of least influence (not very influential), 10 being of greatest influence (very influential).

Part 2 – Specific influences.
This focused on the specific impact on health visiting of the creation and implementation of the SCPHN part of the NMC professional register.

Part 3 – Individual comment.
This focused on generating individual comment on the current 'state' of health visiting and any future opportunities and challenges.

Collection of data
Each participant who replied positively to the scoping exercise was sent a copy of the questionnaire, along with a covering letter, to his/ her occupational e-mail. The content of the e-mail thanked them for agreeing to be part of the research study and a date was stated by which the questionnaires should be returned.

Response rate
In order to enhance the response rate a gentle reminder was sent 3-4 weeks after initial e-mail distribution to those who had not yet returned their questionnaire. Of the fifteen participants who were originally sent questionnaires, twelve participants returned completed questionnaires. I considered this to be a very positive result.

As I embarked on the design and implementation of Stage 3 of the study it was my intention to follow up at a later date comments made by the participants by way of e-mail correspondence. This intention was indicated to participants in the Stage 3 'Introductory Research Letter' (see Appendix VI), that accompanied the questionnaire. However where I did follow up certain aspects of the responses, I received no reply from those participants. As an insider I was extremely aware of the current work, time and professional pressures and circumstances on my particular sample group. This presented for me an ethical dilemma. How far should I pursue my research interest

and zeal? When does a research action fail the proportionate reasoning test and become an invasive, intrusive procedure? Should I not respect the autonomy of the participants to decide whether to reply or not?

During Stage 2 of the study whilst inviting the participants to be part of this study I provided the principles directing this research exercise. One of these principles stated clearly that a participant "may withdraw at any time" (see 'Stage 2 Scoping Exercise and Letter' Appendix IV). I felt ethically that I should therefore respect their right to do so. I accept that following up particular comments, nuances, ambiguities and aspects of the questionnaire responses would have provided an opportunity to extend the scope of the data generated by Stage 3 of the study. This was a significant disappointment to me, but I believe my decision not to further contact those participants who failed to respond to my e-mail correspondence to be ethically correct.

Strengths and weaknesses of questionnaire use

The use of a questionnaire for gathering data in qualitative research endeavours rarely appears in research texts as a suggested or recommended method. However, as Murphy *et al.* (1998) suggest, decisions about which method is most appropriate for a particular research issue should be made on the basis of which approach is likely to answer the question most effectively and efficiently.

It should be acknowledged, however, that using questionnaire data for discourse analysis has certain limitations. The type of text questionnaire data provides for analysis is more likely to be in note form, with abbreviations and subject to truncated responses or incomplete sentences. Such text may also be more prone to blanket assertions and flat pronouncements that may limit analysis of understanding, meaning and personal insight, with no scope for probing and clarifying the responses. I accept that the structured, separated (into questions) nature of this method generates small discreet 'bodies' of information, compartmentalised into specific elements of interest, rather than a complete, unbroken, continuous form of narrative. The possibilities for such a text may not enable the sort of detailed analysis of structure, metaphors etc, that might be possible with longer and more developed texts.

Yet the text from questionnaire responses is still valuable and useful for discourse analysis. In the view of Gee, thanks to the way that human brains and vocal systems are built all languages are produced in "small spurts" (2005, p.118) and the technical details of discourse are not as important as acquiring a text that allows looking "for patterns and links within and across utterances in order … [to discover] how meaning

is being constructed and organized" (p. 118). The text generated from Stage 3 of this study has provided the means of doing this. It has facilitated access to the HVE way-of-being and way-of-seeing in the health visiting world, with their words deriving a force from the familiar, and shared, intertextuality of their lineage and language.

The data was not just analysed incrementally (by specific question) but holistically – across all responses from individual respondents and across all responses, 'shuttling back and forth', as Gee describes (2005, p. 118), between the structure (form, design) of the language and the situated meanings. The text (language) generated from the questionnaire completion was readily accommodating to the application of Gees seven building tasks and areas of reality for discourse analysis (see Appendix VIII). It also illustrated well both the big 'D' broader sociocultural issues, as well as the small 'd' ways of acting, interacting, feeling, valuing, and believing identified within language-in-use.

Using this method the respondents had time to consider their responses and respond in a manner/method culturally comfortable for them – that of synthesising their feelings, thoughts and opinions in a written form. It hopefully allowed a degree of honesty and forthrightness that other methods may have tempered. Their text made a substantive contribution to a view of health visiting reality. It was rarely passive or boring, and demonstrated their individuality and subjectivity. Both individually and collectively their text felt like a constitutive force of lived experience, with a strong sense of self.

According to Bourque and Fielder (1995) the disadvantage of questionnaire use are also related to a) achieving sample participation, and b) questionnaire construction and administration. Stage 2 of this study (scoping exercise) was devised primarily to obtain participation in this study from a hard-to-reach population. Accurate information of this population (i.e. those currently working as a HVE in the HEIs of England) was difficult to obtain, even with the help of the UKSC. The response from those who finally engaged in this study was numerically pleasing but it is impossible to gauge what numerical percentage of their population they represent. I also accept that administratively I had no control over who actually completed the questionnaires or if they consulted with others. Overall however, the participants represent a small but important purposive sample and were selected according to criteria of relevance to the research questions and aims (Willig, 2008),

The questionnaire method provided a means that was both feasible and realistic for the resources available. The use of a self-completion questionnaire, sent electronically, allowed a timely and relatively inexpensive method (in materials, time and travel) for accessing this unique, small sample widely dispersed throughout England. The participants received the questionnaire at approximately the same time, as I wished the context and history affects (McColl *et al*, 2001) on the sample to be similar in nature. However due to sickness, absence from work and workload issues a few participants received, or requested, one reminder and an additional copy of the questionnaire. This extended the completion of the questionnaires over a period of several months.

The development of the questionnaire was a lengthy and challenging undertaking. Each completed questionnaire was allocated a code so although I initially knew the identity of the participants, through their response to the Stage 2 scoping exercise, the text was actually analysed anonymously.

Ethical considerations

Considerations of the ethical dimensions of conducting this research exercise began at the earliest opportunity, and have pervaded every aspect of this study. As the primary research elements of this study did not intend to use NHS practitioners, staff or client/patients, it was not presented to an NHS Research Ethics Committee. An outline of the proposed study was, however, submitted for approval to the EDU Research Ethics Committee and approval was granted.

As a nurse I am bound by a professional ethical code, which for the majority of my study time was contained within *The Code – Standards of conduct, performance and ethics for nurses and midwives* (NMC, 2008), within which the three ethical principles of duty, utility and virtue are inherent. *The Code* states clearly the need to justify the trust that people may place in us as nurse, to "be open and honest, act with integrity and uphold the reputation of your profession" (p. 1).

Oakley reminds us that "all research constitutes an intervention of some kind" (2000, p. 16) and that those of us who intend to intervene in the lives of others should try and ensure that we do so to the most benefit and the least harm. Therefore issues of confidentiality, informed consent and anonymity were considered carefully when selecting the various methods and processes employed for generating and analysing data for this study.

Anonymity

I recognised from the outset that due to the specificity of the participants I would be aware of the names and professional identities of all the participants in this study. However, I promised all of the participants that the interview transcripts and completed questionnaires would be anonymised (by the application of a code) and treated as such during the stages of analysis and written findings.

I guaranteed the participants the right to privacy and security of the data they had provided and this I adhered to. The data generated from the interviews and questionnaires has been seen only by myself. I also promised the participants that any future published material would use only anonymised data, so that their identity is not compromised.

Informed consent

Usher and Arthur (1998) argue that obtaining consent is an active and dynamic process of negotiation and re-negotiation between the researcher and the participant. The gathering of 'true' informed consent from the participants was of particular importance to me.

How much information should be given for participants to be truly informed?

In stage 1 of the study, all three participants when first approached gave initial consent to being part of the research study quite willingly, expressing interest in the topic area. At the very beginning of the actual interviews, the issue of informed consent of the subject was raised by myself and given due weight and consideration. The participants were shown a signed letter from my research supervisor, establishing my credentials as a student on a Doctorate of Education course. The voluntary participation I then sought from each subject was not only to being interviewed by me, but also consenting to the taping of the interaction and/or making written notes as the interview proceeded. I made it clear that the participant could refuse to answer any question put to her and/or withdraw from the study at any time. To make the process of informed consent as explicit as possible I constructed a form (see Appendix I) detailing the purpose of the study and including a section confirming that informed consent had been requested, given and signed for. This rather formal approach felt comfortable and appeared to be anticipated and expected by the participants.

One of the participants declined to give consent to the interview being taped (no explanation was given) but she did agree to written notes being taken. She made it

very clear that her responses were her own and did not represent the organisation that employed her.

Stage 2 – the scoping exercise was an important aspect of gaining the consent and willingness of participants to partake in the final Stage 3 of the research exercise. Although formal consent to participate in the final part of the study was gained during Stage 2, the introductory letter to the questionnaire (for Stage 3) provided information again about the nature and purpose of the study and issues of consent.

Data generated from contextual analysis

An important feature of this study has been the exploration of the contextual discourses that have shaped, and continue to shape, the world of health visiting, see Chapters 3 and 5. As will be seen in the findings of the primary research activities (Chapter 5), such discourses have played an instrumental and profound role in the prevailing practice and identity of health visiting. To understand the responses of the participants such contextual consideration and examination are vital. Therefore, the data generated from the analysis, synthesis and interpretation of the contextual discourses is considered empirical in nature. The notion of empiricism utilised here is in keeping with a constructionist, post-empiricist approach. Such an approach is supported by and described by Durrheim (1997) in his polemic on the [need to] shift away from the mainstream "scientific package of empiricism" (p. 180) in the social sciences. For him such a scientific empiricist account of meaning restricts and fixes the meaning of words, with its aspirations of seeking a unitary truth.

Durrheim suggests that a methodology and critical enterprise such as discourse analysis moves from an empiricist to a social constructionist epistemology. Where the task of research is to be interpretive and productive (rather than descriptive) and empirical data generated by such activities,

> …aims to provide an account of how 'objects' in the world are constructed against a background of socially shared understandings which have become institutionalized and gain a factual status. (p.182, 1997)

So the sense, and use of the term, 'empirical data' in this thesis reflects for me the outcome of this critical enterprise *and* its use of discourse analysis. This approach has allowed me to investigate:

- How meanings of words can fluctuate across contexts;
- How people and organisations produce new meanings in shifting contexts;
- How sets of actions exist within a certain frame of reference;

- How every 'social action' and 'text' can to be treated as an opportunity for creating multiple meanings or further texts;

- How drawing on a variety of discourses can demonstrate the constructed nature of meaning and common understandings, and show "'conditions of possibility' within which they are embedded" (p. 182).

Analysis of data

Central to the analysis of the texts used in this study (completed questionnaires, policy documents, professional reviews etc.) has been the work of James Paul Gee and his method of analysing situations of language-in-action (2005). For Gee language-in–action is always and everywhere an active building process, being a tool inextricably used to design or build things. Humans build (discourse) situations by using language to carry out a series of building tasks – an activity or set of activities, in which people take on certain sorts of identity or roles, contract certain sorts of relationships with each other and use certain sorts of sign systems and forms of knowledge. The building and rebuilding of our worlds, Gee suggests, occurs not just through language but through language used in tandem with actions, interactions, non-linguistic symbol systems, objects, tools, technologies and distinctive ways of thinking, valuing, feeling and believing. In such a situation people and things take on certain meanings or significance, things are connected or disconnected, relevant or non-relevant to each other and various sorts of "social goods" are at stake in various ways (Gee, 2005, p. 27),

> …whenever we speak or write, we always and simultaneously construct
> or build seven things or seven areas of "reality". (Gee, 2005, p. 11)

Gee's framework for discourse analysis therefore consists of seven building blocks (tasks) – significance; activities; identities; relationships; politics; connections; sign systems and knowledge. For Gee such discourse analysis involves asking seven different questions about any piece of language-in-use (see Appendix VIII). Gee accepts that not all building tasks will be readily apparent in all pieces of data, but always asking the associated questions about each one is useful and provides alternative interpretations. Gee's suggested seven building questions and recommended tools of inquiry, were employed to analyse the texts utilised for this study as well as the data generated during Stage 3. A worked example of the analysis of one of the key contextual texts using this method is provided in Appendix IX.

Gee also recommends certain "tools of inquiry" (2005, p. 20) that can be used to analyse the workings of the building tasks in specific instances of language-in-use.

These tools of inquiry he states are "primarily relevant to how people build identities and activities and recognize identities and activities that others are building around them" (2005, p. 20). A premise that is significant and useful for this study. One such tool, the nature of Discourse, consisting of small 'd' and large 'D' elements, has already been introduced earlier in this chapter. For Gee regarding discourse in this way provides a term and a tool for examining the way that language, actions, interactions, ways of thinking, believing, valuing and using various symbols, tools and objects can be combined and integrated to enact a particular sort of socially recognisable identity.

Other tools of inquiry suggested by Gee are:

• Social languages – how different social languages are used and mixed; how people use different styles or varieties of language for different purposes;

• Intertextuality – the cross-reference (alluding, relating to in some fashion) to another text or type of text;

• Conversations – related to themes, debates or motifs that have been the focus of much talk and writing in some social group.

Gee is helpful in reminding us that any "D/discourse analysis must have a point" (p.8), and that all of us should be interested in two things:

    a) illuminating and gaining evidence …that helps to explain how and why language works the way it does when put into action;

    and

    b) contributing, in terms of understanding and intervention, to important issues and problems in some "applied" area that interests and motivates the researcher (p.8).

It is intended that this thesis will provide both.

I. Discursive realities

Analysis of the texts used in this study (completed questionnaires, policy documents, professional reviews etc.) have also been influenced by the writings of Maggie MacLure, which assist researchers intent on grasping, glimpsing and capturing the discursive nature of social realities. The notion of text is central to her *Discourse in Educational and Social Research* (2003). For her, text (talking and writing i.e. language) is a constitutive force with a power to create "that which it seems simply to describe" (p.4), with "the discursive and the real always *entangled* " (p.7, her italics). As a means of doing this, the texts and discourses associated with this study have

been 'interrogated' by the general questions suggested by MacLure to "open up" a research text (2003, p. 82, see Appendix X).

MacLure also proposes that in order to unravel and disarticulate texts it is necessary to spot the binary structure of discursive realities, the ways in which texts are articulated, that is "joined or stitched together" (2003, p. 9). For her one of the most general and commonplace structural discursive occurrences is the setting up of binary oppositions/allegiances. For such oppositions/allegiances (expressed in texts and words) locates "the person it describes within a particular moral universe, and invests them with a particular identity" (2003, p. 9), and is one of the key ways in which meaning and knowledge are produced.

II. Data generated from Stage 3

Each completed questionnaire was allocated a numerical code and then transcribed under each question title and number. The resulting text was then initially analysed in respect of its relevance to the particular research aims of this study, a worked example of this process and outcome can be found as Appendix XIII. The data was then analysed using the discourse analysis concepts, questions and frameworks from Gee, MacClure and Foucault, that have just been further discussed following their introduction in Chapter 2.

This time-consuming and exacting activity however proved its worth. It greatly aided the search for emerging themes; subthemes; repeated, significant words and phrases; frequency of mention and order; clusters of concepts, words etc.; shifts in opinion; consistency/disparity of opinion; patterns of ideas. The next step was to identify and consider how these linked/related, or did not link/relate, to each other.

Throughout the analysis I felt a close occupational lineage and reality to the worlds and community inhabited by the participants. Being able to share the technical discourse, the shared knowledge and understanding of the role and activities of health visiting did make it difficult at times for me to view the text and voice of the participants as oblique constructs. I felt unease about the boundaries thrown up between the researcher and researched. Could I consign to myself, and realise for myself, a separate world? How could I preserve the authentic voice of the researched? It was a challenge to find somewhere to stand in a text that was at the same time detached (nowhere in particular) and yet part of it (specific involvement) (MacLure, 2003). I came to view myself as a broker between the inside and outside worlds, a conduit for their perspectives, thoughts and opinions.

Reflection on writing up and constructing the thesis

As I started the very early, tentative, steps of my research journey I anticipated that writing up and constructing the final thesis would be a considerable challenge, and I was not been disappointed. The style and structure of the thesis has been chosen and assembled to provide a document that offers clarity of purpose, as well as of achievement, and to demonstrate a relative balance between its different parts. The generation of empirical data from both primary and other sources has been undertaken to support, reinforce and enlighten both elements. It is hoped that the way the results of these endeavours have been expressed and presented in this document has allowed this to happen.

For Chapter 5 (the findings from the primary research activities) I initially constructed the data and arguments, emanating from the participants, in a stage-by-stage, sequential fashion. However this led to a tendency to list responses in a way that seemed fragmented and at odds with the holistic and critical approach I was aiming for. Therefore I have adopted for Chapter 5 a holistic approach, where the responses from all the participants (i.e from all stages) are considered 'in the round'. Overall emerging themes are considered and related to the main questions this study has been endeavouring to answer.

In order to facilitate this holistic approach the quantitative data generated from the Stage 3 questionnaire responses, i.e. the number allocated by participants to indicate the degree of influence of factors on health visiting (see Stage 3 Questionnaire Appendix VII), is presented in tabular form as Appendices XI and XII.

When writing Chapter 5 I also started by delivering the words of the participants by their code numbers, for a more neutral stance, rather than by giving them pseudonyms. However, for those reading my initial drafts there appeared difficulty in remembering who was who amongst the participants therefore pseudonyms have been given to the participants which hopefully facilitates the following of the responses of individual participants. The pseudonyms have been chosen to reflect the gender and ethnicity of the participants. The pseudonyms for participants in Stage 1 are presented at the beginning of Chapter 5 those for Stage 3 participants are recorded, with their corresponding code number in Appendix XI.

Issues of validity

When considering issues of validity in research activities the scientific holy trinity of reliability, generalisability, and validity often come to the fore, as the principal mechanisms for ensuring truth and correctness. For others from a more interpretive perspective, however, this trinity can represent "oppressive positivist concepts that hamper creative and emancipatory qualitative research" (Kvale, 1996, p. 231).

Denzin and Lincoln (2003b) suggest that terms such as trustworthiness, credibility, transferability, dependability and confirmability should replace the usual positivist criteria of internal and external validity, reliability and objectivity. These terms certainly appear more consistent with the philosophy, purposes and goals of this research exercise.

Trustworthiness of qualitative endeavours for Oakley (2000) characterises how the research is done, how it is described and how its audience is able to decide whether or not its findings are trustworthy. Issues of verification have been addressed at each stage of this research study. My qualitative approach does not imply a lack of rigour or adequacy, or a lack of careful and systematic attention to each research stage. I have been mindful that the 'truth' of the research study rests on the quality of my own credibility and craftsmanship in relation to each aspect of the study. I have been vigilant for possible sources of 'invalidity' by continually checking and questioning the appropriateness of the design, methods, processes, interpretations and findings.

I accept that with such small, non-random samples, my findings could be viewed as tenuous and value-laden. I recognise the greater possibility and opportunity for bias with such a small overall number of participants, which cannot hold any intention of being representative of the entire health visiting population. However this study has allowed those who did participate an opportunity to have their lived experience explored, listened to and validated.

CHAPTER 5

THEMES AND MEANINGS EMERGING FROM THE PRIMARY DATA

The nature and purpose of this chapter

- This chapter contains the findings from the two principal stages, and time period, of the primary research activities of this study – i.e. Stages 1 and 3. It also contains supplementary material from discourses emanating from key documents discussing and debating the role and purpose of health visiting during the period from June 2007 to December 2009. The concluding Chapter 6 reflects how the contextual and political environment for health visiting has continued to evolve since this period of time, and is still in fact developing as this thesis goes to press. The supplementary material used within this chapter is drawn from three documents key to the recent discourses associated with health visiting, they are as follows:

- *Facing the future. A review of the role of health visitors* (DoH, June 2007a). The outcome of a government commissioned review tasked with describing the future role of the health visitor and making recommendations for developing and implementing this role in the context of *Modernising Nursing Careers* (DoH, 2006).

- *The government response to Facing the Future: a review of the role of health visitors* (Department of Health, October 2007b). The government response to the recommendations of the *Facing the future* review. The publication presents the government's perspective on a range of issues including workforce numbers and reductions in health visitor training and the level, nature and location of health visiting services.

- *Health Visiting Matters, re-establishing health visiting* (UK Public Health Association (UKPHA), November 2009b). This is the final report of an eighteen-month project commenced in Summer 2008 (following lobbying of the government) and undertaken by the UKPHA on behalf of many stakeholders interested in health visiting i.e. unions, charities, voluntary groups and academics. The project was viewed as "a specific regeneration project, to renew and energise [health visiting] service provision, practice and the health visiting profession" (p. 6). The project received government funding to look "in depth at some of the underlying issues that have contributed to the current [health visiting] staffing and service delivery crisis" (p. 10).

This thesis aims to consider the recent state of the professional identity of health visiting and to examine the crucial developments and range of discourses, as well as their degree of influence, shaping the role and identity of health visiting. Data generated from exploring the contextual and historical positioning of health visiting

has been presented in Chapters 2 and 3. The main focus of this chapter is on the data from all participants in all stages of the study, and the key documents/discourses of the time.

This chapter is presented in two sections – Section 1 considers the presentation of data and Section 2 focuses upon the analysis and interpretation of that data. Presenting data in this way, i.e. separating it from analysis and interpretation, poses a problem, and more so when a section of the data is material from public documents. For as MacLure reminds us, there

> …is no such thing as innocent description or observation: to describe is always to do something else at the same time. (MacLure, 2003, p. 95)

Also, separating data into themes for presentation and then again for analysis/comment can imbue a feeling of repetition. Nevertheless, this chapter has been structured in this way to render more explicit aspects of my analysis and interpretation.

Both sections are structured around the themes identified and interpreted through analysis of participant's data and key public texts. This chapter aims to generate a holistic and critical account of all of these spoken and written 'voices'. Where possible, the actual words of the texts and responses of the participants are presented verbatim; they are expressed in italics and accompanied by the pseudonym of that participant or title of the document. In respect of the participants, it is acknowledged that 'letting respondents speak for themselves' may be viewed by some as an inadequate response, as it obscures the researcher's role in shaping what has been induced/elicited, selected and presented. Yet the voices of such a unique and generally hidden group of participants are rarely heard so it is important that they should be presented as they have been said or written – hence also, the two sections to the chapter.

My own comments about the issues arising will be presented in normal font format, and where words have been actually said by me, the researcher, during interviews, these are presented in quotation marks. The quantitative element of Stage 3, previously referred to in Chapter 4 (p. 66), is also used to inform the findings discussed here in this chapter. Details of this data can be seen in Appendices XI and XII.

When deciding what to select and include in this chapter, from a large amount of data, I have been assisted by Nolan's paper 'How do we decide what is 'significant'?'

(2003). For both sources of data, i.e. public documents and participant responses, the themes were selected as those considered important or noteworthy in relation to the overall aims of this study:

- the current state of the professional identity of health visiting.
- the historical context and meaning associated with health visiting.
- the nature and degree of influence of the discourses currently shaping health visiting.
- the changes these discourses make to the professional identity and status of health visiting.

Identifying the participants and their responses

The coding and pseudonyms given to participants in Stage 3 of the study (i.e. health visitor educators across England) can be seen in Appendix XI. An important aspect of Stage 3 of this study was the exploration of factors considered to be influencing the professional identity of health visiting – and their <u>degree</u> of influence. Full details of these particular participant responses can be viewed in Appendices XI and XII. The participants in Stage 1 consisted of three senior health visitors, an advisor on Specialist Community Public Health Nursing for the Nursing and Midwifery Council; a Professor of Community Practice Development for a London University; and a senior health visitor educator, working within an English university. In order to provide anonymity they have been given the pseudonyms of Clare, Sue and Alice, names that are not linked to the order of professional roles just presented. Their current links with health visiting (in their own words) are as follows:

Participant 1 (P1 - Clare) – *daily through Higher Education Institutions and professional bodies.*
Participant 2 (P2 - Sue) - *mainly through research links and supervision.*
Participant 3 (P3 - Alice) – *through involvement in the education of health visitors and regular visits to practice areas in the community.*

Section 1 – Presentation of data

This study is concerned with exploring and investigating the factors and the discourses influencing/shaping the recent role, identity and purpose of health visiting. One recurring theme that emerges clearly from the findings is the impact on health visiting of the Nursing and Midwifery Council (NMC) regulatory and register changes that occurred in 2004 (see Chapter 3). The presentation of findings will, therefore, begin with this theme before exploring others like the present state of the professional

identity of health visitors; role and professional specificity of health visitors; disinvestments in health visiting; influence of health visitors on health visiting; and other stakeholders influencing health visiting like the government, SHAs, commissioners, managers, the public and CPHVA.

I. The influence of the NMC register changes

The findings of Stage 3 of this study show that the factor 'NMC Register (particularly SCPHN element)' achieved the greatest number of 10s (very influential, x 4), and the largest number of the combination of 10s, 9s + 8s (x 9) awarded by the participants - indicating their belief that this factor had a significantly high degree of influence on health visiting and was the <u>most</u> significant recent influence on health visiting. Related influential factors were the SCPHN training and the role of HEIs, which are also considered here:

a. The creation of the SCPHN part of the NMC register

The one-to-one interviews of Stage 1 provided a unique insight and personal perspective on the creation of the SCPHN part of the NMC register. All three expressed their familiarity with the changes. The responses from Clare and Alice held few surprises, and confirmed their specialist knowledge and interest in the changes to the NMC register:

> (Clare) *very, direct role since* [NMC] *changes happened.*
> (Alice) *Fairly familiar* (smile and ironic tone) – *I have a lead role in public health curriculum development here* (her employing university).

The response from Sue, however, demonstrated the particular nature and degree of her involvement: *I wrote the* [SCPHN] *standards* (hearty laughter) …*I was commissioned by the NMC.* Her narrative flowed freely and was illuminating and revealing. She began by explaining that in 2003 she had led:

> *a quite strong campaign against the closure of the health visitor register.*
> **"The May Day campaign?"**
> *That's right and I was very reluctant to have anything actually to do with setting up of this register but they* [the NMC] *said 'please help us you are the only person who can help us – you understand what is needed' so I was actually seconded to the NMC for a period of time …in the end I thought I hate, I hate what they have done but there are people out there who need a service and there are students out there half way through a qualification… you can't just take your ball away and say 'I don't like the*

> *way you have changed the rules so I'm not going to play', I was really pleased in the end that I did.*

Sue continued to assert that although the NMC had made some amendments to the final document containing the required SCPHN standards (*Standards of proficiency for specialist community public health nurses,* NMC, 2004b), most of the document had been written by her. She had suggested to the NMC that instead of having a generic title and role for these new specialist community public health nurses, they should design separate and distinct 'pathways' or 'branches' within the SCPHN part of the register for health visiting, occupational health nursing, school nursing, etc., but

> *…then the various government nurses got involved and said 'no we don't want separate branches we only want one qualification' except they didn't say it as politely as that! …There were really vitriolic exchanges, particularly from Scotland – they really, REALLY* (emphasis on word) *wanted rid of health visiting.*

In the end

> *…we ended up with the fudge about annotation and areas of practice … but the NMC were leaned on from the Department of Health and we were left with this extremely confusing document* (hearty laughter from her) … *the document was only just ready for the launch of the new register… it would have been better to put it out for public consultation and tighten it up.*

When Clare, Sue and Alice were asked for their personal view on what the change in the NMC register (and creation of the SCPHN part) was intended to do/mean in respect of health visiting, a variety of differing viewpoints emerged:

The response of Clare was brief and to the point, the changes were *… to recognise nurses who work in public health practice, …to widen the remit of public health nursing in terms of regulating work with whole populations.* From Sue came a very immediate and different reply *…to get rid of health visiting and promote nursing* (enthusiastic laughter). She expressed her mystification in respect of the motive for the changes. She recalled past conversations with senior nurses who,

> *…somehow could not believe that they could develop public health nursing as long as health visiting existed.*
> **"**Did they see it as a barrier?"
> *That's right – lots of people have said 'we can't get public health as health visiting steals it all' – a kind of professional animosity which is really quite interesting.*

Sue expressed her belief that the main reason for the NMC register changes was the hopes of some senior nurses for …*unifying nursing.* She relayed descriptions of some heated exchanges *(huge rows)* with various senior nurses about whether health visitors were nurses or not, quoting one senior nurse:

> *'But if health visitors are not nurses you will be completely on your own because there is nobody else out there'. It was sort of, 'everything is nursing so why would you want to be nothing?'* (laughter).

In the opinion of Sue such kinds of discussions …*creates enormous hostility, which has actually gone back decades.* For her the NMC register changes …*take away...* health visiting's distinction and difference from nursing and is …*a battle that's been lost really by health visiting …nursing would see it as having won.* At this point she paused and appeared to reflect, she then pronounced,

> *…what on earth is the function and role of these people called Specialist Community …*(looks confused) *Public Health Nurses? I get a mental block …I cannot say without …you know, because it's so awful …I have to admit that not everybody feels as strongly about it as I do. Some people feel happy about it I suppose …maybe that's progress.*

The important role played by senior nurses in the NMC and Department of Health at the time of the creation of the new nursing register was an aspect also raised by Alice. For her the purpose and meaning of the NMC register changes …*was something about the Department of Health's general agenda.* In her opinion certain key senior nurses (she named one specifically – X) working in the Department of Health at the time (of the decision-making concerning the creation of the new NMC register) thought the NMC register changes would promote a more community public health focus rather than the individualist public health approach of health visitors. Probing further I enquired "So do you think there was a specific agenda?"

She replied,

> *…no, I think the agenda was about promoting the health of the population and the government's focus on targets, albeit with a 'social wing' attached to them.*

Alice described the difficulty for health visiting in demonstrating and measuring the effectiveness of what it did and its positive influence on the health of the population. During the debate at the time she spoke with people like "X" who said:

> *These are a very expensive group of practitioners and we cannot see the evidence for the difference that they are making.*

The participants in Stage 1 were asked for their views on the potential impact of the NMC register changes on health visiting, and this stimulated a range of opinions demonstrating the differing notions and ideas about health visiting. Seeking Clare's comments was of particular interest to me due to her position within the NMC, however when asked this question she declined to comment, shrugged her shoulders and smiled. Yet her comments overall during the interview reflected a position of acceptance, promotion, and an explicit desire to move on to a new position and identity for health visiting. The hope expressed by Clare was that the NMC register change would ...*bring back health visiting to a population perspective,* and that their practice would change to address …*health inequalities* and improve outcomes for public health and *…give more credibility to the skills they have.* From Alice came a sense of neutral and resigned acceptance. For Sue, however, the removal of the title "health visitor" and replacement by "Specialist Community Public Health Nurse" amounted to a significant change and generated a strong response from her. She reminded me that the term "health visitor" had been in use for almost 150 years, and added:

> *…naming is terribly important isn't it? …I was fascinated and horrified during the debate the number of people who said 'names don't matter'. Of course names matter! The fact that health visiting was a profession in statute for 85 years and now it is not, for me is horrendous.*

When the participants in Stage 1 were asked, "Do you envisage a consequent change to the professional identity and culture of health visiting?" Clare replied,

> *…change has been a long time coming, health visiting has a distinct character and competences… it is so ingrained…* (pause) *health visiting is only a PART* (her emphasis) *of public health nursing, it is complementary to other parts …these register changes mark a major shift in the culture of the public health nursing area of practice.* These changes are*… ahead of its time…* [commissioners of health care] *don't know what they want.*

She concluded by adding it does not pay to be *… too precious about health visiting.*

From Alice came a differing perspective. When asked about the possible impact on health visiting of the new NMC register she replied …*it's interesting that you should ask me because I have spent the last week in practice*. Reflecting on this recent experience of visiting health visitor students in practice she noted:

> *The public call them health visitors, the primary care team within which they work call them health visitors… and their work is predominantly*

essentially an individualist approach… essentially the perception in practice is that they are health visitor students working with health visitors in health visiting.

In Alice's opinion the NMC register changes may have happened legally and technically but in practice, and reality, the mothers, clients and GPs appeared unaware of any change to the title, meaning and purpose of being a health visitor. She related how during her week in practice she had wondered how long it would take before

…you had that 'sea change', …for as long as they are called health visitors, as long as they call themselves health visitors… the practice remains essentially similar to what it has been in the past.

She expanded on this by adding,

…you must be talking about some years for such a significant sea change… the only people who seem to realise that health visiting has changed is us (meaning her and I as health visitor educators) … *the health visitors don't particularly… certainly don't!* (emphasis on last two words, some laughter)… *that's interesting.*

Relating back to her recent time spent in practice, Alice explained that health visitors and practice teachers

…are quite surprised when I bring up the subject of public health nursing. They are not entirely clear themselves that they have switched to another part of the register, and if they are aware they do not see that affecting their lives at the moment… so I have no sense of their consciousness being changed… or even having the debate.

Yet for Alice such change, although a long time coming, would eventually happen for health visiting as

…once you have a situation where you have a public health course rather than a health visiting course… [the result is] *a different course put together in a different way… My belief is that when these courses are running… and* (students) *coming out the other end as public health nurses, the whole thing will be marketed differently, expectations will change.*

For Sue the impact of the NMC register changes on health visiting represented,

…the law of unintended consequences. Although I don't think it was the intention of [government] *Ministers, …during the campaign we actually*

met John Hutton and he was mystified about why changing the name and the register was so important. 'Of course we want health visitors, we're not saying we want rid of health visitors' …but the message heard by commissioners was 'health visiting is gone' …and lo and behold, within a couple of years we have 25% of trusts currently disinvesting in health visiting.

For her …*the message has gone out that health visiting is not supported,* and health visiting had somehow failed to transmit the valuable difference it could make to the public's health:

We have done a lot of apologising for our own existence – we have apologised for being different – 'you think you are special, you think you are elitist'… and we've said – shock, horror, we are not different, and that has not been good for us as a profession… We haven't had friends on our side like midwifery has. We need colleagues to speak for us, we need clients to speak for us, we need a consumer voice speaking for us… Interestingly it's just starting as people realise they are in danger of losing something precious.

The words of many of the HVEs in Stage 3 demonstrate a similar strength of opinion at the impact of the NMC regulatory changes. For Emma the NMC register …*totally obliterated its* [health visiting's] *position and offers poor direction* [for] *practice.* For others the …*confusion around Part 3 has led to uncertainty about future direction* (Jane). Anne suggests that the register represents the …*NMC view… to the detriment of the profession* [of health visiting] *with a lack of true leadership from the NMC for HV concerns.*

Many participants bemoaned, disputed and challenged the loss of the titles *'health visiting'* and *'health visitor'*, first from legislative and regulatory use by the new professional regulatory body (NMC) in 2002, and again in 2004 with the title and register part of 'Health Visitor' replaced by that of 'Specialist Community Public Health Nurse (SCPHN)', …*the name HV was dropped from the official title… there is no reason to believe that* [this will not continue] *as long HV stays within nursing* (Katy).

More neutral comments expressed the hope that the new title and status would at least …*provide professional recognition and identifies HV clearly as a separate role* (Pam)*, whilst establishing the importance of regulating health visiting for the public's protection* (Lucy). Sue, during the Stage 1 interviews, discussed her recent research

study (conducted at the beginning of 2005), which involved the sending out of 3,000 questionnaires to all nurses on the SCPHN Part of the NMC register. One of the questions she asked was 'Do you think health visitors should have a different name [from that of a specialist community public health nurse]?' For her the results were a surprise:

> *Far more people liked the change in name than I expected …a lot of people hated it …one third weren't concerned …the negativity wasn't as much as I expected …there were some very interesting contradictions – one third very unhappy with title (27%), 82% didn't like title SCPHN and many said health visitors should still be called health visitors.*

The project *Health Visiting Matters* (UKPHA, 2009b) considered in depth the change in registration status, title and identity of health visitors following the regulatory changes of 2004 and the creation of the Nursing and Midwifery Council (NMC) in 2002. For them the historical journey, status and identity of health visiting prior to 1983 was significant. For this was the time when health visiting was accepted as a profession in its own right, with its own regulatory Council, prior to its attachment to nursing and its "*absorption*" (p. 44) in 1983 into the United Kingdom Central Council for Nurses, Midwives and Health Visitors. In the opinion of the project members the creation of the NMC …*was a controversial move at the time* [when] *health visiting ceased to be recognised as a profession in its own right, being regulated instead as a post-registration nursing qualification* (p. 44). In their assessment there is a direct correlation between …*the* [present] *workforce crisis* (p. 45) in health visiting, the closing of the health visitor register and the creation of the SCPHN part of the register. Looking in depth at the statistics they state:

> *The dedicated health visitor register was closed in 2004, and at that point the number of health visitors employed began to fall quite dramatically …* [the] *removal from statute* [of health visiting] *made a very clear statement about the lack of government support for the profession, paving the way for substitution by less skilled workers.* (p. 44)

However, during the government supported review of health visiting (*Facing the future*, DoH, 2007a) the recent NMC changes to the regulation, naming, practice and training of health visitors receives little attention or consideration. Even the actual name 'Specialist community public health nurse' does not occur once within the final report, with only the titles 'health visitor' and 'health visiting' used throughout the document. A similar picture also emerges in the government's response to the health visiting review where again the NMC and its regulatory register receive no mention or discussion. Yet within *The government response to Facing the Future* (DoH, 2007b) there is

acknowledgement that health visiting is experiencing a significant amount of change …*both in how they are trained and in what they do* (p. 3).

b. SCPHN training programmes

Of particular interest to this study was how the new SCPHN training programmes were influencing the role and identity of health visiting. All of the participants in Stage 3 acknowledged (in Stage 2) their involvement in the development and/or delivery of the new SCPHN programmes (see Glossary for further details of the SCPHN programme) that replaced existing <u>specific</u> training programmes for health visitors alone.

Part 2 of the main questionnaire (developed for Stage 3 of the study) had been designed to capitalise on the unique nature of the health visitor educator (HVE) and generate an important insight into their views on the new SCPHN training programmes. Their responses represent a valuable contribution to this subject area and show that from their perspective the creation of the SCPHN part of the NMC register has had a significant impact on the nature, content and delivery of the programmes to train new health visitors. The HVEs showed common agreement that the programmes, specific health visitor training programmes versus the new SCPHN training programmes, were different:

> *The main one* [difference] *is that the programme prepares a specialist public health nurse who can work in any area of public health on completion of the programme* (Ruth).

There was also general accord on the prescriptive influence of the NMC on the …s*etting of standards for practice and education of health visitors* (John), and that …*the influence of the NMC has been significant on the focus of training and education for health visiting* (Gill). For Clare (in Stage 1) the influence and SCPHN standards were intended …*to bring back health visiting to a population perspective …change practice to address health inequalities* …[and] *improve outcomes for public health.*

Yet for Sue (in Stage 1) changes had already been happening to health visiting training programmes even prior to 2004 ever since …*we lost education in 1995 …we have had 10 years of* [health visitor training] *programmes …that have primarily been about nursing not health visiting.* The result had, in her opinion, led to a diminishing of the expertise and

> *…wonderful, competent, sensitive* [health visiting] *practice… It's not surprising if PCTs and consumers do not find favour with health visiting.*

We are all… on the cusp right now… of change to health visiting training. But… I think the new standards do give us the opportunity, 'the unification agenda'… of working with other nurses interested in public health – there could be a shared agenda.

The majority of HVEs signalled a belief that the new SCPHN programmes had strengthened the underpinning proficiency and importance of a public health focus for health visiting, not just within the theoretical curriculum, but also in the role and its perception in practice. As stated by the NMC:

The standards of proficiency [for SCPHNs] must …reflect a breadth of [public health] practice and learning (p. 5) …[practice] orientation must be …responsive to the needs of various client groups across different settings for public health practice (p. 6) …experiences should be planned to enable students to understand the context for practice in all community public health settings (p. 15). (NMC, 2004b)

A perspective shared by many of the HVEs (mentioned by seven out of the twelve) is echoed in the following opinions - from John, …*the new standards appear to be an attempt to define the role of health visiting more specifically in terms of public health principles; …the SCPHN course as validated supports a strong public health role* (Gill); …*Programme content – there is clearly more emphasis on a public health approach* (Emma). For many of the participants though the new programmes had brought certain difficulties. For some HVEs the strong curriculum and theoretical emphasis on the approaches, frameworks and theories associated with public health and health promotion (*Large parts of curriculum devoted to public health skills, HNA, health promotion* (Jean)*, …distracts from the fundamental relationship building with clients that enable them to have the time dedicated to them to develop their own solutions* (Jane)*.* For some participants the stronger emphasis of public health approaches and principles in the SCPHN programmes had led to more discursive use of the terms 'populations' and 'communities', …*HEIs talk of populations and communities and yet the* [health visiting] *practice is often restricted to individual contact with families and individuals* (Jean)*.*

For some HVEs the more generic nature of the SCPHN programme did not prepare the health visitor student sufficiently for the specific nature of the actual job of health visiting expected by their provider organisations and consumers. For Anne,

…the [SCPHN programme] *modules were devised as more generic than I would have liked …I felt that HV students new to the job need that*

> *intensive HV input to "brand" them into the job rather than generally into the SCPHN role …I do provide additional lunch time sessions for the HV students with practice teachers because I do not believe that I can fit in everything the student requires because of the generic nature of the course.*

An opinion shared by Jane,

> *…Don't think enough time in curriculum for skills based learning – assumption that students will learn this in practice and this is very variable.*

The principal concern of many of the HVEs appeared to lie in various paradoxes, *…at the moment there is a definite gap between what we teach academically and then what the student is exposed to in practice* (Mary) …W*hat students are seeing in practice and hearing about in the universities is not the same* (Jean). For John,

> *…it does not seem evident that health visitors who trained prior to these new standards have now automatically adopted them or responded to them in a significant way. Essentially this means that changes within the profession may be slow to materialise.*

A general sense emerged from the HVEs that although the new SCPHN programmes called for an enhanced emphasis on public health, health visiting itself, as a profession, had 'lost' its unique public health position within nursing.

The difference between classroom teaching and what health visitor students experience in practice was highlighted as a significant issue. It was evident from the findings that HVEs were witnessing a significant dissonance and ambiguity between the health visiting/SCPHN role as perceived by the SCPHN programmes (and the NMC, 2004b) and that observed in the reality of day-to-day health visiting practice and practitioners, which for some …*has resulted in an ambiguous message being received by SCPHN students* (Emma). For Mary …*the students entering practice, fired up and ready to trail-blaze,* [are] *met by some practitioners who are reluctant to change, feel disempowered and have become cynical as a result.* This issue is also highlighted by *Facing the future* (DoH, 2007a) that notes that …*there is a mismatch between training and the service requirements* (p. 14).

A difference also seems evident between what is 'required' to be a health visitor (and SCPHN) from the NMC perspective and what is 'required' of a health visitor from the

NHS primary care provider organisations, employers, and commissioners of their service. Although the intent of the NMC SCPHN standards (and programmes) is clearly recognised by the HVEs (to develop the public health role and practice of SCPHNs) for some of them achieving this …*role content* was *very challenging to provide for, as providers often require something different to that implied by the NMC standards and sometimes do not know exactly what they want* (Emma).

Several HVEs remark that in their experience the …*roles of the SCPHN (HV) vary across employer* (Ruth). Other HVEs comment that where a stronger emphasis on public health activities had been attempted in practice there had been difficulties in initiating or sustaining these activities or even receiving the necessary organisational support …*there is an attempt to develop the public health role of HVs* [by health visitors] *however it is not clear that providers or commissioners are ready to embrace this developed role* (Katy). Other HVEs agreed that an emphasis on a wider public health role for health visitors …*is not reflected in the practice experience* (Gill); …*this is not necessarily facilitated or reflected in practice …this has been hampered …by resource restrictions which have for example limited group work and working with communities* (Emma); [and] …*it is not clear that providers or commissioners are ready to embrace this developed role* (Rita). Similar thoughts are echoed by members of the health visiting review team:

> *Whilst there is a view in some parts of the* [health visiting] *profession that health visitors have a generic community public health role, we found little evidence that this role has been picked up on any scale by the profession or commissioners.* (*Facing the future,* DoH, 2007a, p. 18)

Other interconnecting themes raised by the HVEs pertained to two of the underpinning NMC proficiencies for practising as a specialist community public health nurse - those of being able to apply "strategic leadership for health and wellbeing" and engage in "collaborative working for health and wellbeing" (NMC, 2004b, pp. 11 – 12). Both principles/proficiencies include the requirement to lead and manage 'skill mix' community teams (See Glossary for 'skill mix'). The emphasis on the discourses of leadership and partnership within this NMC document are seen by the HVEs as a clear requirement and influence on the content and focus of SCPHN programmes. However little detailed explanation and suggested application of the principles are provided within the document itself.

The overall thoughts of the HVEs on the influence and impact of these two elements (leadership and partnership) within the SCPHN programme on health visiting are

varied and often multifaceted. They link these elements with the challenge of achieving partnership working within child health and social care services and skill mix within health visiting teams. Their comments illustrate some of the difficulties with achieving a) a leadership role for health visiting due to reduced service capacity, resource restraints, …*the general reduction in whole time equivalent HVs across the trusts have led HV to feel undermined and more crisis driven* (Anne); and b) the (lack of) ability for health visitors to influence managerial/commissioning decisions,

> …*there is a clear and defined role for HVs* [within the CPP] *which could be picked up by commissioners and providers, but they are not legally bound to do so. It will be up to the HV profession to emphasise this and take the lead* (Emma)*.*

Their remarks highlight compatibility between the principles of the SCPHN programme (NMC, 2004b) and the governmental health policy agenda, philosophy, and ideology of seeking a …*greater emphasis on partnership working* (Emma).

They acknowledge the heightened emphasis of health visitors being viewed not just as public health practitioners, …*SCPHN programme equips the student to deal with all aspects of public health* (Ruth), but also as leaders of 'skill mix' community teams. For some HVEs this represents a new role for health visiting, one that moves health visitors from the expectation and requirement of just autonomously leading themselves to one where they are expected to lead and manage a varied team of support workers. One aspect that appears not in doubt from any of the HVEs is the degree of change expected within the role, purpose and meaning of being a health visitor from the new SCPHN programme. For Katy the decline in health visiting is because …*in the same way the name HV was dropped from the official title so has the specific education.* Ruth expresses the view that, …*it is a SCPHN profession now with health visiting just a role within it.* For Jean the change in programmes meant a challenge for health visiting to survive as …*a specific work area*, now that it had become …*merely a post registration area of nursing practice.* Before expanding further on these themes it is useful to explore the attention shown to the methodological change and means of training health visitors from some key initiatives associated with health visiting.

It is of interest that the review into identifying and defining the future role of health visiting (*Facing the future,* DoH, 2007a) makes no mention, nor starts any discussion, in respect of the 'new' SCPHN programmes. The final report repeatedly expresses the desire to reform and renew health visiting yet there is no detailed exploration of the present or future recruitment or training of health visitors. The language of the report

is couched in terms of attracting a new generation to the profession of health visiting. It describes the present workforce as …*older …largely female and white,* and states their aspiration for a …*younger generation of health visitors …*[with] *an ethnic and gender mix to reflect diversity in population* (p. 39). Yet once again the specifics concerning how this may be accomplished are absent. The document acknowledges the frequent reports of reductions in the number of health visitors trained and the …*mismatch between training and the service requirements* (p. 14), but do not investigate these issues any further. Their only words on the subject are that the present …*52 week …'one size fits all' programme* should be changed to more …*modular learning,* [with a] *flexible curriculum with national standards* (p. 29).

The government response to the health visiting review (DoH, 2007b) also gives little consideration to the nature and specifics of the SCPHN training programme. The report expresses its keenness and support for health visitors to have a coherent and relevant future and …*to see more done to develop health visiting* (p. 21) and to increase the number of health visitors. Yet the means of how this could/should be achieved is not discussed and there is no reference to the existing SCPHN/health visitor training programmes. The only, very general, comment is the recommendation for …*new training programmes …that better reflect the needs of the service and aspirations of the workforce* (p. 17). There seems little evidence within the document of a joined up, "third way" of government thinking as the main professional body for nursing (the NMC) seems invisible.

The document presents as an 'outstanding issue' the fact that PCTs and SHAs report to the government that the current training programme for new health visitors …*is not seen to be value for money or effective in preparing nurses to deliver services* (p. 17). The report does not specify whether these training programmes are either the traditional specific health visitor training programmes or the new SCPHN programmes, or indeed both. It is clear, however, within *The government response to Facing the Future* (DoH, 2007b) the support of the government for the generic, shared, nature of the SCPHN programmes, with their view that health visitors are (just?) one of …*a range of practitioners with a role in public health and children* (p. 11).

Unlike the findings of the review of health visiting and the government's response to it, *Heath Visiting Matters* (UKPHA, 2009b) considers the recruitment and training of health visitors to be an important issue requiring in depth examination. For the members of this project the education of health visitors (new and existing) is …*the*

major instrument for workforce planning (p. 47), [so] …*strong educational programmes are needed to ensure the 'health professional' status of health visiting is maintained* (p. 43). As far as the project members are concerned …*the public health basis of the* [SCPHN] *programme is clear* (p. 48), however they express their concern at the length of the SCPHN programme (52 weeks) …*which is too short to include all the relevant content* and the proficiencies and requirements for working with children and families. Their concluding belief is that it is

> *…too soon to have a clear view about whether the current (SCPHN) proficiencies are ensuring new entrants to health visiting are well prepared for their role.* (p. 48)

Their investigations describe recruitment of nurses onto SCPHN training programmes to be problematic, with …*unfilled, funded spaces* [on SCPHN training programmes] *after five or more rounds of interviews* (p. 42), and difficulty in attracting experienced nurses or midwives, as …*they would need to take a fall in salary to gain the qualification* (p. 46). The report expresses an urgent need for the review of current criteria and mechanisms for selecting and training new health visitors. In their opinion the current entry requirements are too narrowly restricted to only nurses registered with the NMC. The project team actively promote the need to widen the entry gate to health visiting, indeed back to how it was before the early 1960s. From their viewpoint they believe that there is

> *…enormous interest in* [joining] *the profession from non-nurse graduates and others working in similar fields …* [which] *contrasts with the lack of interest in a health visiting career from within the nursing profession.* (p. 44)

c. The influence of Higher Education Institutions (HEI)

With all but one of the participants being employees of higher educational institutions, this study was particularly interested in the influence of such institutions on health visiting. The HVE response to this possible factor of influence intriguingly indicated a low numerical degree of influence, with 4 participants even indicating "NA" – not applicable. This gave this factor an overall influential position of being tenth (out of a possible 14 factors).

Yet within the comments of the HVEs can be seen signs of a descriptive model of influence. The influence of HEIs (and HVEs) is portrayed by them as providing and delivering the training of new health visitors; working to sustain and promote the programmes to train new health visitors; leading health visiting practice and development; and attempting to stimulate professional awareness and effectiveness.

For *Health Visiting Matters* (UKPHA, 2009b) the role, and influence, of HEIs is clear in that they are responsible for ensuring that health visiting students learn how to apply the current proficiencies for a SCPHN in their practice with children, young people and families (p. 43).

However, HVE comments reflect the HEI factor as having minimal influence on health visiting. For Pam there was …*limited influence due to constraints of educational market force* while John acknowledges their …*influence on academic level expected by practitioners and practice teachers,* as well as health visitor …*numbers available in workforce.* Yet in the area of educating new health visitors and supporting the teaching, learning and assessment of students in practice, their comments describe a considerably influential position, of …*leading development of health visiting practice* (Emma). Their aspirations to lead health visiting practice and development and …*to push professional awareness* (Emma), emerges strongly from their written words. The general opinion of their influence, however, seems best summed up by one of their number …w*ell we do try don't we ...but frequently we are caught between a rock and a hard place* (Mary). Suggesting perhaps being caught between the needs of primary care managers, health visitors, students, the SHAs, Department of Health, the government, the NMC, and not least their own institutions.

The influence of HEIs and its members can be seen in the HVE descriptions of their activities associated with a particular defence and/or sustenance of SCPHN programmes, at a time of considerable national disinvestment, as exampled by the words of Jean:

> *HEIs have a big impact on the sustaining of the* [SCPHN] *programmes* [but] *HV/SCPHN programmes are not as important as they once were. They have less prestige, and with less numbers bring in fewer fees. They are looked at to see if they are viable. Some will inevitably go to the wall.*

From Anne comes a similar message:

> *HEIs are often fighting for the dwindling number of students, and HVEs are being pulled from SCPHN courses to teach on other routes. Competitiveness has increased …this is dangerous for the profession because once a course stops they often do not run again.*

Such opinions are also expressed within *Health Visiting Matters* (UKPHA, 2009b), which highlights that

> *…educational programmes are under subscribed with an uncertain infrastructure in terms of numbers of practice teachers or availability of sufficient and appropriate programmes.* (p. 41)

In their view:

> *Many of the underlying reasons for recruitment difficulties appear to be bound up with the fact that health visitor education is seen, currently as a post-registration qualification, despite the lack of a specific pre-registration qualification.* (p. 46)

For Rita …*HEIs are subject to their own restrictions based on funding and SHA contracts and 'second guessing' the way forward for health visiting,* as illustrated by Emma …*sometimes* [the HEIs] *are not able to match academic demand with practice/service provider demand.* For Katy the degree of influence of an HEI was related to their degree of involvement with health visiting,

> …*difficult to engage* [with] *if they are not providing the* [health visiting] *course* …[and] *difficult to deliver anything other than very specific courses.*

II. What is the current state of the professional identity of health visiting?

The above question has been at the heart of this study since its inception. The exploration of the term 'professional identity' has been pursued earlier in the thesis and found to encapsulate issues of occupational and professional role, meaning, purpose, specificity, attitudes, values, beliefs and skills – all of which transpire to produce an identity. From all the various stages of this study the findings have clearly and repeatedly shown the significant degree of change, uncertainty and turbulence recently surrounding the role and identity of health visiting.

Emanating from the participants is a clear concern for the professional identity of health visiting which for some is …*somewhat confused at present …over the past few years the role of the HV has become blurred with a shift towards a more medical model of practice due to government policy relating to targets* (Anne); …*somewhat blurred at the moment* (John). For others the feelings and opinions are much stronger with the professional identity of health visiting …*in crisis. There are reduced numbers of health visitors in post and being trained …Health visitors are not a confident group and they are not making their voice heard within the PCTs or at national level …Overall health visiting seems passive, just waiting to see what happens next* (Jean), and at …*serious risk of identity being eroded* (Pam and Lucy). For Katy the challenge being faced by health visiting was simply for …*survival.* In the view of Emma,

…health visiting is struggling to secure a professional identity. This is due, in my opinion, to a multitude of historical elements. There has continually been a lack of understanding by society in general of the role health visiting and more latterly the role of the public health nurse within the concept of health visiting.

One of the key reasons given by participants for such change and confusion is that of the NMC changes to their title, registration status, role, title and purpose as a Specialist Community Public Health Nurse (SCPHN). For a significant number of participants …w*ithin the public arena the* [health visiting] *identity is lost under the SCPHN title* (Katy)*.* It is described as a situation where health visiting was …*no longer a profession in its own right …there is now no body of knowledge, attitudes and values identified by the role of the health visitor, these are now embedded in the standards for specialist community public health nursing and predicated on nursing and midwifery* (Ruth)*.* Both Pam and Lucy used the phrase "*significantly threatened"* in their view of the professional identity of health visiting.

For Alice the NMC changes in role and title for health visitors had in fact yet to reach the collective consciousness of most health visitors*,* particularly those in practice …*I have no sense of their consciousness being changed.* Yet for Sue the world of health visiting …*has become a different place.* She expressed her considerable disappointment at the removal of the title and qualification of health visitor from …*statute …removed from 85 pieces of legislation!* For her there was concern that the SCPHN standards were so broad and general that …*they could be used to do anything, but they could be used to do brilliant things!*

In Stage 3 of the study the participants/HVEs were asked whether health visiting was in a stage of reinvention, adaptation, evolution, extension (of traditional role), stasis, decline, or other. The majority of HVEs (7 out of 12) considered that health visiting was currently in a stage of …*adaptation.* For them this adaptation was required …*by existing HVs to new expectations* (John), yet for Gill even during this time of adaptation …*the four principles of health visiting remain key …as the* [NMC] *proficiencies are based on these HVs should develop transferable skills to adapt to the needs of the client.* For her, however*,* the concern is that …*health visitors may understand what their role should be but do not have the resources to carry this out.*

The propensity for health visiting to adapt is highlighted in *Health Visiting Matters* (UKPHA, 2009b), which commends the way that the health visiting workforce uses its particular skills and place within child health and public health and has

> *…developed gradually since the Victorian era of philanthropic public health, changing and adapting over the years to meet new challenges and health needs …there is a consensus that the low point for the profession at the start of the 21st century, when this project began, should be seen as a starting point for regeneration and development.* (p. 59)

Half of the participants (from Stage 3) indicated that health visiting was in a stage of …*evolution.* For John such evolution represented a positive step as …*the new* [NMC] *standards are seeking to develop a stronger, wider PH role and skills to work as a leader of a team rather than in isolation.* Emma also expressed …*hope it is in a state of evolution, having very recently experienced a period of decline. The time is ripe for HVs to secure their identity within the area of supporting families.*

However most of the participants expressing the view that health visiting was currently in a state of evolution often qualified, or added words in less positive terms. For Rita …*health visiting is evolving due to restrictions on practice (i.e. limited to core work/child protection) also struggling to evolve a more developed public health role.* For others their concerns lay in the possible resistance to evolution from the existing health visitor workforce. From Mary …*I would like to say evolution …but I fear that the best we can hope for in the traditional workforce is adaptation …I feel it may be necessary to 'put a rope around and drag traditional practitioners forward'.* In the opinion of Gill*,* health visiting was in a stage of …e*volution …but could end up as decline if individuals do not adapt their practice to meet market needs.*

For four HVEs health visiting was currently in decline due to a range of factors. For Jean,

> *…there are opportunities for reinvention, adaptation, evolution and extension* (of health visiting) *but there seems to be more stasis and decline …HVs are under pressure from management (PCT, Commissioners, SHA) and declining workforce with older staff. Reduced morale has had an impact on recruitment.*

For John health visiting was …*in decline due to erosion of the role by other agencies such as LAs and voluntary sector and undermining by undervaluing the contribution made to public health.* Such a view was supported by Rita for whom the *…decline*

[was] *due to erosion of role by other agencies,* as well as …*lack of investment in* [health visitor] *establishment and demography.* For Katy the decline of health visiting could be attributed to the fact that …*HV as it stands does not fit well with the current nursing framework …where has the political dimension of HV gone?*

Two HVEs considered health visiting to be in a state of reinvention …*due to the 'Facing the future' document and the acknowledgement of HV as leaders of teams dealing with a universal approach and complex needs* (Anne)*.*

Within the CPHVA's response to *Facing the future* (Unite/CPHVA, 2007) there is the observation that morale amongst health visitors "is at an all time low" (p. 3). In their opinion the recent financially driven medical model in health had eroded the role of the health visitor, a role more suited to a psycho-social model of service provision (p. 4) and that demonstrating health outcomes, "is not possible under the current provision (of health visiting) as current services are being run on a shoe string with little attention being paid to quality or long term health outcomes by those who commission them" (p. 5).

III. The role and professional specificity of health visiting

As shown within Chapter 2 occupations place considerable value on the 'uniqueness' and 'specificity' of their role in order to facilitate the possession of a clear and recognised (and recognisable) professional identity. Health visiting appears no different.

a. Professional role and specificity

For some participants specifying the unique role of the health visitor was important for …*emerging as a specific group rather than as a nebulous entity* (Pam) and for their …*survival as a specific work area* (Mary)*.* Achieving such professional specification was generally acknowledged as a challenge for it required …*fighting for our corner and the unique role of leading a team of practitioners to really make a difference to every child and their family* (Jane). But John concedes the difficulty of …*getting all HVs to agree on their role and identity …perhaps the role is too multifaceted to be realistically achieved?*

Gill's opinion is echoed by a significant number of participants, that …*health visitors need to be clear about what is unique about their role and what cannot be done more effectively and cheaper by anyone else.* Interestingly several comments agreed with Emma that

> *…some HVs are still struggling with what they should actually be doing in the different aspects of their roles …the challenges are to accommodate specific roles …with the service, but continue to maintain overall control for the many interventions that HVs should be leading …Health visiting may not be just 'one role' and there needs to be direction for HVs in how to address this.*

This view is supported within the health visiting review findings (*Facing the future*, DoH, 2007a). Under the heading 'where the profession is now' comes the finding that:

> *Parents, commissioners, GPs, Local authorities, policy makers and the profession all seem to have different expectations of the role and what services should be provided.* (p. 14)

Several participants supported Ruth's aspiration that

> *…we need to move our thinking into the 21st century and develop our areas of expertise and sell them to the highest bidder... Those working in the field of health visiting will need to read policy, adapt practice to the changing demographic picture and provide a service that clients want.*

For other participants Anne's words are reflective of their thoughts around the typical traditional role and aspiration of health visiting, *…I feel the profession needs to become the specialist in child and family health and development skills which will stand them in a position of authority.*

Of particular concern is the maintenance of their important (and historic) public health, preventative role with children and families and the difficulty that managers, commissioners and other professionals have in understanding or appreciating it. For Rita, *…health visiting has a unique public health role …in a way that no other professional group has… based on the establishment of relationships with parents.* Yet Pam suggests that *…the profession needs to develop its public health focus to ensure that the community perspective remains high on the healthcare agenda.* It should take opportunities to *…develop links with PH* [public health] *departments in PCOs* [primary care organisations] (Katy).

Yet there is noted concern from the HVEs about the "*struggles*" facing health visiting for this aspect of their role, particularly since becoming SCPHNs. For John … *there is a struggle between this* [health visiting] *identity and the wider public health* [SCPHN] *identity.* From her frequent visits to practice Alice considered that the public health

role of health visitors was generally unclear and undeveloped, with health visitors concentrating primarily on responding to individual and family needs only:

> *Health visitors do not see themselves as public health nurses in fact some of them are surprised when I bring up the subject of public health nursing… I get no sense of viewing themselves as public health nurses, or even having the debate.*

However, there is a recognition from several of the HVEs that health visitors now share an identity, not just with other SCPHNs, but also with other nurses involved in public health activities. Such a view is echoed in *The government response to Facing the Future* (DoH, 2007b) which acknowledges

> *…the unique contribution that health visitors , as highly skilled public health nurses, bring to services for children and families …in particular …their emphasis on inequalities, social inclusion, tackling public health priorities and promoting infant and maternal mental health.* (p. 7)

Yet for the government the nature of their specificity is firmly linked and maintained to, and with, nursing as the report makes clear health visitors are (just?) one of

> *…a range of practitioners with a role in public health and children* (p. 11)
>
> *…[and in integrated services] each partner needs to be clear what they bring and what their specific responsibility and contribution is, at the same time as valuing the contributions of others.* (p. 15)

In 1998 Billingham, a Director of public health nursing, and Hall, Professor of community paediatrics, wrote of the turbulent future ahead for school nursing and health visiting (*Change the bathwater- but hang on to the baby*). With some foresight they finish their piece by noting "school nurses and health visitors must expect to compete with other professions for the important public health task of the next decade" (p. 406).

Yet from *Health Visiting Matters* (UKPHA, 2009b) comes a tone and belief that concerns for the survival of health visiting is largely misplaced for despite …*the constantly shifting sands of political and organisational influences*, *Health Visitors today are alive to the challenges that confront public health* (p. 2). The document begins by stating that health visitors today

> *…might appear to have lost the edge and determination essential to tackling health inequalities within the context of the social determinants of health. However, even a cursory glance at this report will scotch such an impression.* (Foreword, p. 2)

The response of the government to *Facing the future* (DoH, 2007b) acknowledges the issue and concern that the range of roles, activities and intensive programmes expected of health visiting *…may be decisive and undermine the generic role of health visitors* (p. 19). They state that *…society today is too complex for one role to be effective in delivering a population based universal service at the same time as doing intensive work with individual high needs families* (p. 19). From their perspective such a range of expected activities, along with the integration of services would require, and result in, new career paths and educational preparation for health visitors.

The government response highlights how the *…contribution of health visitors and their teams* [remains] *central to meeting the government's aspirations for all children and families* (p. 7), particularly in meeting their aspirations for all children and families set out in Public Sector Agreement (PSA) 18 ('To improve the health and wellbeing of children and young people') and PSA 12 ('Promote better health and wellbeing for all'). The government provides little detail around the specific activities or services connected with undertaking this role merely stating that,

> *…what services are needed to deliver these priorities* [will be decided by] *local commissioners* [who] *will want to consider the significant contribution that health visitors can make across a wide range of public and child health priorities.* (p. 7)

The second priority for health visiting envisaged by the government is that of a leadership role in the Child Health Promotion Programme, a role that needs to be clarified so as to *…ensure that this is a 'hands on' role not a managerial one* (p. 10). However the wider opportunities for leading and developing the profession is not considered yet literature shows that central to achieving a distinct professional specificity is the important requirement for effective professional leadership.

The need for stronger, enhanced leadership for health visitors (within and without the profession) emerges strongly from the voices of the participants. There are strong calls for the leadership of health visiting to be enhanced, embraced, be proactive and have a louder voice, for health visitors *…to become leaders again* (Jane) and *…embrace the scope for team leadership inherent in the new roles* (Lucy). The comments predominantly reflect a desired situation where *…the profession must develop confidence within its leaders (once they have been nurtured) to secure the unique role of health visiting* (Emma) and where *…skills in leadership could move the profession on if a louder voice is heard* (John). The words of Emma reflect a majority of the comment on this theme:

…there has been a notable lack of leadership to secure a health visiting strategy for the UK – there have been notable commentators but this has led the academic drive, rather than leading practice.

A sense of real energy emerges from the thoughts of some participants, *…we need to be able to be ready to say "we can do that" …especially when it comes to engaging proactive prevention with vulnerable groups* (Mary); *Skills in leadership could move the profession on if a louder voice is heard* (John). Many comments express ambition for health visiting to be an effective contributor and leader in the Child Health Promotion Programme (CHPP). They also express the belief that without leadership, from the profession itself, the service of health visiting will remain subject to *…poor leadership in trusts and SHA, keeping the profession with too many foci and being a jack-of-all trades …which as a defined profession renders health visiting significantly threatened* (Anne).

Health Visiting Matters (UKPHA, 2009b) considers in depth the importance of leadership to the profession and service of health visiting. One of the recommendations is for *…a focus of professional leadership in health visiting* (p. 4) and sufficient skilled leaders at all levels (local, regional, national). This is a theme that threads throughout the entire report, which highlights the existing parlous state of professional leadership for health visiting. However it also states that health visitors today *…are in the vanguard of leading the changes essential to reinvigorate and widen the scope and influence of the profession* (Foreword, p. 2).

b. The Agenda for change

The context for the government commissioned review of health visiting (detailed in Chapter 3) required the development of a vision for the future of health visiting, to *…sharpen, clarify and revitalise* the health visitors role (p. 4). Its final report, *Facing the future* (DoH, 2007a), made clear that the review was not about *…more health visitors doing the same job they have always done* (Foreword) but a firm endorsement for the role and meaning of the health visiting service to change. The word 'change' and its derivatives are used seventeen times in a relatively short thirty-page document. The tone, expectation, language and thrust of the review is for the role, purpose and expected outcomes of health visiting to be specified, clarified, reformed, sharpened, adapted, improved, redesigned in a new, proactive way – in essence to be 'revitalised' to match a rapidly changing world, technology, communication, health needs and services. Although the report acknowledges the "*important*" and often "*unseen work*" that health visitors were doing, that had "*gone unrecognised and*

therefore undervalued' (Foreword), the agenda for change is linked to the concerns that for some time health visiting

> *…had lost its focus, or rather, there seemed to be too many foci for anyone, even health visitors themselves, to be able to define what health visitors should be doing.* (Foreword)

The review clearly and discursively distinguishes between a 'present role' and a 'future role' for health visitors – both of which are ascribed distinctive characteristics and it is around these binary oppositions that the review is structured. Unusually, no third way is mentioned or proposed. The essence of the review is presented on page 29 of the document in a table/list entitled *Getting from here to there*, an explicit list of twenty '*Coming from'* and '*Going towards*' statements. The *Going towards* column reflects what the review considers the right and favoured way for health visiting to develop/proceed in contrast to the *Coming from* column e.g.:

<u>Getting from here to there (*Facing the future*, DoH, 2007a, p.29)</u>

Coming from	Going towards
'Cradle to grave'	Focus on young children and families
'Just in case', 'my caseload'', we've always done it this way'	Outcome focused, planned input, team player and community leader
One service provider with no competition	Commissioners contracting from new providers with competition
Universal health visitor	Entitlement to a universal children and families integrated preventative team
Individual or public health	Public health at both individual and population level
Stand alone health visitors	Part of integrated children's team in a range of settings
Community midwifery, health visiting and school nursing as separate services	Integrated child and family health service from conception to 19 years
Working largely with mothers	Engaging fathers as well

Health visiting of the 'present' appears mainly constructed through negative terminology. It is described as having …*lost its focus* (p.4) and the profession is described as being …*lost and under pressure* (p. 9). Parents too are described as …*concerned about access to health visitors and confused about what to expect from*

the service (p. 14). In contrast, the future role of health visiting is described in aspirational and positive terms and proposes a shift away from health visitor's traditional emphasis on building supportive relationships with clients toward a stronger emphasis on outcome-orientated service provision by multi-skilled teams. The document also reinforces the future role of health visitors being one that supports individuals to make lifestyle changes to improve their health rather than addressing wider environmental and social determinants.

There is encouragement for health visitors to see themselves less as individuals (with their own caseloads) and more as team players and leaders of multi-skilled teams. Two primary roles are identified for health visitors – leading and developing the potential Child Health Promotion Programme (*Child Health Promotion Programme Guide,* DoH, 2008a) and delivering intensive programmes for the most vulnerable children and families. The review also recommends additional areas of practice that health visitors can provide …*depending on local circumstances* (p. 7) (e.g. wider public health packages). The recommendations are provided in very general, broad-brush terms and statements with no specific detail. The future desired/described responsibilities of the primary role of a health visitor, e.g. build healthy communities, work in partnership, provide evidence-based programmes, promote child health (p.24), are also devoid of specifics. They are, however, evocative of the traditional, historic role of health visitors. The words and concept of 'progressive universalism' are however a new addition to the repertoire of language associated with health visiting. The review proposes the use of this concept to build a new service model for health visiting where their services

> …*should be individually tailored to need, providing different levels of support and provision according to levels of need and in a range of settings including the home when required.* (p. 24)

A service model where those with the greatest risks receive more intensive support may remind existing health visitors of the traditional model of 'targeted health visiting'. The important question 'How is such a model of practise positioned within the universal core health visiting service?' however is neither raised nor discussed**.**

In *The government response to Facing the Future* (DoH, 2007b) there is an admission that …*there is a lack of clarity about what progressive universalism means* (p. 18) yet the government professes support for this model of working where those …*with high risk and low protective factors receive more intensive support and those with lower levels of need receive a lighter touch appropriate to their needs* (p. 18)*.* They also

suggest that the Child Health Promotion Programme …*needs to move beyond being seen as a minimum* universal core to a model of progressive universalism (p. 18).

The health visiting review also offers the idea of a 'level of practice' for health visitors to work at and …*be responsible for* (DoH, 2007a, p. 7). This includes health visitors being responsible for …*the complex* [and] *the difficult things* (p. 7), which are defined as managing risk and decision making in conditions of complex need, vulnerability, uncertainty and accessing 'hard to reach' groups and individuals. *Health Visiting Matters* (UKPHA, 2009b) also suggests a similar approach to service delivery – one

> …*based on tiered interventions for families who are at low, medium or*
> *high risk, providing a basis for determining who within teams can carry*
> *out different levels of service delivery.* (p. 23)

Whilst acknowledging that for many generations health visitors have been a valued resource and a positive influence, the review document reiterates the need to describe a new role to ensure that health visitors are 'fit for the future' (*Facing the future,* DoH, 2007b, p. 9). Throughout the document health visiting is referred to as a profession – a profession that faces many challenges, according to the review, not least that of health visitors having an image …*of being defensive and resistant to change* (p. 14).

For the CPHVA the review of health visiting presented an ideal opportunity for it to consult with its members and undertake an in-depth examination of where health visiting sat currently within the NHS and how it should move forward into the twenty-first century and beyond. Its response to this consultation and the document *Facing the future* (DoH, 2007a) states "unequivocal" support for the need to renew the role of the health visitor for

> …no one can deny that health visiting has reached a crossroads and that
> there is a need for a catalyst to breathe new life into the profession.
> (Unite/CPHVA, 2007, p. 3)

The CPHVA response highlights the fact that the review alludes to the need for clarity and direction about the current and future role of health visitors for commissioners, health visitors and other professions, leaders and the public, "but fails to take the opportunity to provide it. Rather it leaves the reader to interpret the recommendations" (p. 6). Yet in the opinion of the government response (DoH, 2007b) the review of health visiting …*provides a clear direction for the profession that fits well with the*

government's aspirations (Foreword, p. 3) and …*describes a coherent and relevant future for health visitors* (p. 21).

IV. Disinvestment in health visitors and health visiting

One principal theme emerging from this study is concern at the extent of disinvestment and decline in the workforce and services of health visiting. For Anne, …*the general reduction in whole time equivalent HVs across trusts have led HVs to feel undermined and more crisis driven, thereby the Public Health remit has been eroded away …the profession* [reduced] *down to measurable components.* Rita describes the challenge for health visiting as …*struggling to overcome reductions in establishment following financial problems in PCOs,* [which] *will affect development of the role.*

The participants depict the voice of health visitors as "*diminished*" and "*powerless*" to influence the resourcing, workload and workforce decisions of others that are directly affecting health visiting. For Gill, …*the concern is that they* [health visitors] *may understand what their role should be but do not have the resources or autonomy to carry this out.* A sense emerges that although the *Facing the future* (DoH, 2007a) initiative acknowledged the value and contribution of health visiting their overall voice and autonomy had been reduced to one of dependence on others, particularly for the resourcing and/or commissioning of their services. The responses of the HVEs highlight the need not only for health visitors to understand and be able to define their role, practice and identity, but even more importantly that commissioners and providers of the their service are able to do so as well. Emma suggests that,

> …*the time is ripe for HVs to secure their identity within the area of supporting families with the recent development of the CHPP* [Child Health Promotion Programme]. *There is a clear and defined role for HVs, which could be picked up by commissioners and providers, but they are not legally bound to do so. It will be up to the HV profession itself to emphasise this and take the lead.*

The significance, and degree, of disinvestment in the health visiting workforce is given considerably more prominence within *Health Visiting Matters* (UKPHA, 2009b), …*during the life of the project, the workforce crisis has become the most central issue upon which all progress depends* (p. 5):

> *At the start of this project, health visiting was in significant decline, with staff numbers lower than at any time in the last 20 years* (p. 8) …*the health visiting workforce has contracted by 1, 355 since 2004 …health*

visiting workforce numbers are in freefall (p. 12) …*The workforce crisis in health visiting has escalated over the past five years* (p. 41).

The report remarks that although a key strength of health visiting has been its diversity and versatility to respond to the changing health needs and circumstances of children and families they admit …*that* [this strength] *has been somewhat circumscribed by reduction in staff numbers and resource availability in recent years* (p. 16). Such a situation the project members believe reduces the awareness of others to the potential breadth of the service and leaves little time for health visitors to address some of the wider social issues that can lie behind health inequalities, disadvantage and potential vulnerability.

V. The influence of health visitors on health visiting
It was of particular interest to me to explore what the participants of this study, all health visitors, felt about the influence of health visitors on health visiting. In stage 3 the questionnaire encouraged responses concerning this specific area of interest. In respect of the factor 'Individual health visitors' only 1 participant gave it a number 9; and 1 gave a number 8; 3 participants allocated a score of 1; and 4 others gave it a 4, 3 or 2. This gave this factor a position of being eighth in degree of influence in the table of fourteen factors. In response to the factor 'HV practice Innovation' came a similar pattern of response – only 1 participant scored the influence of this on health visiting as a number 9, the majority of responses indicated a degree of 5 or below. This places it in the position of being twelfth out of the possible fourteen influential factors.

Looking closely at the responses to both these factors reveals an interesting picture. For both Pam and Lucy influence occurred through local good practice and co-operation, yet for Pam there was …*little impact on wider policy/decision making*, and for Lucy there was …*insufficient dissemination.* In contrast Anne believed that …*some influential HVs are still around, but too few.* Jane supported the view that there were …*still some real champions,* but acknowledged that …*I don't know of many.* A similar outlook was echoed by Jean, …*there are some leaders, but not many.*

For Mary individual health visitors have …*high influence on both education and practice …but not always positively,* and John considered them …*influential on newcomers to profession.* However, for many other HVEs the influence of health visitors on health visiting is a matter of concern:

- *HVs have to have some influence over their identity, but many appear confused and demoralised and feel that they are losing autonomy* (Gill).
- *Disempowered with very little influence* (Katy).
- *Some HVs will lead change, others will just keep their heads down and keep on with the job and others will be frustrated and leave the profession taking their expertise with them* (Rita)*.
- *Most HVs so busy and overloaded have not had time to influence wider sphere of health visiting* (Emma).
- *Many* [health visitors] *worn out by current demands on role* (John).

The influence of health visitor practice innovation, although receiving a significantly low position in numerical degree of influence, received some positive comments. However, these were often qualified by further less positive comments. For Mary the influence was generally positive and for Pam it was …*desirable to highlight scope of practice to management.* Rita believed that health visitor innovation provided …*good models of practice.* Jane, Ruth, Jean and Emma shared similar beliefs: …*some excellent examples around the country but not enough to make an impact* (Ruth); …*small pockets of innovation have developed through UK - but not facilitated to share good practice* (Emma); …*I think there are real pockets of development for example in Warrington. Good in parts but not shared enough* (Jane); …t*his is going on (in some places) but there is a huge difficulty in getting it known* (Jean).

Some HVE comments suggested that innovation was difficult to achieve in a service where …*many HVs are demoralised* (Jane) and where …*most practitioners have been stifled by unwieldy caseloads and lack of resources* (Gill). For John health visitors …*should have influence to improve practice, but* suggests …*not much opportunity? Depends on dissemination and opportunity.* In the view of Anne,

> …*health visitors are currently lacking innovation ideas probably due to the profession failing often to attract the highest calibre of students.*

The project 'Health visiting matters' looked carefully at the factors diminishing the influence of health visiting on its own profession. For them the difficulties facing health visiting and the reduction of its voice was not only due to cut backs in service provision:

> …*career opportunities have also been truncated, with few senior posts or managers specifically responsible for health visiting services …*[and] *in many places practitioners are managed by individuals from a different*

background, or with a very wide brief, and no expertise in health visiting or child public health. (UKPHA, 2009b, p. 20)

Their report talks of …*the negative influence of authoritarian and directive approaches to management, which appear to prioritise organisational needs above the requirements of good health visiting practice* (p. 26). In their view such directive forms of managerialism inhibit the emergence of health visiting leaders and oppose the development of their good practice. For them the lack of positive health visiting leadership had had …*a direct impact on the form of* [health visiting] *service received by clients* (p. 25)*.* The report describes …*distressing examples* [of] *health visitors being expressly forbidden from using their skills in some places …without first gaining approval from a manager …*[and some mangers] *rejecting the professional knowledge and skills of health visitors in practice* (p. 25).

Health Visiting Matters generates -a vigorous use of language (and implied feeling) when discussing the impact of the present nursing regulatory principles and framework on the profession of health visiting. In their opinion the regulation of the profession by the Nursing and Midwifery Council (since 2002) has been a contributory factor in diminishing the influence of health visiting. For since then,

> …*health visiting ceased to be recognised as a profession in its own right, being regulated instead as a post-registration nursing qualification.* (UKPHA, 2009b, p. 44)

They express their conviction that,

> *The NMC is not legally empowered to regulate health visiting as an occupation; they are only charged and enabled to regulate nurses and midwives.* (p. 44)

Yet despite these concerns the project group, whilst looking closely at how to support both service provision and professional leadership in health visiting, talk about finding a notable degree of consensus within the profession, …*there is a very definite sense in which the health visiting profession knows what it needs to do*" (p. 23).

In The government response to Facing The Future (DoH, 2007b) a very differing view is adopted. Although referring to health visiting throughout the report as a profession, the government's position is clear:

> *Being a nurse gives health visitors legitimacy and credibility with the public as well as the skills and knowledge needed in child and family health promotion.* (p. 8)

The role of the health visitor is described regularly as being one part of an integrated range of nursing practitioners making up the children and families service and workforce. Although acknowledged as <u>key</u> practitioners they are not described as <u>unique</u> practitioners (my emphasis) within community based child and family public health services. The government asks the question '*Universal health visiting or universal child health services*?' (p. 19). For them this is an important distinction. The traditional 'generic' role of health visitors causes them concern:

> *Society today is too complex for one role to be effective in delivering a population based universal service at the same time as doing intensive work with individual high need families.* (p. 19)

Their plans for the development of health visiting are resolutely seen as occurring as part of the 'Modernising Nursing Careers' initiative with whom the government states its intention to …c*onsult on a post-registration framework that includes a proposed career pathway for 'children, family and public health'* (p. 22). The report states that building a

> *…confident, valued and appropriately trained [health visitor] workforce with a secure future also requires support from the profession, its leaders and the* [health visiting] *service* (p. 22) [and that] *most of the recommendations in Facing the Future are for the* [health visiting] *service and the profession to take forward* (p. 7).

Yet the very next sentence asserts that …*It is for local commissioners working with providers, both NHS and local authority, to decide how services should be provided, resourced and delivered* (p. 7). Such a verdict occurs also from the health visiting review, which finds that:

> *It is clear that the solution to the problems facing health visitors today does not necessarily lie in the profession but in the commissioning of child and family health services* (p. 21) …*the role will depend on what public health services are commissioned locally. (Facing the future,* DoH*, 2007a, p. 27)*

The positive influence of health visiting over the past decades on the health and well being of families and young children is consistently acknowledged throughout the commentary of the review findings, yet no discussion arises about the influence of health visiting on health visiting. Intriguingly at the start of the report it raises the very question being asked by many health visitors:

Throughout this review we have been faced with the question of why the profession seems lost and under pressure when the very issues where health visitors can make a positive difference have never had greater prominence in the public's mind and government policy. (*Facing the future*, DoH, 2007a, Introduction, p. 9)

VI. The nature and degree of other factors influencing health visiting

a. Government influence on the professional identity of health visiting

In the opinion of the HVEs, the factor 'Government policy, Reviews, actions, activities' was considered to be the second greatest recent influence on health visiting. Out of the twelve participants in Stage 3, three HVEs allocated this factor a number of 10, and a number 10, 9 or 8 was given by a total of eight participants.

The overwhelming view from the participants was …*the significant impact* [of this factor] *on the direction of the* [health visiting] *profession* (Lucy). The findings offer a general agreement that …*policies and reviews highly influence practice and the development of practice actions and activities* (Katy). Yet it is felt that these …*often cause challenges for health visiting* [as] …*often there is no sense of public health rhetoric …and lack of joined-up working across government sectors …and NHS continues to be target driven* (Rita)*.* Several voices support the opinion of Katy that often this amounts only to …*usual government rhetoric in that no money follows policy directions for HV.*

For John, government actions …*can have positive and negative influence, many changes lately and some policies sideline the HV workforce.* For some this sidelining of health visitors and health visiting has occurred …*indirectly by developing family support roles in other agencies and directly by recent reviews* (Emma). The words of the participants carry a sense of health visitors being …*barely mentioned, forgotten, 'airbrushed out'* (Jean) from government circles. For Anne …*government policy is one of social inclusion etc., but all too often failing to identify the HV role in this.* For some HVEs the words of Ruth echo their view that,

…Government over the last decade has been on a mission to reduce the power of professions. One way of doing this is to streamline regulatory bodies and their registers. This is what they have done and as a consequence let health visiting be deregulated.

For some participants, the review of the role of the health visitor (DoH, 2007a) represents an encouraging and positive attention, yet for others it merely signifies

another …*prescriptive model focused on high-risk families; progressive universalism …yet another way of working that is not fundamentally different* (Jane).

The government response to Facing the Future (DoH, 2007b) welcomes and endorses the findings of the health visiting review as,

> *…it provides a clear direction for the profession that fits well with the government's aspirations and, at the same time makes important links between national policy and professional practice.* (Foreword, p. 3)

Yet the governmental methods, means and influence for achieving such aspirations is not at all clearly articulated, particularly as the response states that *…most of the recommendations in Facing the Future are for the* [health] *service and the profession* [of health visiting] *to take forward.* (p. 7)

Health Visiting Matters (UKPHA, 2009b) acknowledges that the project …*would not have been possible without support from the Department of Health, who have also contributed in an advisory capacity* (p. 2). The report use words such as "*crisis*" and "*major decline*" regularly in relation to the cut backs in health visiting provision, service, training, career opportunities and development yet any direct criticism of government activity is muted. A reference though is made to the …c*oncerted effort to refute any suggestion of government ambivalence about the value of health visiting services* (p. 21) from the Department of Health.

Health Visiting Matters (UKPHA, 2009b) highlights governmental influence in diminishing the discourse around professional 'titles'. Citing government guidance (*The NHS in England: The Operating framework for 2009/10*, DoH, 2008d), it highlights the government requirement for services to be commissioned according to their target purpose, rather than by the title of professionals delivering them,

> *…with health visiting being given as an example of one service that will be affected by this change* (p.14) *…*[as a] *form of provision that would need to form one part of a 'portfolio of services' to be commissioned in future* (p. 21).

A point that is made clearly in *The government response to Facing the Future*:

> *Services are* [to be] *commissioned and organised around a care group or pathway, rather than the title of the profession delivering the service.* (2007b, DoH, p. 19)

Interestingly the factor 'Government publications' received within Stage 3 a smaller number of 10s, 9s or 8s (x 3) (than the factor 'Government policy, reviews, actions,

activities'), but a significant number of 7s (x6) indicating a noteworthy and important, if not high, influence in respect of health visiting, giving it overall a seventh position of influence.

Several HVEs commented on the …*raft* of *directive* publications forthcoming from government. For some the focus of these were predominantly on ...*costs rather than evidence* (Anne) and constituted …*a lot of guidance, but little actual resource or investment allocated* (Emma). In the words of Ruth:

> *Political drives to increase public health activity on the cheap, targeted money short term to demonstrate quick fixes, have all impacted on the view of the value of health visiting… Proposed development of new roles, which are less expensive than the employment of a qualified, registered health visitor in delivering public health activity to families and children.*

One theme mentioned by several HVEs is that of the governments' determined policy agenda to achieve more integrated, partnership and skill mix working across and within state funded organisations. Certain HVEs viewed this as a double-edged sword with the outcomes of such partnership working as causes for concern:

- *rather than re-emphasising the importance of health visiting, …there has been greater investment in other agencies (such as local authority)* (Emma);
- *most often it is the most disadvantaged ones* [PCTs] *who seem to be reducing HV numbers in preference for N/nurses* [nursery nurses] (Anne);
- *resources have reduced the capability of HV to carry out their role appropriately and has led to an inappropriate skill mix* (Gill);
- [local authorities] *sometimes taking on roles previously associated with HVs* (Rita);
- [In relation to the issue of leading and managing skill mix within health visiting teams] …*this is in a state of flux – I think there has been a great deal of confusion in relation to the identity of HVs that has become undifferentiated in many ways from other community nurses, children's centres, public health workers* (Jane).
- [commissioning bodies] *will go for the cheapest option that offers safe practice* (Ruth).

Yet Ruth also expresses her view that,

> …*children's services are focused around those with the greatest need, and skill mix teams manage these much more efficiently than health visitors working in isolation.*

b. The influence of Strategic Health Authorities (SHAs)

The factor 'Strategic Health Authority decisions, actions/activities' was considered by the HVEs in Stage 3 to share the position of having the second highest influence on health visiting (along with the factor 'Government policy, Reviews, actions/activities'). Three principal themes emerged in relation to the impact of such SHA decision-making which were:

i) The reduction in monies/investment for the training of new health visitors. This is mentioned by 10 of the HVEs and the following quotes encapsulate their various feelings and opinions:

- *Dramatic effect* [of SHAs] *on availability of funds for training* (John);
- *The cuts in training over the last few years… has now made recruitment in some areas really difficult* (Gill);
- *Influence of their actions and activities huge as they hold all the purse strings and have put HV in a hole vis-à-vis no money in training, so no HVs trained and now too many posts unable to be filled* (Katy).

ii) The health visiting workforce:

- [SHAs] *need to be more supportive to the delivery of public health rather than traditional roles* (Pam);
- *SHA often failing to understand what is going on in trusts and failing to see the bigger picture* (Anne);
- *Because they can only do what the government want, they have their hands tied. If the drive from the centre is for more nurses and less health visitors because they are seen as an expensive luxury, they will reduce the numbers they send on* [training] *programmes* (Ruth);
- *HV workforce strategies are severely affected when funding is restricted. Because results from public health and HV are often long term, they do not suit the target mentality* (Rita).

iii) The influence of health visiting on SHA decisions:

- *HVs hardly mentioned, HVs have or feel they have no influence here* (Jean);
- *Evidence of the measurement of the success of health visitor interventions is limited so it's difficult for them to support health visiting* (Ruth).

For such an influential factor receiving such a vociferous response from the participants, it is interesting that the role of SHAs and the decisions that they make

receive little direct consideration in any of the three key texts being examined for this chapter. Even in *The government response to Facing the Future* (DoH, 2007b) SHAs are referred to only briefly, under the heading 'Reductions in training' (p. 17). They do also feature in the final section of the document 'Taking *Facing the Future* Forward' where the government lists one of its future actions being:

> *To work with Strategic Health Authority workforce and nursing leads to remind them of the importance of the health visitor workforce and the need to increase capacity in deprived communities.* (p. 22)

c. The influence of those providing, organising and/or managing health visiting

From the HVEs the factor 'Organisation and/or management of health visiting' achieved a significant number of 10s, 9s + 8s (x 7) – thus being the fourth most influential factor numerically. This element can be linked with the factor 'Provider Primary Care Organisations' which emerged as the fifth most influential factor numerically (number of 10s, 9s + 8s x 6) in Stage 3 of the study.

The cluster of responses generated from these factors produced some of the most strident comments. Those managing and organising health visitors in practice were shown to adopt a variety, and inconsistency, of approaches and responses, …[they]*can be developmental, or restrictive – can encourage wider role or perpetuate older models of health visiting* (John). In the view of the majority of the HVEs managers of health visitors/health visiting services appeared confused and uncertain about how to respond to the multiplicity of governmental, budgetary, consumer, and health visiting service needs. For some of them there was …*little evidence that* [managers] *raise profile of health visiting profession* (Pam). Generally the management of health visitors was viewed as a cause for concern. The words "*very poor*" and "*very top heavy*" were used to describe organisational structures that appear to have a …*high influence on practice* (Mary), but whose …*weaknesses and strengths influence HV services in terms of demanding resources and establishment* (Rita). For Katy these structures tended to …*conform to* [an] *organizational culture …which is not usually supportive of* [health visiting] *practice and doesn't lead to innovative solutions and practice.* In Jane's opinion the management and organisation of health visiting …was *very poor, I am not sure who the leaders are anymore …can be very influential but is become target driven and primarily about cost containment*

Some recognition is shown for the fact that …*continuing reorganisation of management structures have caused more problems* (Gill), which has resulted in health visitors being …*often led by managers with little experience or expertise* (Katy).

An impression is gained of the difficult position some mangers of health visitors find themselves in, …*HV managers, like HVs, have low morale and come across as passive, just responding* (Jean).

A landscape of managers and provider organisations disinvesting in health visitors/heath visiting is reflected in the comments of the participants. From the outlook of many of them these elements are inclined to …s*ee HV as a luxury commodity rather than a vital part of the staff organisation* (Anne), and more …*overtly clinical services take the priority* (Jean).

One HVE, however, had a distinctly different message. Although indicating the influence of the management and organisation of health visiting to be 9 out of 10, for her …*health visiting has been too precious about itself and slow in integrating and developing its service to meet the modernisation agenda. In part this has influenced its demise* (Ruth).

In the view of some in the study, the …*PCTs have had their hands tied and influence has been directed by SHA* (Emma), yet in the opinion of others they have had …*complete control over finance and practice* (Katy). For Ruth this factor had been,

> …*key in some parts of the country for the demise of health visiting …reasons driven by reduced funding, bailing out acute hospital trusts and guidance on modernising the NHS in order to reduce targets like waiting lists for surgery. Health visitors are seen as costly extras in this agenda.*

These exchanges reveal little trust between HVs/HVEs, and those in charge of organising and managing health visiting.

Such strong views appear supported by the words, and concerns of the CPHVA in their joint briefing paper for Members of Parliament (Amicus/CPHVA, 2006). The concern expressed was that in the current era of financial NHS reforms a properly resourced and delivered health visiting service would be dependent upon commissioners <u>understanding</u> (their emphasis) the role and potential impact that such a service could make to improving the health and wellbeing of children, families and communities.

Health Visiting Matters (UKPHA, 2009b) looked in depth at the future/potential employer (including management and organisational) options for health visitors. In their view "*What should a key provider of health visiting service look like*" (p. 35) is the 'crunch question':

At present, health visiting is located within the NHS and in the nursing workforce, but neither has a strong track record of championing the needs of health visiting service users or health visitors (p. 33) …[as the NHS] is *essentially focused on clinical conditions and a medical model, which does not fit well with the more social and preventive models of health embraced by health visiting* (p. 35) …[and] *because* [health visitor] *numbers are comparatively low, so issues get lost within the wider nursing workforce* (p. 47).

In essence their conclusion is that,

…the initial responsibility for securing suitable services lies with commissioners, and for delivering safe and effective provision lies with the profession, but there is, arguably, a need for employers and provider organisations that would prioritise securing commissions and providing high quality health visiting services as a major priority. (p. 33)

d. The influence of NHS Commissioning bodies

The factor 'Commissioning bodies' was placed sixth in the degree of influence on health visiting by the HVEs in Stage 3. Interestingly nine HVEs allocated a numerical degree of influence (10 x 1; 9 x 3; 7 x 3; 6 x 1; 5 x 1) but three of their number indicated "NA" (not applicable). A working definition of the concept and meaning of 'commissioning' is provided in the Glossary.

The HVE responses confer a sense of uncertainty and confusion regarding this factor, *…not sure that commissioners are yet fully familiar with health visiting – but they could soon have a greater impact* (Emma). For Rita, commissioning had …*some degree* [of influence] *but expect to rise once commissioning becomes more active.* From Jean, *…HVs* [were] *unclear about how to influence the commissioning process,* whilst others considered it …*too early to make a judgement* (Ruth).

A general impression of the lack of influence of health visiting on the commissioning process pervaded the responses, but also anticipation of the potential considerable significance for health visiting services in the future which some felt could be to the detriment of the health visiting role and service, for …*this could be provided by any public company employing child experts, does not need someone with an SCPHN qualification …they will go for the cheapest option* (Ruth), with *…purchasing decisions affecting how much CHPP will be sought* (Jane). There is comment from several HVEs on the …*lack of commissioning of preventative services* (Jane)*.*

The views offered suggest that the ownership of, and articulation around, commissioning has yet to become a day-to-day reality for members of the profession of health visiting. Yet for those working at a more strategic NHS level, the concept, processes and outcomes of commissioning appears very much at the forefront of their thoughts and decision making.

Within *Facing the future* (DoH, 2007a) is a recurring and prominent theme – that of creating, building, and strengthening the relationship between commissioners/commissioning and the purpose, role and service of health visiting. Such a relationship is described as an important matter for the future of health visiting. The words 'commissioner' and 'commissioning' feature strongly in the report (on pages 5, 7, 8, 9,10,12,13,15,16, 21, 24, 27, 28, 29, 30, 31 and 33). 'Commissioning' is even allocated its own specific final recommendation, this being that …*Commissioners should commission early intervention, preventive and health promotion services for all young children and families* (p. 21). No details or specifics are provided, however, on how this should be operationalised or achieved.

Whilst exploring the commissioning of health visiting services the review members acknowledge that they had been struck by the national, regional and PCT variation in the nature and extent of - the health visiting service offered to users; the level of available resources for the service; and the quality of health visiting leadership. In their view the governmental rhetoric on health prevention, inequalities and children was welcome but …*this was not being translated into action, with reality being dominated by short term acute commissioning decisions* (p. 16). The report states its intention not to tell the health visiting service what to do, nor make recommendations on numbers and resources, but to describe a role that the health visiting profession needs to implement. Yet it does admit that …*showing the way is not enough to make it happen* (p. 30) and may require the …*strengthening* (p. 10) of the decisions and actions of certain others:

> *It is clear that the solution to the problems facing health visitors today does not necessarily lie in the profession but in the commissioning of child and family health services.* (p. 21) …T*he role* [of health visiting] *will depend on what public health services are commissioned locally.* (p. 27)

For *The government response to Facing the Future* (DoH, 2007b) …*effective commissioning is the key mechanism for developing the services provided by health visitors* (p. 14). The report is clear that …*Commissioners should commission early intervention, preventive and health promotion services for all young children and*

families (p. 9), yet there is no specification of which type of practitioner(s) should be commissioned to undertake these services.

For *Health Visiting Matters* (UKPHA, 2009b) the promotion and maintenance of health visiting professional specificity is closely linked to the issue of commissioning, for health visiting as a service

> *…needs to be commissioned specifically as one part of services for children, young people and their families …this offers an important opportunity to expand and reclaim the place of health visiting services as a key part of a multi-disciplinary, multi-agency service.* (p. 18)

It is their view that the commissioning of health visiting services has been negatively impacted by recurring governmental commissioning advice that services be commissioned according to target purpose and not by the title of professionals delivering them (as previously discussed in this Chapter). The report also suggests that service commissioners do not always make the link between policy needs for certain kinds of activities and the activities in which health visitors can engage in and contribute to. It is their belief that,

> *…in each Trust, with each annual commissioning round, someone needs to explain to commissioners how and why health visiting provision justifies the funding required. This is not an easy task.* (p. 20)

Here, the report suggests …*it would help to have a designated local health visiting leader with a role to support and inform the commissioning process* (p. 18).

VII. The influence of the Community Practitioners' and Health Visitors' Association (CPHVA)

The findings in respect of the factor 'CPHVA influence and/or activities' present a mixed picture. The CPHVA was rated numerically only ninth in influence yet it is the key professional union for health visiting. The opinions expressed concerning the CPHVA were at times censorious and disappointed, …*don't think they shout loud enough* (Jane)*, …too little too late. They are not very powerful in the scheme of things. They were silent when health visiting was being deregulated* (Ruth). From some HVEs came the views that …*the strength of this group has diminished over time* (Emma), and that …*much of their work seems to be preaching to the converted* (Jean).

Its affiliation with the larger union Unite prompted thoughts from several HVEs. From Jane there was concern that the CPHVA might now be …*too closely aligned to union business rather than profession's needs,* with the influence of the CPHVA diminished

…*notably when absorbed into Amicus/Unite* [Emma]. For Jean, …*the local network of CPHVA branches, never strong in East Anglia, seems to have largely disappeared,* yet the influence of the CPHVA …*seems to have improved at national level in the past two years.* From Gill there was more of a mixed message, …*there has been some positive influences on the media and to a certain extent government but* [CPHVA] *has not really influenced at ground level.*

Other comments signal a more positive and important role for the CPHVA, particularly in …*raising awareness of scope of professional practice* [and] …*dissemination of good practice* (Pam). Katy considered the CPHVA

> …*very supportive of practice. Works very hard and is just about the only source that supports practitioners and client perspectives. Offers opportunities for the voice of practitioners to go forward.*

Some opinions are, however, more critical …*but they have to recognise that they have been responsible for the demise of HV as a profession in the first place* (Katy)*.* There appears a yearning for the CPHVA to …*provide a professional voice that will strengthen HV identity* (John) and …*be more radical in its condemnation of trusts etc.* (Anne). As well as provide the …*opportunity to bring HVs together for development and action* (Rita).

Within the narrative of *Facing the future* (DoH, 2007a) the participation of "*professional bodies*" to the Health Visiting Review Group is mentioned briefly (p. 13). Two senior members of Amicus/CPHVA and one senior member of UNISON are listed in the membership list (p. 34). Otherwise no specific mention is made of any involvement or importance for such bodies in the future of health visiting. One of the report's recurring and main messages is that of the variety of …*levers for change* [for health visiting], that reside at every level and with many individuals and organisations. These 'levers' are described as having …*an equally important role to play*, and are listed as commissioners, providers, the profession, educationalists, …*and the regulatory body* (p. 30). There is no mention of professional bodies.

Similarly within *The government response to Facing the Future* (DoH, 2007b) the only mention of professional bodies related to health visiting occurs in one sentence in its Introduction, …w*e welcome CPHVA/UNITE's support for the majority of the review's recommendations and have taken account of their comments and concerns* (p. 5).

The report on the project 'Health Visiting Matters' (UKPHA, 2009b) acknowledges the attendance of the CPHVA at one of their key workshops, but no members of the organisation feature in the names listed in the main working groups. However the CPHVA interest and activity in developing a funding model specifically designed to guide and support the commissioning of health visiting services is acknowledged (p. 14) and linked with one of the project's key areas of interest - the need to establish secure funding for the health visiting service.

VIII. The influence of the public and consumer opinion

The HVEs gave the factor 'Public/consumer opinion' a variety of written and numerical responses. The numerical degree of influence given by them ranged between number 9 (high degree of influence) and number 1 (low degree of influence). The majority of responses gave a number of only four or below (x 6 participants), and three HVEs did not allocate any score, thus giving this factor a position of thirteenth (out of fourteen) in degree of influence.

In the opinion of Jane the influence of the public/consumer opinion was …*missing from HV practice,* and Emma considered it …*not particularly strong.* For Rita public and consumer opinion had …*not much influence at this time.* However several HVEs commented that the influence of the consumer on health visiting depended on …*the individual consumer experience of the health visiting service* (John), or …*upon* [type of] *community, i.e. Sure Start area very influential in my experience* (Mary). The influence also appeared subject to other factors, …*in the more privileged areas often the service is revived due to public demand* [Anne], *unfortunately although public opinion of HVs is very positive* – resources *do not follow* (Gill).

In general such influence was thought to be …*becoming stronger …*[yet with] *some opinion positive, some negative* (John). Other responses suggested that …*a relatively positive opinion of consumer groups/public supports HVs in their everyday work* (Pam). Jean considered that public and consumer influence …*seems more in evidence with increase in material from Netmums and similar, but families will not value what they have never had, a good HV service.* Netmums was also mentioned by Katy who felt that they …*have been very good promoting HV and engaging the media.*

The review of health visiting (DoH, 2007a) included in its Working Group four (out of thirty four) members from consumer groups i.e. Parentline Plus, One Plus One, Netmums and the National Children's Bureau. However neither consumers and/or the

public are mentioned in the context of being one of the necessary 'levers for change' in the reform of the existing health visiting service.

One of the priorities highlighted by the review for a future health visiting service is …*supporting the capacity for better parenting* (p. 6). It is interesting to note that the important interface between health visitors and their clients, particularly the building and maintenance of effective relationships, receives little deliberation. More attention is given to relating the bio-medical aspects of child development (genes, bio-chemistry, early neurological development) on infants and their impact on the ability of children to attach with, and to, their parents.

The government response to Facing the Future (DoH, 2007b) makes little reference to consumers or public opinion. It does not mention the creation of channels of communication with them or seeking or listening to their views. In the final section, 'Outstanding Issues', fathers receive a particular mention, …*the government wishes to see services engaging and supporting fathers as this benefits children, mothers and fathers* [which] …*requires a cultural change for child health services and health visiting* (p. 18).

Within *Health Visiting Matters* (UKPHA, 2009b) a particular example of consumer interest and influence on health visiting is cited as the endorsement of groups such as the Family and Parenting Institute (Gimson, 2007) and Netmums (Russell, 2008) for the term 'health visiting' as a "*trusted brand*" (p. 12). The report highlights how such groups have led the calls to reverse the reduction in health visiting services and the claim that …p*arents using the* [health visiting] *service do not want alternative titles, such as the new official regulatory term of 'Specialist Community Public Health Nursing'* (p. 12).

Health Visiting Matters also poses the question '*who should decide suitable criteria for evaluating the appropriateness of a service*? (UKPHA, 2009b, p. 20) and responds by saying,

> …*surely this needs to be the people who most understand it: that is, health visitors themselves, in conjunction with service users*, *whose voices are heard far too little in commissioning.* (p. 20)

They acknowledge that strengthening the voice of service users is an important but not easy task, but consider it …*an essential part of public service governance* (p. 20).

IX. Other factors influencing the current professional identity of health visiting

Two factors stimulated a muted response from the HVEs in Stage 3 and were indicated as having some of the least influence on health visiting, they were the factors 'Organisations external to health care' and 'Individual GP practices'.

'Organisations external to health care (e.g. LA's [local authorities], other Agencies etc.)' received the position of eleventh in the table of degree of influence. The numerical allocations were mixed, with six HVEs giving this factor a number 4 or less, however three gave a number of 7 or 8. The majority of written answers gave a sense that the influence of this factor on health visiting was uncertain yet at times of concern.

The factor 'Individual GP practices' achieved the position of being fourteenth in the table of degree of influence on health visiting, making it (in the opinion of the HVEs) the least influential on health visiting. Indeed two respondents thought this factor 'not applicable'. Five HVEs gave this element a numerical degree of 5 or below with two adding the word "*minimal*". Two HVEs, however, gave this factor a 7, although one added the words, …*as HVs move out of practices, influence may diminish* (Rita). The words of the participants indicated quite mixed and variable feelings about this factor.

Several participants thought that the influence of this factor depended upon certain aspects of the local health visiting service e.g. …*depends upon on area and case load management and allocation* (Mary), and characteristics of the GP practice, …*depends on the culture of the GP practice and on geographical location* (John). For many participants the move of health visiting …*to corporate and geographical working* (Gill) (i.e. central teams led by health visitors prioritising and delegating the requirements of the day-to-day service), and away from 'attachment' to GPs, had significantly reduced the influence and significance of GPs on health visiting - …*as more areas move to corporate and geographical caseloads the influence is becoming less* (Gill). Yet in Jean's opinion, …r*eduction of GP attachment has made this less significant but the GP role in commissioning could be important, but GPs are not campaigning for HVs.*

The health visiting review (DoH, 2007a) raises the question, *What relationship should health visitors have with general practice and practice based commissioners*? (p. 16). Their final conclusion is that any decision regarding the location of health visitors in the future …*will need to be flexible*, …[and] *should be determined locally* (p. 28).

Within the questionnaire of Stage 3 the opportunity was provided for HVEs to add any different, extra factors that they considered might be currently influencing health

visiting. Three HVEs added comments to this section. For Jean the recently emerging, and supportive, comments of David Cameron (leader of the Conservative party) towards health visiting left her speculating whether this could be significant for the future of the profession, …*I am left wondering if this is real commitment or political point scoring. However it does raise the profile of health visiting.* Gill wrote of the rising public concern over the protection of children and how it …*may be responded to positively by an increase in HVs, …underlining their significant role in safeguarding.* Rising public interest in health visiting is also mentioned by Emma who cites Netmums as an example of …*an 'independent' agency pro health visiting. Getting more pr-active - involving HVs to give advice to mums.*

Section 2 – Analysis and interpretation of data

Within section 1 I have tried to restrict myself to conveying central 'themes' so as to allow readers to discern my 'hand' in analysing, interpreting and commenting on them in this section. To do so, I draw on theorists, discourse analysts and literature on health visiting and have incorporated their perspectives into my argument. This section is structured around the central issues arising from the previous section: change of title and status; SCPHN education programmes; relationship with Nursing and influence of the NMC; the influence of various bodies/organisations like the government, SHAs, managers of health visitors/health visiting, NHS Commissioners, the CPHVA and public opinion.

I. The change of title and registration status for health visiting

This study highlights the impact that organisational and regulatory restructuring can have on professional identity. The change in title 'health visitor' to that of a 'specialist community public health nurse' is felt keenly by many members of this study and it is the theme that has generated the greatest degree of emotive and powerful language. Comments at times have been vociferous and demonstrative of considerable strength of feeling, including anger. Their words have established the strength and importance for the use of certain language and titles. Their 'voices' indicate how significant a role language plays in shaping realities, and how discourses can equal representations, constituted by and operating through language and other symbolic systems (Burr, 2003).

In the view of all of the participants of this study, the most significant influence on health visiting in recent times has been the loss of its unique professional, and historical specificity. Such change they directly relate to the creation of the new Nursing and Midwifery Council in 2002 and its regulatory framework and register, particularly the creation of its SCPHN element and the loss of its unique title (health visitor), individual registration status and distinct public health position within nursing.

However, the findings also show that amongst health visitors, consumers, the public, health bodies and government circles, the use of the title 'health visitor' remains largely unchanged. Likewise the perceived role and identity of what it means to be a health visitor. By 2007 the terms 'health visitor' and 'health visiting' began to return into official use again within the government-funded reviews (DoH, 2007a, 2007b). The reasoning for this is unclear and unstated, but may have been prompted by the activities of consumer groups such as the Family and Parenting Institute and Netmums, which heartily endorsed the use of the terms as a trusted brand.

Yet the government's response to the health visiting review (DoH, 2007b) strongly indicates its belief that titles can be a barrier to modernising and creating a more effective health service. For them it is important that NHS services should be commissioned …*around a care group or pathway, rather than the title of the profession* (p. 19). *Health Visiting Matters* (2009b), however, contests this view. Its project members are deeply critical of the attempt to change the name of 'health visitor':

> *The start of this collapse* [in the health visiting workforce and] *in service provision coincided with a period when use of the term 'health visiting' had been quite controversial, as a result of regulatory changes that removed the profession (and the health visiting title) from statute in 2001. However, the term began to come back into official use with the independent Review of Health Visiting…* (p. 12).

In the view of the majority of HVEs, many health visitors in day-to-day practice seem unclear, or even ignorant, of the required changes to their role and identity as SCPHNs. It would also seem that even those health visitors, who are acknowledged as recognising the evolution of their role, appear to be struggling to convince their employers of the need and the resources to achieve this wider community public health role. For health visitors in practice it looks as if the influence of their employment organisation and the commissioners of their service is greater than that of their own professional and regulatory organisation.

The findings of this study display a sense of regret that health visiting's historically unique public health position within nursing is now one that is shared with other types of nurses. Even though some voices have spoken of their previous (to SCPHN) identity as one often considered marginal, invisible and lacking in influence within the larger constellation of nursing, many of them also felt that such a position did at least acknowledge their professional specificity and uniqueness.

The strong opinions evidenced within these findings of the importance of names and titles offers support for Allan Luke's (1995) proposition that life in the twenty-first century will be more of a 'text saturated' condition than ever. For him many of the new social conflicts will be about representation and subjectivity – "they involve how one is named, positioned, desired and described and in which language, texts and terms of reference" (p.5). As Wodak suggests, language is not just powerful on its own – "it gains power by the use powerful people make of it" (2001, p. 10). How language is used or functions in constituting and transmitting knowledge, and in organising social institutions or exercising power, can be witnessed in the power of institutions (such as

the NMC and nursing division of the Department of Health). Such institutions have the power to "create that which it seems simply to describe" (MacLure, 2003, p. 4) and establish "what kind of person one is entitled/obliged to be" (MacLure, 2003, p.176). From the voices of the participants can be seen how the discursive and the real are always entangled through a "discursive literacy" – i.e. the rhetorical fabric out of which institutions are built (MacLure, 2003, p. 5).

Such rhetorical fabric consists also of the commentary from others within the nursing community. During my period of study I regularly searched for comment, articles or debate concerning my topic area from the wider nursing community. I found little published discussion or comment on the new role, title and regulatory status for health visitors as SCPHNs, examples of some now follow.

Long reflected on the changes to the NMC register when he asked *'When is a nurse not a nurse?'* (2005). He considered the 'new' status for health visiting within the new NMC register (as part of the SCPHN umbrella) "contradictory and illogical" (p. 437). He pointed to the fact that since its inception in 1983, the UKCC had held health visiting to be a distinct and separate profession from both nursing and midwifery and that the title 'health visitor' appeared well established for over a century. He points out that no organisation had previously sought to modify it, even though the role and practice of health visiting had been an enduring topic for debate. He notes that since the demise of the UKCC (in 2001), there had been a noticeable change in terminology: "we no longer refer to nurses, midwives and health visitors, simply to nurses and midwives. This seems to reinforce the notion that there are only two relevant professions, not three" (p. 438).

For Brocklehurst, writing in 2004, these changes were quite extraordinary, for although titles are accepted as an important means of carving out a professional territory, this change appeared to have generated little discussion. For others, however, such territorialism around titles, in the prevailing climate of joined-up health care and integrated working (DoH, 1997), is viewed as 'unhelpful' and antithetical to a modern 'client'-led service. Practice nurse Amber Kelly asked *'What's in a name?'* (2004) in her exploration of nursing roles and names. She concludes that it is the *origins* of the plethora of nursing titles that are dear to the hearts of many nurses. She writes:

> Juliet famously asked: 'What's in a name? That which we call a 'rose' by
> any other name would smell as sweet' (Shakespeare, 2.2.43-45). Not so
> in nursing, where it would seem that names really matter. (p. 224)

For Long (2005) the replacing of the title 'health visitor' for 'Specialist Community Public Health Nurse' leads only to confusion and lack of clarity, particularly for the general public. Such a situation strikes him as ironic and "simply unfathomable"   (p. 437), as the whole review of the NMC regulatory framework was "allegedly intended to simplify the existing complication of the professional register" (p. 438). Yet from the perspective of Williams (2004, former NMC Officer) the loss of health visiting's title is the price it has had to pay for becoming the rightful leader of public health delivery. However she acknowledges that the new title has produced,

> …some angst among the health visiting profession, given that one government document could effectively 'airbrush' out a whole profession. One wonders what would have happened if they had tried to do that to midwifery? (p. 326)

The strength of the participants' feeling around this issue raises many questions - Is the aspiration and maintenance of an identified (titled) professional identity a means of retaining power and status through ownership over a specific knowledge and expertise? Is this vital to carving out a boundary around knowledge, i.e. protecting their turf/territory? Is professional identity constructed not just in relation to the nature of that knowledge but also in relation to its interpretation and translation into expertise?

II. Specialist Community Public Health Nursing (SCPHN) educational programmes

It is clear from the findings that the regulatory changes created by the NMC (and establishment of the SCPHN) have significantly impacted upon those required to develop and deliver the new training programmes for these new practitioners. From a comparison and analysis of the views of HVEs, stage 1 respondents, and the differing views of the government, and the two different kinds reviews, i.e. *Facing the future*, *The government response to Facing the Future*, and *Health Visiting Matters*, it is evident that each of these parties brings their own perspective to the issue of training and education. In the following pages, I will juxtapose these differing views so that the full strength of the dissimiliarities and occasional overlaps between these parties can be understood.

The HEIs involved with educational programmes have been at the forefront of creating this new SCPHN practitioner. From their comments can be distinguished a significant and conscientious professional commitment to the commands of their regulatory body. The standards of proficiency for SCPHNs (NMC, 2004b) can be clearly seen to be

fundamental to the content and delivery of the SCPHN programmes. The HVEs recognise the increased emphasis and requirement within the programmes for SCPHNs to adopt more of a leadership role within community child health services, and the obligation of SCPHNs to lead and manage multi-skilled teams. They acknowledge the NMC/SCPHN requirement for an enhanced public health role yet also perceive a dissonance between programme content and the realities of day-to-day health visitor practice. They are witnessing what appears to be a consequential mismatch between how SCPHN students view the role and identity of what a SCPHN/health visitor means and does (as perceived by the NMC), and that perceived and enacted by existing health visitors in practice, some of whom will be supervising and assessing the practice of students as practice teachers.

This issue is also raised by the review of health visiting (*Facing the future*, DoH, 2007a). Perhaps one important reason for this, highlighted within these findings, lies in the generic nature of the SCPHN programme, whose content, outcome qualification and title is shared by others (e.g. school nurses and occupational therapists) as well as health visitors. The standards underpinning the SCPHN programmes (NMC, 2004b) seem intent on defining a common interest for a diverse group rather than defining (and providing) a collective identity for them all. So the diversity of individual groupings continues, yet the common interest takes prominent position over that of the specific skills and service activities of each group. In the minds of many taking part in this study, this situation has diminished the quantity and quality of educational preparedness now available for developing the skills, knowledge and activities unique to the role and identity of the health visitor.

The factor 'Higher Educational Institution decisions' rated a position of only tenth within the table of degree of influence (Stage 3). Yet the words of the HVEs indicate the important influence of such institutions for maintaining the provision and delivery of new SCPHNs/health visitors and reveal their individual attempts to sustain and promote the SCPHN programmes, as well as stimulating and informing professional awareness and effectiveness, both in practice as well as in the classroom. They seem unable from their educational position to influence the political/financial dis/investment in the service of health visiting and the recruitment/funding of SCPHN students. The HVEs symbolise their position as being frequently …*caught between a rock and a hard place,* caught between the competing needs and demands of primary care managers, health visitors, students, the SHAs, Department of Health, the government, the NMC, and not least their own institutions. The language of their responses on this topic contain such words as *constraints*, *less numbers*, *less prestige*, *limited influence*,

fighting, *competitiveness*, *pressure*, *dangerous*, *restrictions*, *second guessing* – a pattern of language often associated with markets and battles, particularly when relating to their own regulatory body, the NMC.

By 2007 it is interesting to note that the government, in its response to the health visiting review (*The government response to Facing the Future,* DoH, 2007b), significantly enters into the debate around the training and education of health visitors. In their view the integration of health and social services, and the changing roles in both nursing and the children's workforce, increases the need for new training programmes for health visitors. These new programmes are to represent better value for money and be more effective in preparing health visitors to deliver services. To achieve this the government looks to the Department of Health initiative 'Modernising Nursing Careers' for *…new training programmes and career pathways* [for health visitors] *that better reflect the needs of the service and aspirations of the workforce* (p. 17). The government appears to welcome the innovative approaches being taken by some local commissioners and educationalists *…who are developing flexible and modular training programmes* (p. 17). There is no mention of the NMC's important role in deciding and prescribing the content, design and requirements for such programmes.

In 2009, whilst such changes to the training of student health visitors were still being awaited, the project *Health Visiting Matters* (UKPHA, 2009b) looked in depth at what they termed "*Health Visitor Programmes*" (p. 42). They were concerned at what they found. For them the recruitment onto such programmes and the "*uncertain*" (p. 41) infrastructure supporting them were significant factors in contributing to the '*urgent*' and '*major*' '*workforce crisis'* in health visiting. From their analysis of these factors they express *…little doubt that the expanding* [of] *the entry gates to health visitor education would be a positive and important way forward* (p. 45). Their final recommendation promotes the need for a specially designed, new health visiting programme that could *…draw upon the skills of a variety of workers across the public health and children's workforce, as well as nurses* (p. 48), and be suited to a wider pool of entrants.

One particular issue described as "*urgent*" within their conclusion is the need to 'map' data concerning the shortage of practice teachers, particularly if health visitor training places are to be substantially increased. The project findings call for a review of the educational infrastructure currently existing in higher education institutions (HEIs), which is described as of "gr*eat concern*". For in their view,

> *…although the system is in place, it is constantly under pressure to conform to requirements suited to other parts of the* [nursing] *workforce …the calls are not about removing all nursing elements from the programmes; instead they are largely about removing health visitor education from a restrictive system that is unsuited to the task of promoting and developing the workforce* (p. 47).

The report describes a mismatch between the educational and professional systems within which health visitor education is professionally and academically managed and provided. For not only, they suggest, is such education geared towards post-registration nursing, but it is also subject to the different HEI educational requirements. However from their investigations they state the belief that the body regulating the educational requirements of all nurses, the NMC, would not welcome any amendment to legislation that would allow changes to the educational provision and regulation of new programmes for health visitors. Yet for them, developing more regulated options for such programmes …*seems increasingly urgent* [as] *increasing anecdotal evidence* (p. 50) suggests that HEIs and PCTs are already designing a range of programmes to train and deliver health visitor support workers to meet the service delivery needs of local providers - an initiative being undertaken without any …*national overview or quality assurance* (p. 50), a situation they imply that should be of concern to the NMC.

Given such different understandings of the implications of the SCPHN education, primarily between HVEs/HEIs on the one side, and the rhetoric of the *Facing the future* review and the government response to it on the other, it is not surprising that the language of the HVEs in the study is one of frustration and battles with the NMC. The discursive positions offered to each of these parties, even just within the realm of the SCPHN education, seems to pit one against the other, setting up intransigent relationships. One such difficult relationship seems to exist between health visiting and nursing, explored below.

III. Being the 'other' - health visiting's relationship with nursing

The contested position and relationship health visiting holds with the wider community of nursing, currently and historically, is a recurring theme in the study. The sense of health visiting being in the position of the 'other' of nursing appears in one form or another. A debatable point would be whether health visiting's identity is currently defined and decided by other nurses, with differing historical inceptions, ideologies, ontological perspectives, expertise and journeys? Is this conscious and

deliberate? Even inevitable, given the closeness of their status and identities within the world of health and medicine?

The findings of this study give credence to the belief that boundary disputes between nursing and health visiting have not yet been resolved or diminished, but possibly heightened by the recent nursing regulatory decisions and changes. For some of the participants, the ongoing relationship between nursing and health visiting is still troubled and confused …w*hen health visitors were deregulated …they felt devalued and no one, no one, tried to help them develop and grow in order to be equipped for the market of today. Nurses were delighted to see their colleagues' struggle* (Ruth). This relationship with nursing, particularly its senior members, is identified by some as being responsible for all mention of health visiting being removed from statute and the loss of their title 'health visitor'.

One associated theme that emerges strongly is the importance that health visitors have placed over the years on being recognised and identified as having the status of a 'profession', that is considered distinct and different from nursing, characterised by its own form of expertise, entrance qualifications and extended training. Yet health visiting's historical quest for individual professional status has, paradoxically, often been associated with a regular angst, and ebb and flow of concern, around its survival and direction, as can be witnessed in the literature (from both within and without the profession). Brocklehurst (freelance consultant in public health), in his article (2004), proposed that four words seemed to sum up much of what was happening recently in health visiting - "chaos, confusion, contradiction and complexity" (p. 135) - in virtually every sphere of its professional activity, education and regulation.

Some health visitors appear keen to establish a discipline that is completely distinct from nursing, believing that changing the content of health visiting practice alone will not change the context within which it is practised. Their historical coalition with nursing had allowed them to be allied to it without being subsumed within it. They had like, midwifery ('midwife'), a title with no 'nurse' component, and had striven for distinction as a separate profession. Yet such groups as midwifery and health visiting are now considered to be part of the institution of nursing. Perhaps, as Netting and Williams said back in 1996, it is not surprising

> …that the contemporary climate in which no profession is sacred provides
>
> an unsteady foundation on which to build the collaborations that are being
>
> forced on those who have been socialized to believe that they must be

unique to prove their worth and demonstrate their professional identity (p. 218).

It is quite clear within *Facing the future* (DoH, 2007a) and *The government response to Facing the Future* (DoH, 2007b), that health visiting is seen to firmly lie within the province and jurisdiction of nursing, having a position in post-registration nursing. Both reports acknowledge a professional specificity unique to health visiting, although this 'specificity' is described as being one part of a shared entity with all nurses working in the public health nursing arena. Both documents are, however, silent on the salient ontological and epistemological differences between these 'nurses' working within the public health nursing field. Perhaps this reflects their concern with managing uncertainty and complexity whilst creating consensus.

However opinions displayed in *Health Visiting Matters* (UKPHA, 2009b) present a differing perspective. Their linguistic resources express a direct and indirect alignment and solidarity with health visiting that is missing from the documents named above. There is also a sense that compared to the other two documents, they are enacting a different **who** seeking to accomplish a different **what** (Gee, 2005, p. 37). Throughout *Health Visiting Matters* it is clear that health visiting is viewed as possessing a unique and distinct professional specificity and identity and that it should reclaim a (rightfully) unique place within services for children. A place that is distinct and separate from that of nursing. It is their belief that although health visiting shares common ground with nursing and midwifery, it also uses knowledge and skills drawn from other fields, …*such as epidemiology, psychology, sociology and early years studies* (p.43), which renders the health visitor a distinctly different species of practitioner. They consequently call for the establishment of

> …*an Institute, a Faculty or a College of Health Visiting* [to] …*support the idea of re-establishing health visiting as a profession in its own right. In turn, such a move would help to improve recruitment, provide a basis for developing and improving education and improving services. It would provide a platform from which to engage service users, to ensure their voice is heard, which does not exist at present.* (p. 58)

Their position and desire, they suggest, is shared by many informed consumers and consumer bodies. However they also observe that,

> …*there is a strongly held opinion in some quarters that health visitors have credibility with the public only because of their nursing qualification* (p. 43).

The details and naming of these 'quarters' is not provided.

In the opinion of Chua and Clegg (1990), the profession of nursing has historically always been subject to inter- and intra-occupational contest and is not characterised by an ideology of shared norms and values that can bind populations together. For them this is a functional imperative – one that has been vital to the existence and survival of certain types of nurses. Celia Davies (1995, Professor of Health Care) too, has argued that any attempt to define and shape the nature of nursing work presents a 'professional predicament', in that this exercise frequently results in marginalisation or silencing of those with a minority status. Similarly, in theorising about identities, Davies (2002a) brings to the fore the significance of binary thought – a form of thought that "locks us into power relations that value some kinds of contribution and minimize others" (p. 31). For Davies, identities frequently derive their meaning from the logic of pairing - the mother and child, the professional and the client, perhaps the health visitor and the nurse? Establishing an identity in this way, Davies suggests, sets up a boundary that stresses the differences rather than the similarities and connections. Within such a theory there is always an 'other'. Yet the 'other' is a devalued other, lacking in some key qualities, with the dominant group defining what is valued and what is normal with reference to itself and hence excluding and oppressing others.

Lingard *et al.* (2002) define the 'construction of the other' as the process by which we perceive and implicitly categorise, or form impressions about, those with whom we come into contact. One important aspect of this process is 'situated language practices' – the talk and rhetoric used to interact, relate and perform. For it is this situated language that shapes reality and selects words to describe it. As Lingard *et al.* state, "Words act on us; they both make possible and constrain our understanding of our lives" (p. 253). So how something is described shapes or constructs its meaning. Although historically the word 'nurse' has never featured in the title 'health visitor', it now features in the new title of specialist community public health *nurse*. This could be the cause of frustration amongst health visitors who even if they were defined as the 'other' of nursing, felt this offered them a clear boundary. With the conferring of the title 'nurse' on to them, their sense of being subsumed, and losing even the marginal position they once 'enjoyed' perhaps explains the threat to their identity experienced by the vast majority of respondents.

From the perspective of Duverger (1972), rivalries and conflict between territorial groups can contribute greatly to political antagonisms within that institution/society. They are 'political' in the sense that such antagonisms derive from the power, authority and command within the human relationships in that society. From his perspective, antagonism is generally deeper between territorial groups if their

134

territorial status predates (i.e is firmly rooted in history – as with health visiting) that of the 'merged' society, and they have contributed in some degree to its formation, rather than being created from the society itself.

Sawicki (1988), suggests that 'difference' can be as much a resource as a threat, and should not be regarded as an obstacle to effective resistance for "if we redefine our differences, discover new ways of understanding ourselves and each other, then our differences are less likely to be used against us" (p.187). Individuals involved in such conflicts of personal legitimacy, she suggests, sometimes become more preoccupied with bolstering their own identities than with their collective goals – and such identity politics, she warns, can be self-defeating as it can lead to internal struggles over who really belongs to that community. Whether the shift from bolstering 'identity' to defining 'collective goals' by both nursing and health visiting can be achieved in the climate of distrust and fractious relationships remains doubtful. Nevertheless, a key lesson from the analysis of these relationships is that this is an area that deserves further attention by all parties.

IV. Influence of the Nursing and Midwifery Council

Emerging from the participants' responses is the NMC's general, taken-for-granted position as a symbol of professional order, regulation and control. Its position of inside-ness (MacLure, 2003, p.15) in respect of the nursing community appears unique, tangible and prominent. Its dominant influence includes the decision-making and construction of professional nursing boundaries, policies, standards and politics. From the voices of the participants, the NMC is perceived as having the power to decide and establish what is 'normal' and 'required' in respect of nursing - giving identities, purpose, reason and meaning to those whom it regulates. For many taking part in this study, the power and influence of the NMC is being used to manufacture, and impose, a new professional identity for, and on, health visiting.

Perhaps such actions represent the intent of the NMC to bring health visiting in from the 'margins' of the larger nursing world, thereby removing its elitist and unique position? Or perhaps it is simply a quest for a simplified professional register? And/or the promotion of the integrity and coherence of nursing as a unitary self? This is an intent that may be societally useful but possibly professionally problematic. Within nursing (as nurses, midwives and health visitors) we know only too well the conflicts and differences between our disciplines, as we recognise how much we are not like others in our field. However, Caughie (2003) reminds us "…the point is that from the outside, those within a discipline all look alike. And perception is the better part of

identity" (p. 426). For Patterson (2009), cohesion within nursing requires an acceptance and even valuing of long-standing divisions (being more, not less, explicit in presenting disciplinary origins); a focus on common bonds; an appreciation of the differences; and a harnessing of the collective strengths of our diversity.

Whatever the motives of the NMC, in the opinion of the participants of this study, the consequences of the register changes have led to confusion and uncertainty about the health visitor's role, identity and future direction. One key finding from this study is the mismatch between the standards and requirements of the NMC (for health visitors, SCPHN training, role and practice) and the role and identity expected of, and supplied by, health visitors in practice, the consumers of their service, the provider/employer organisations and the commissioners of their service.

Perhaps such a mismatch raises the question – just how influential is the NMC? *Facing the future* (DoH, 2007a) contains no mention of the initials 'NMC' or 'SCPHN'. Nor does the regulation, naming and proficiency changes for health visiting (by the NMC) receive any reference. Are these factors irrelevant to this review? The answer must surely be 'no' as the purpose of the review was to define the competencies, knowledge and under pinning beliefs required for health visiting's new role and the training of its new members. If the role is to be renewed how can this be achieved without the direct involvement of health visiting's regulatory and governing body? There appears little connectedness between the review outcomes and the activities of the NMC. Yet the Modernising Nursing Careers strategy, overseen by the Chief Nursing Officer and the nursing division of the Department of Health, receives several mentions (on pages 8, 9, 10), and is described as the key context for undertaking and shaping the purpose of the review. There are no definite answers to this puzzle leaving open room for speculation that this 'sleight of hand' of not mentioning the NMC directly could be to avoid further controversy. However, of the thirty-four members of the Health Visitor Working Group undertaking the review of health visiting (from professional bodies, academics, parenting organisations, service providers, commissioners, practitioners and educationalists), only one representative from the NMC is listed and only one member is accorded the title 'Health Visitor'. By far the greatest numbers of members have 'Nurse' as part of their occupational title, revealing potential links between the rhetoric of the document and the composition of the review group.

In response, and perhaps inevitably, from *Health Visiting Matters* (UKPHA, 2009b) comes a clear and censorious perspective on the actions of the NMC. The report

firmly identifies the workforce, recruitment and regulation "*crisis*" (p. 5) of health visiting to be directly associated with the …*systemic failures* [of the NMC, that] *relate to the treatment of health visiting as post-registration nursing, instead of as a distinct profession* (p. 5). In their opinion this position,

> …*reflects official enthusiasm for substituting nurses into health visiting roles* (p. 44) …[health visiting] *is taken less seriously, with an increasing degree of substitution of other workers into health visiting roles. In turn, this diminishes the overall attractiveness of health visiting as a potential career* (p. 46).

Their analysis of the influence and impact of the NMC on health visiting does not hold back (the emphasis is mine):

> *There is **no** health visitor representative on the council of the NMC, **nor** is there a committee or any organisational representation for health visiting within the structures of the regulatory body* [the NMC], *so there is **no** mechanism to assure the suitability of programmes for health visitors. This is because the NMC is **not** legally empowered to regulate health visiting as an occupation; they are only charged and enabled to regulate nurses and midwives* (p.44).

This quotation perhaps brings to the surface the animosity between the NMC and health visitors that seeps through most of the documents and participant responses. Once again, this underscores the importance of the fact that historically health visiting has never been regulated by the NMC, and as a result developed a unique sense of identity and professional role. That this may not be perceived as such by the NMC, or indeed accepted, reveals the distance between the two factions. The authors of *Health Visiting Matters* go further, stating that the debate about the future regulation of health visitors is …*ripe for development* (p. 45), with evidence of increasing support for expanding the entry gate into health visiting for people outside of nursing.

These discussions reflect the on-going power struggles between the worlds of health visiting and nursing. Duverger (1972), whilst exploring the notions of politics and power, proposes that the power contained within, and exercised by, institutions, is not just that of a physical phenomenon of domination (the authority of the structural model) but also a psychological phenomenon, tied up with human beliefs and notions of 'legitimacy' for, and of, that institution. "Power is felt as power by those who obey it and those who wield it" (p.18).

Foucauldian ideas (1980) about the expanding network of regulatory and controlling ('policing') processes and powers by the state (and its associated bodies) suggest that

such 'policing' fosters a mentality that requires ever more explicit definition of what is appropriate human behaviour, and operates out of a deep need to mobilise power – to impose structure upon behaviour (p.129). The imperative of such a policing process, Foucault explains, is for the elaboration of rules and the establishment of boundaries between regulated and unregulated domains of human activity, which in turn define boundaries of professional legitimacy. In this sense the policing process is the public expression of human essential activity; the construction of modes of discourse and of action that shape our conception of human nature. For it is in the formalities of our words and our deeds that we define ourselves (Hutton, 1988).

It is helpful when considering the influence of the NMC to consider Foucault's ideas on external and internal procedures of exclusion (1972, 1981). Such procedures, he proposes, are concerned with classifying, distributing and ordering discourse, with the aim of distinguishing ultimately between those who are authorised to speak and those who are not. Those in positions of authority are the ones seen to be 'experts', who can speak the truth, and thus those who are not in positions of power will be considered not to be speaking the truth. From the perspective of a beleaguered health visiting service, the evidence contained within this thesis suggests that the NMC is one of those institutions that "work to exclude statements which they characterise as false and keep in circulation those statements which they characterise as true" (Mills, 2003, p. 58).

The NMC would also appear to represent another type of internal exclusion, as defined by Foucault (1981), that of 'rarefaction', where limitations are placed on who can speak authoritatively. For rituals and rules are designed to provide for some limited access to those 'in authority', and their type of knowledge is subsequently excluded or diminished. This study has provided evidence of the limited response and understanding of health visitors in practice to the changes in their title, role and identity instigated by the NMC in 2004. As such they appear excluded, and unprepared for these significant changes.

Foucault (1981) has also suggested that internal procedures of exclusion on discourse can be related to the setting and creation of disciplinary boundaries, with limits placed on certain subject areas. Perhaps for the NMC, health visiting is one such subject area and entity whose disciplinary boundaries are viewed and approached only from their own particular methodology – that of the general nursing, positivistic, curative and bio-medical. Just how well can health visiting 'fit' with this model?

V. Influence of various other organisations and bodies on health visiting

a. Government influence on the professional identity of health visiting

The findings of this study demonstrate the keen interest and involvement of the Labour government in the NHS since it came to power. This interest has significantly included health visiting, both *directly* through the government requested review of health visiting (*Facing the future,* DoH, 2007a, 2007b), and *indirectly* due to its influence on NHS policy direction, decision-making and its authority over NHS managerial, strategic bodies and professional organisations regulating health care practitioners. The impact of the decisions and activities of the government, on the role and identity of health visiting, features strongly within the narratives of the participants, often with an emotive force. For them a paradox exists between the raft of government policies impacting on the direction and meaning of health visiting whilst at the same time feeling as if the profession has been sidelined and "*airbrushed out*". It could be argued that the marginalisation of professional opinion and bodies by governmental discourse (reducing the importance of professional titles and associated service territory) witnessed by some participants is not just related to health visiting but generally towards professions.

The participants in this study considered governmental policy and actions the second most influential factor on the recent professional identity of health visiting. The Labour government is clear that their role …*is to set the direction and the goals we want services to deliver and support the service in deciding what workforce it needs* (DoH, 2007b, p.3). These findings have demonstrated the key role played by statutory NHS managerial, strategic and commissioning elements in delivering these goals. Whilst reconsidering the underpinning principles of health visiting Cowley and Frost (2006) accepted that:

> Health visiting has always been heavily influenced by policies pursued by the government of the day. This is because so much of its work is focused on areas about which political views are strongly held and often polarised, such as families and communities …and there are always likely to be marked shifts when governments change (p. 1).

All three documents examined in this chapter have shown a strong intertextual interest in the requirements of various governmental health policies – giving them a strong emphasis and significance. These requirements have been varied and extensive with certain themes emerging – the need for service redesign and accountability; the promotion of choice and contestability; an emphasis on providing evidence of effectiveness; the demonstration of value for money and measurable health outcomes; the importance of health commissioning nationally and locally.

Facing the future (DoH, 2007a) appears intent to align, mediate and 'co-locate' (Gee, 2005, p. 4) its pronouncements through a close relationship with government policy and requirements. It is open about its dependence upon government influence and interest for its recommendations to be acted upon,

> …t*he next steps however, will be critical to the success of this report's acceptance and implementation …it is recommended that the DH* [Department of Health] *continues to engage key stakeholders in deciding how to take these recommendations forward.* (Conclusion, p. 31)

The participants seem unclear about where the ultimate responsibility lies for the significant disinvestment in the health visiting workforce and training of new health visitors. They wonder whether governmental reluctance to resource and invest in health visiting has been influenced by the inconsistent messages of their worth, value and effectiveness emanating from various government circles. Or whether it is associated with the directives and requirement to balance the NHS books and demonstrate short-term effectiveness and value for money. Although the government acknowledges the reduction in the health visiting workforce and the financial constraints on SHAs (DoH, 2007b), it considers that the occupation of nursing overall has generally received substantial investment. It does, however, state their view that …*the government sees public health nursing and the health visitor as a priority* (p. 17) and that more needed to be …*done to develop health visiting and to increase the number of health visitors working with deprived communities* (DoH, 2007b, p. 21).

From the government perspective the 'new' Public Sector Agreements (PSAs 12 and 18) are the key to giving health visitors …*a confident and relevant future* (DoH, 2007b, p. 20). Whilst accepting the main recommendations of the health visiting review (DoH, 2007a) they state that these …*are for the service and the profession* [of health visiting] *to take forward* (p. 7). Yet conversely within the same paragraph is stated that,

> …*it is for local commissioners working with providers, both NHS and local authority, to decide how services should be provided, resourced and delivered in order to meet the PSA targets.* (p. 7)

For some the reduction and disinvestment in the health visiting workforce has seemed at odds with the considerable family and parenting agenda and presiding health philosophy of the Labour government since 1997. In December 2007 Sir Aynsley-Green (Children's Commissioner) told a conference of his real concern about the loss of health visitors and the serious paradox between policy and the reality of delivering

the government's aspirations (CPHVA, 2007c). More recently a Health Select Committee Report on Health Inequalities commented on the fall in health visitor numbers, describing it as 'odd', in the light of the fact that the government's target to reduce health inequalities in terms of infant mortality had yet to be met (House of Commons Health Committee, 2009).

b. The influence of Strategic Health Authorities

This factor shared the position of being perceived as the second highest influence on health visiting (along with 'Government policy, Reviews, actions/activities'*).* The views of participants demonstrated a clear understanding of the role of SHAs in providing the strategic direction for practice, healthcare planning, and subsequent funding. Overall the voices and feelings emerging from those involved in this study displayed strength of feeling (anger, frustration, disappointment) towards the high, and often detrimental, influence of their SHA on financial support for the health visiting workforce, its service, and particularly the training of new health visitors.

These findings illustrate the perceived difficulty for health visitors and health visiting to demonstrate evidence of effectiveness in a culture of short-term targets and performance measurement. They also show the sense of impotence and disempowerment felt by health visitors/health visiting unable to connect with, be listened to, or influence the decision-making of SHAs.

c. The influence of those providing, organising and/or managing health visiting

The factor 'Organisation and/or management of health visiting' was shown to be the fourth most influential factor on health visiting, with the factor 'Provider Primary Care Organisations' being placed fifth. The cluster of responses generated by these two factors produced some vociferous comments from participants. These comments clearly expressed the apparent firm link between Primary Care Organisations (that employ and provide health visitors) and their ability to influence and regulate the resourcing and funding of the numbers, service and development of health visitors. The management and organisation of health visitors in practice is shown to adopt a variety (and inconsistency) of approaches, from developmental to restrictive. The participants describe managers of health visitors/health visiting services as confused and uncertain about how to respond to the multiplicity of governmental, budgetary, consumer, and health visiting service needs.

Although the HVEs acknowledge the important role of the staff involved in the management and organisation of health visitors, the picture drawn was one mainly

negative in nature for the role and identity of health visiting. A landscape of managers and their organisations disinvesting in the service of heath visiting, due to a culture driven by targets and focused on cost containment, emerges from the comments of the participants. For some, this influence was their greatest source of disquiet as it often led provider organisations to view health visiting services as a luxury they could not afford rather than as a vital part of their organisation. Yet a degree of understanding is exhibited by some HVEs for the negative impact of the continuous reorganisation of NHS management structures, felt as much by managers as health visitors.

Facing the future (DoH, 2007a) acknowledged the complexities and difficulties facing those organising and managing health visiting services. It speaks of the …*real tension* (p. 28) associated with deciding whether health visitors should be located within a primary health care team, or in children's centres, or with other geographically located health visitors. The review's final pragmatic (if vague) contribution is that …*any decision regarding the location of health visitors in the future will need to be flexible* (p. 28) and …*determined locally* (p. 8). Again the words 'flexibility' and 'health visiting' are entwined for useful and positive reasons, yet once again this very 'utility' of health visiting runs the risk of creating even more confusion, uncertainty and reduced contestability in the eyes of others.

As an alternative, the project '*Health Visiting Matters*' gave serious thought to identifying a more suitable system for employing, managing and organising health visitors. Their analysis of the associated problems for such an occupation that crosses both social and health organisational structures, is thoughtful and interesting. They explore the 'bodies' that have employed health visitors in the past and present (the NHS, local authorities, Social Enterprise schemes, Charitable Trusts, self employment) and admit to finding the …*multiplicity of potential employers confusing* (UKPHA, 2009b, p. 36). Their quest for an appropriate organisational form to offer sufficient stability and expertise to the service of health visiting, …*despite seeming somewhat radical* (p. 39), is for …*some form of national body, with outreach, possibly federated locally autonomous organisations* (p. 36). For it is their belief that,

> …*organisational form should follow function …*[and that] *the current organisational forms makes it very difficult to meet the functions required for by a successful provider of health visiting services.* (p. 39)

Their vision is for a national organisation responsible specifically for child public health, that would enable greater integration across child and family public health, and

provide "*robust*" national support and leadership for health visiting. This solution would overcome the fragmented employment of health visitors, allow innovation and partnership to flourish, enable a strong and consistent service to develop across the country, and …*exploit the unique combination of clinical and social models that underpins the value of health visiting* (p. 39). The provided example for a successful model is given as The Royal New Zealand Plunket Society, a national charitable body, wholly funded by government, employing Plunket Nurses …*who are similar to British health visitors* (p. 34). The report makes no comment about how such nurses are used in New Zealand, or their meaning or purpose, or even the implications of the use of the term 'nurse'. The project document clearly displays a significant link, and importance, for matching organisational form with the ability to function effectively in a specific role, with a specific identity.

d. The influence of NHS Commissioning bodies

This specific factor was included to capture any perceived changes from the government's intent to develop a diversity of provision and commissioning for health services, with the activities of local (rather than national and regional) commissioning gaining in importance and influence. The factor 'Commissioning bodies' was placed sixth in degree of influence on health visiting by the HVEs in Stage 3. Interestingly, three of their number indicated "NA" (not applicable). Their comments related to this factor were notably less in volume and detail than for other factors, a situation that perhaps reflected a sense of uncertainty or a lack of understanding of the possible implications for health visiting.

The views expressed by the HVEs suggest that health visiting appears to have little influence on commissioning decisions, processes or outcomes. Their words suggest that "*ownership*", "*embracing*" and "*articulation*" of commissioning had yet to become a reality with members of their profession. There also appeared concern at the general lack of commissioning of preventative services. It is interesting to raise the question why practitioners and educators associated with health visiting do not feel a part of any partnership for achieving better child health outcomes based on local priorities.

All the key documents studied for this chapter are united in their conviction that service commissioning is the key mechanism for re-establishing the importance and purpose of the health visiting service as a core provision for families and young children, as well as developing the services they provide. Both *Facing the future* (DoH, 2007a) and *The government response to Facing the Future* (DoH, 2007b) assert their expectations of commissioners – that they will recognise the leading role

that health visitors should play in leading and delivering the Child Health Promotion Programme (CHPP) and in achieving new Public Service Agreements.

Within *Facing the future* (DoH, 2007a) factors associated with commissioning the health visiting service feature prominently and the document calls for the relationship between commissioners and the service of health visiting to be strengthened. The report expresses concern at the variation nationally for commissioning health visiting services and the lack of impact of government rhetoric on commissioning decisions. For in their view 'commissioning' was still dominated by short term and acute decision-making rather than long term considerations around preventative activities, and reducing inequalities in health and children's services. The report explicitly suggests that the power and influence of the health visiting profession to address the problems they face does not lie with them but in local commissioning decisions around child and family health services. A view echoed by the government response for it acknowledges the reality that …*the investment and support for health visitors is highly dependent on local commissioning of the CHPP* (DoH, 2007b, p. 13).

Throughout *The government response to Facing the Future* (DoH, 2007b) there is no mention of, or direction for, commissioners and provider organisations to work with the service providers (health visitors), or their professional leaders or even the consumers of the service. For the government commissioning is seen as …*the process by which the NHS is held to account* (p. 14), yet who (and how) will the commissioners be held to account for the decisions they make? And what of their own accountability for the decisions that commissioners make or do not make? How does the government expect to achieve its stated policy aims without greater influence over local commissioning?

It would appear that the government's main interest lies in quality assuring the **process** of commissioning rather than the decisions being made, by providing commissioning frameworks (e.g. *The Commissioning Framework for Health and Wellbeing,* DoH*,* 2007c*)* and developing national performance competencies for commissioners. They acknowledge that commissioning competence and capacity in PCTs is urgently required, with current …*significant areas of weakness* (DoH, 2007b, p.14). Their stated belief is to strengthen the commissioning of early intervention and prevention health services for children yet the vagueness of their directive potential can be seen in their suggestion that health visiting development lies in the development of the Child Health Promotion Programme which,

> *…will also assist local commissioners to develop their universal services for children and families thereby renewing the role of health visitors.* (DoH, 2007b, p. 15)

The report of *Health Visiting Matters* (UKPHA, 2009b) is clear that …a *robust, public health focused health visiting service could assist commissioners in the key aspects of the PSA targets relating to life expectancy, infant mortality and health inequalities* (p.13). Yet achieving this situation is acknowledged as problematic. To ensure the commissioning of a universal service such as health visiting the report suggests the establishment of a funding model specifically for health visiting, which would assist commissioners to understand the resources required by health visitors to impact positively on child and family public health, whilst also giving some initial markers of success and anticipated outcomes from the service. They convey the pressing need for the establishment of designated local health visiting leaders to support and inform the commissioning process so that health visiting services are not lost within the entirety of the community service portfolio.

e. The influence of the Community Practitioners' and Health Visitors' Association (CPHVA)

The key professional union for health visiting, the CPHVA, was not viewed by the participants as having a particularly high influence on health visiting and this factor was rated numerically ninth (out of fourteen). The expressed opinions concerning the CPHVA were predominantly critical, and dissatisfied in tone. The concerns of the HVEs centred principally on the perceived lack of vigour by the CPHVA in defending and promoting the profession of health visiting, particularly within senior nursing and governmental circles. Some suggestions were made that the close alignment of the CPHVA to the union Unite had been detrimental to the degree of influence it wielded and its relationship with its health visiting members.

These results are surprising when considered against the cascade of comment and initiatives generated by the CPHVA on behalf of health visiting over the past decade. These include the *Who Cares Campaign* launched in August 2006 to save the jobs of health visitors and other community nurses as well as their robust response to the *Facing the future* review of health visiting (CPHVA, 2007b). There is considerable evidence available of the verbal and written data generated by the CPHVA on behalf of health visiting, that has repeatedly called for health visiting to be free from the constraints "of inadequately informed service providers and commissioners dictating the level of service provision" (Unite/CPHVA, 2007, p. 3). During the past decade the

CPHVA has issued regular bulletins, press releases, résumés, papers, briefing papers for MPs and regular reports for the UKSC Forum. It has published frequent articles and comments on the problems facing health visitors in its own CPHVA publication *Community Practitioner* - the main journal for community nurses. It has undertaken regular surveys (telephone, web-based) with members and others to show details of the reduction in health visitor training places, the substantial rise in health visitor caseloads, and the declining size of the health visiting workforce. In addition the CPHVA organises and presents an annual conference which constitutes the principal professional conference and forum for community/public health nurses and health visitors.

One reason, perhaps, for the HVEs expressed disappointment may be connected to CPHVA comments and actions around the time of the governmental consultation period on the proposed/draft Nurses and Midwives Order 2001. A Briefing Paper generated at that time by SENATE (2001, see Glossary), for distribution to all CPHVA members, states that it had become clear to Senate that "the position of the CPHVA in this debate is causing confusion and urgently needs analysis and clarification" (p. 1). The Paper goes on to explain that "officials" had reported that one reason 'health visiting' had been left out of the draft Order had been because the government was advised that,

> …the CPHVA feel health visiting is 'part of the family of nursing' …and as it is currently organised health visiting 'is an old-fashioned profession'. The modern solution is, therefore, for health visiting to become a branch of nursing (p. 1).
> …the CPHVA mention health visiting rarely these days …and do not encourage the use of the term health visiting …and no longer express support for the continuance of health visiting as a statutory profession which is unique and distinct from nursing (p. 2).

As many of the HVE participants are probably members of the forum SENATE perhaps such historical thoughts still resonate with them.

A profession such as health visiting requires the support of a strong professional body, so it is disappointing that the findings indicate that the CPHVA presents as a body with a relatively low degree of perceived influence on health visiting. Others within the profession may feel differently.

f. The influence of the public and consumer opinion

The Labour government of 1997 began with a concerted commitment to increase public involvement by putting patients, users and the public first and increasing their voice and influence. Yet the HVEs considered the factor 'Public/consumer opinion' to have relatively little influence on health visiting, giving this factor a position of thirteenth in degree of influence.

Yet the voices of the HVEs bestow a sense of positive association between health visitors and their clients. Several participants mention the important support and promotion of health visiting demonstrated by the parenting groups Netmums and the Family and Parenting Institute (FPI). These two consumer bodies, as highlighted within *Health Visiting Matters* (UKPHA, 2009b), have provided the loudest and most sustained support for the role and function of health visitors in the past five years. During these years both groups have undertaken their own polls and research to highlight the declining, uncertain, endangered state of health visiting services and the trusted and valued nature of this brand to parents (see Chapter 3).

The results of this study have shown the general uncertainty around the health visitors' role and identity – from the government, from their employers, from those purchasing their services and even from health visitors themselves, yet the least confusion and uncertainty would seem to come from its consumers. One wonders how much the majority of clients are aware of the recent confusion and debate around the future purpose, title, sustainability and identity of health visitors. For many health visitors their perception of the regular consumers of their service (i.e. principally mothers and infants) is that they have relatively limited power to influence the professional, political, and financial decisions associated with sustaining the service of health visiting – even if it is to their own detriment.

One burning question from these findings is - 'where is the promised transfer of influence and decision making from government, professional bodies and practitioners to empowered service users?' These findings suggest that the power and ability of the NHS consumer to influence the role and service of health visitors is so small as to be almost negligible. Although *Facing the future* (DoH, 2007a) professes not to have lost sight of the needs of service users during the period of the review the report contains little on the important and key interface between health visitor and client – that of building and maintaining an effective relationship. Yet the nature and efficacy of this interaction would significantly affect the reciprocal influence between the health visitor and client, to the benefit of both.

VI. Other factors considered least influential on health visiting

<u>a.</u> Organisations external to health care

The factors indicated by the HVEs as having some of the least influence on health visiting, were 'Organisations external to health care' and 'Individual GP practices'.

'Organisations external to health care' received the position of eleventh in the table of degree of influence. The numerical allocations for this factor showed varying and uncertain convictions – with the majority of opinion indicating that working in a more integrated, collaborative way was now a reality for most health visitors. Yet the strengthening of the position and influence of local authorities appeared for some to be an area of concern, as they witnessed health visitor roles, and consequently identity, being eroded or diluted as such organisations involved themselves more in providing family and parenting support services. There is a general sense from the findings of the challenges that partnership and inter-professional working can present, yet Children's trusts, Children centres and Sure Start are mentioned as examples of where health visitors are gaining acceptance and making an impact. The safeguarding of children is highlighted as one element that is positively benefiting from more inter agency working. Once again the high workload and low morale of health visitors is cited as one of the main reasons for a lack of more collaborative engagement by the profession.

<u>b.</u> Individual GP Practices

The factor of 'Individual GP practices' achieved the position of being fourteenth in the table of degree of influence, making this factor, in the view of the HVEs, the <u>least</u> influential on health visiting. Indeed two respondents thought this factor 'not applicable'. Several participants appeared disappointed that General Practitioners (GPs) were not actively campaigning for health visiting whilst still wishing to have access to, and use of, a particular health visitor. The degree of influence of GP practices on health visiting was summed up in the words of …*it depends*. It seemed to depend on the location of the health visitors, their relationship with particular GPs and degree of 'attachment' to that surgery, the local organisation of the health visiting service (i.e whether by geographical area or corporate (team working), and/or the local management structure and requirements.

The review of health visiting does not indicate this factor as being one of the levers for changing health visiting, but does acknowledge the value that GPs place on health

visitors, although adding the rider …*in general* (DoH, 2007a, p. 28). The review highlights the …*real tension* in the primary care/community arena around deciding where health visitors should be based (p. 28). The government response to the review makes more mention of GPs and states that …*General Practices will need to continue to have a named health visitor* (DoH, 2007b. p. 18), and yet at the same time appear keen for GPs involved in Practice Based Commissioning to use …*savings* …[to] …*develop new child health nursing roles within the team* (p. 18). Further guidance on the character and purpose of these new roles is not provided.

In addition to these factors, although many were heartened by comments of David Cameron in his earlier role as leader of the opposition, it still remains to be seen how the coalition government view health visiting and the SCPHN. While organisations like Netmums and the general concern voiced over the protection of children could be factors that lead to a higher profile for health visiting, as I have tried to point out, this is a complex area where the agendas and priorities of several bodies and organisations come together to shape the future, not to mention the current budgetary constraints on the public purse.

VII. The current professional identity of health visiting

To end this chapter, I want to place here, the analysis of some key issues that lie at the heart of the findings. This study has given a voice to the opinions and thoughts of many senior health visitors. In the view of most participants in the study, the identity of health visiting is in a stage of adaptation and evolution – but to what no one sounds sure. For some participants this situation constitutes a crisis in the profession, a profession that is in decline and significantly threatened. A few think it is a time for adaptation and redefinition, or for some, refinement, re-invention and renewal for health visiting.

Overall there appears a convergence of opinion that these are troubled times for the role, occupational position, and identity of health visiting, with a strong sense of confusion and concern around the present meaning and value for/of health visiting. There appears to be the lack of a stable frame of reference for health visiting, and a general sentiment of their profession being "buffeted about the identity landscape" (Gubrium and Holstein, 2001, p.1). The participants' voices reflect clearly a professional identity 'in production', rather than an already accomplished fact (Hall, 1990). As Sachs (2001) reminds us, the notion of identity is an entity that must be forever re-established and negotiated.

A significant finding of this study is the perceived small degree of influence that individual health visitors (placed eighth) and health visiting practice innovation (placed twelfth) has on its own profession, certainly less than that of their 'governing' bodies - a noteworthy finding for a profession that places considerable importance on its autonomy and independence. One principal issue of concern emerging from these findings is the picture of a health visitor workforce declining in numbers, morale and influence due to significant financial constraints, commissioning decisions, lack of investment in training of new health visitors and the demographic reality of being an aging workforce. Weariness, bordering on exasperation, is evident when they describe the cascade of copious governmental publications, constituting (in their view) little more than the usual government rhetoric, in that no money had followed policy directions for health visitors. The participants seem generally bewildered and dispirited by the activities of their government, Department of Health and regulatory body, the NMC. The role of the health visitor emerges as struggling to accommodate many external requirements – the development of an enhanced public health identity as required by the NMC; the prioritisation and management of caseloads with a reduced numbers of health visitors; the rising interest and influence of other agencies in child health care; all set within an ever-increasing demand for more complex interventions in areas of need.

The language of the participants in respect of the professional identity of health visiting is couched in descriptive and powerful words, such as – "*feel disempowered*"; "*eroded*"; "*in crisis*"; "*passive*"; "*not confident*"; "*blurred*"; "*confused*"; "*in a state of flux*"; "*struggling*". The words give a sense of health visiting being in a position of confusion, erosion, with reducing - influence, uniqueness, investment, numbers and in leadership. There is a pervading impression of an identity, particularly its role and specificity, lacking clarity, understanding, differentiation and definition.

From the findings of this study it is reasonable to conclude that health visiting and individual health visitors feel somewhat remote and distant from those with the real influence and power over their form of practice. The ability of health visitors to influence day-to-day health visiting practice appears higher than their ability to influence wider policy/decision making. Yet the health visiting literature, from the profession itself, has often shown previously a spirited and proactive response to the defence and maintenance of its role and identity. The literature (Chapter 2) shows clearly how health visitors have, in the past become adept at incorporating different interpretative repertoires, political requirements and societal changes into their presentation of self and the production of the service they offer.

It could be argued that any attempt to define anything indicates limitations to that endeavour. Any inspection of the literature shows that there are many ways that health visiting can be conceptualised, and defined, *by field of practice*; *by practice settings*; *by functions performed*; *by methods used and services provided*; *by practice goals.* In examining what heath visitors 'do' many authors have suggested the concept of 'ambiguity' as a useful concept with which to understand health visiting. For Littlewood the work of health visitors is often perceived as vague and unclassifiable, as they visit unsolicited and proactively the well, yet concern themselves with managing "the 'sickness' of disordered households or neglect" (2000, p. 597), by contextualising the individual and "their expression of suffering or need" (p. 599). In spending time in this way, Littlewood suggests, the health visitor becomes a marginal, ambiguous figure, relating to societal members who are also marginal and ambiguous (e.g. mothers, children, parents, those experiencing negative social consequences). Quoting the work of Douglas (1966) she argues how ambiguous states can be ignored, condemned or redefined and as such,

> …health visitors remain invisible, as the outcome of their work is not in relation to sickness and recuperation but rather an avoidance of that category (p. 599).

Cowley, however, argues that the management of uncertainty, unpredictability and ambiguity are central to the role of health visitors, and requires an ability to cope in a safe and therapeutic way with shifting, uncertain and ill-defined health needs, recognising and responding to complex potentially risk-filled situations (1995, p. 276). This is often compounded, she argues, by health visitors being in the delicate position of offering a service that has not been requested, and which may also be perceived as unnecessary or unwanted.

The very nature of the strengths and flexibility of the health visiting service (covering the fields of nursing, medicine, public/environmental health, and social care at individual, family, community and public level) appear also to contribute to its difficulties. Perhaps the ways that health visitors talk about their professional role and identity - bringing something extra and 'indeterminate' to the arena of early years child health care - has denied them the possibility of rationalisation, confirmation and clarity of identity. Tensions result from expecting something as complex and multifaceted as health visiting practice, with its beneficial ability, utility and usefulness, to be able to expand its boundaries of interest and service in response to changing societal health

needs, whilst at the same time providing a succinct, defined, encapsulated and readily agreeable/purchasable description of their role and meaning. As Emma asks - is there only one role and meaning of/for health visiting? Is only one allowed? In these post-modernist, psot-structuralist times why cannot complexity be accepted, or even embraced, rather than the required singularity of meaning and definition?

In *Health Visiting Matters* (UKPHA, 2009b) the project members attempted to provide their definition of the term 'health visiting'. which took ninety three words and three bullet points to achieve, the threads of which describe a:

> *Proactive, universal service …reaching out …and reducing inequalities in health,* [working for] *individuals, families and groups, and the community as a whole* [with] *the capacity and vision to contribute to public health* (p. 6).

This example of the difficulty of succinctly and simply defining a service such as health visiting that …*encompasses a broad, multi-disciplinary and multi-agency area, which crosses numerous different research fields and themes* (p. 53), is significant for its identity and promotion. As is also the need to develop, strengthen, co-ordinate and disseminate the evidence base for it. The dilemma for *Health Visiting Matters* is that, at a time of financial restraint and reduction, the role of health visiting still requires subtlety, skill and …*sufficient time to engage* [with] *families with both obvious and hidden health needs, and to work with those who have yet to recognise their own levels of vulnerability* (p. 59).

Some pertinent questions need airing: How much does health visiting continue to be influenced by its professional inheritance and connections to its past? Does this inhibit its ability to reshape and conform to the present need for change? Is the historical connection of health visiting with its past, real, or imagined/perceived in the collective memory of what it currently means to be a health visitor? How much of health visiting's collective memory is that bequeathed to them from the collective precedents of residing within, and dealing with, the wider nursing world?

Hutton (1988), after exploring Foucault's genealogical investigation of past technologies of the self, suggests that fathoming the past teaches us that there are options among which we are free to choose, not simply continuities to which we must adapt. As he says, "Who we are, has as much to do with what we affirm in the present, as it does with what we revere in the past" (p. 140). Perhaps as Robert Scholes has proposed (1998), nostalgia is not a useful guide for action. Yet it may not be just the historical ties that influence the role and identity of health visiting. As the

literature demonstrates clearly, health visiting has always been influenced at any given time by its place in the larger social environment. This 'place' with its contextual economic, social, environmental and political forces has perhaps been more influential in shaping the nature of health visiting practice than intra professional factors.

From Foucault's (1977) perspective, the subject and those exercising power (at different points) are bound together. He reminds us of the fact that power is not totally entrusted to someone who would exercise it alone, for everyone is caught in this situation, "those who exercise this power as well as those who are subjected to it" (p. 156). Yet as can be seen from the findings of this study those seen to be exercising power (NMC, Department of Health, PCTs, SHAs) can perhaps isolate what they consider 'anomalies' (health visiting/visitors), and can then normalise such anomalies through corrective or 'therapeutic' procedures – as those in 'governance mode' are prone to do, when confronted by difference and diversity.

Brocklehurst (2004) explored the complex relationship between health visiting, nursing and the state and illustrated the uneasy co-dependency between the state, "as ultimate guarantor to its people of welfare and social justice, and the professions who provide the means to these grand aims" (p. 137). He recounts how for over a century health visitors have contributed to the achievement of key aspects of family, child and public health policy and in return have been regarded with special status through self-regulation and protection of title. For him, writing at the time when such a status was about to be removed, this indicated, "something profound has happened to the balance of power between the state and the profession" (p. 138). He openly muses whether the autonomy of health visiting is being threatened by its regulatory domination by nursing, "aided and abetted by government".

The lack of influence of health visiting over its own role and identity is highlighted consistently within the voices of the participants. Such concerns are often related to their perception that there are now few leaders and even fewer 'champions' within, and for, health visiting. For without such leadership, they suggest, the power and opportunity to positively inform, influence, and change opinion and decisions of those in positions of power are diminished.

The picture drawn here contrasts sharply with the buoyant, aspirational tone contained within the review of health visiting (*Facing the future,* DoH, 2007a) which served particularly to convince health visitors of the need for them to change. The review states its aim to be that of supporting …*those leaders and practitioners on the*

ground who are forging ahead and developing a profession that will have a confident, relevant and sustainable future (p. 10), yet this study finds no sense or evidence of health visiting being developed, supported or confident in a sustainable future. It is also interesting that the participants do not mention in more detail, or more often, the health visiting review itself. Perhaps they are unsure just how much influence *Facing the future* (DoH, 2007a) has actually had on government direction and decision making concerning health visiting. So what has been the influence of this health visiting review? Within the document there is frequent reference to the significance and importance of the initiative yet the word "*should*" is the most commonly used word within the review's findings and recommendations. There appears a disconnection between its own perceived importance as a national activity and its ability to connect, impact or influence health commissioners, providers of the service or even health visitors themselves.

Examination of the three key documents featured in this chapter shows clearly a language and agenda for changing the role, identity and meaning of health visiting.

The tone, expectation, language and thrust of the review *Facing the future* (DOH, 2007a) is for the role, purpose and expected outcomes of health visiting to be specified, clarified, reformed, sharpened, adapted, improved, redesigned in a new, proactive way – in essence to be 'revitalised' to match a rapidly changing world, technology, communication, health needs and services. The review clearly distinguishes between a 'present role' and a 'future role' for health visitors – both of which are ascribed distinctive characteristics and it is around these binary oppositions that the review is structured. Unusually, no third way is mentioned or proposed. Health visiting of the 'present' appears mainly constructed through negative terminology. It is described as having …*lost its focus* (p. 4) and the profession is described as being …*lost and under pressure* (p. 9). Parents too are described as …*concerned about access to health visitors and confused about what to expect from the service* (p. 14). In contrast, the future role of health visiting is described in aspirational and positive terms and proposes a shift away from health visitor's traditional emphasis on building supportive relationships with clients toward a stronger emphasis on outcome-orientated service provision by multi-skilled teams. The document also reinforces the future role of health visitors being one that supports individuals to make lifestyle changes to improve their health rather than addressing wider environmental and social determinants.

The image of moving health visiting … *from here to there* (p. 29) reflects in many ways, MacLure's thoughts on how texts may be structured and "articulated" through the setting up of binary oppositions (2003, p. 9). The construction of the oppositional pairings, along with the choice of words, invests the review team with certain allegiances, authority and identity. The list is also used to generate and establish new meaning and knowledge about the future for health visiting, to persuade the various stakeholders, as well as health visitors themselves, of why and how they should change. The new position offered to health visitors is that of 'experts' with more focused skills and knowledge and a focus on …*early intervention, prevention and health promotion for young children and families* (p. 6), rather than on "*a generic community public health role*"(p. 18). It ascribes the status of what is proper, correct, appropriate and valuable in health visiting, and enables review members …*to describe the road we think should be taken by the profession* (p. 30) and highlight …*the need to reform the existing health visiting service into a fully integrated preventative service for children and families within a public health context* (Conclusion, p. 31). The lists carry the 'scent' and 'influence of governmental policy' with its preferred direction for all health services, i.e. of increasing expert professionalism, creating a plurality of service providers and employers, and integrating child and family health services, as opposed to the earlier position for health visitors of being 'jack of all trades', operating autonomously with individual interpretation and no competition.

The review found little evidence that the 'generic community public health role' of health visitors had …*been picked up on any scale by the profession or commissioners* (p. 18). Yet this is the very role designed by the NMC for a 'specialist community public health nurse' (SCPHN). As part of such an identity, the requirements of the NMC are clear – SCPHNs are designated to engage in "the whole range of settings and clients relevant to community public health" (NMC*, 2004b, p. 18). This goes some way to explaining why health visitors/health visiting is confused as to which role and identity it should be providing or aspiring to achieve.

Julia Greenway and other health academics from universities in England and Scotland conducted a discourse analysis of *Facing the future* from a Foucauldian perspective. For them, this document, whilst constructing the present and future roles of health visitors elucidates the 'regimes of truth' that operate in official policy (2008). Their summary of the document *Facing the future* is that although it purports to reflect a consultative review and to encourage debate within the health visiting profession, its form is "more akin to a promotional document to implement government proposals for

social change" (2008, p. 29). For Greenway *et al.*, the text locates the role of the health visitor within wider discourses which govern what is acceptable to say or think about the role of the health visitor at this particular time, discourses that emanate from other policies, statements and utterances from government factions and governing bodies of nursing (i.e. Department of Health, Nursing Division, Nursing and Midwifery Council).

Facing the future (DoH, 2007a) is described as providing …*an analysis of health visiting today* (p. 9) yet the prevailing and significant reduction in health visiting workforce numbers is hardly mentioned. The only comment made in the report is to be found with the findings of the review within a section entitled '*On where the profession is now*'. The sixth bullet point states that …*there were frequent reports of reductions in the number of health visitors being trained* (p. 14). There is some mention of '*anecdotal evidence*' concerning unfilled health visitor vacancies and large health visitor workloads, and that health visitors were …*particularly vulnerable when organisations are faced with financial constraints* (p. 14). The results of, or causes for, such vulnerability are not explored further, nor is the state of morale within the health visiting profession. The document acknowledges that the profession …*seems lost* (p. 9) and …*at a crossroads* (p. 30) but the tone of the language remains determinedly up beat throughout.

However within certain speech balloons, inserted around the main text, voices of health visitors appear that offer a more sombre picture:

> *The service is funded for today, not the required outcomes of tomorrow* (p. 14); …*We have lost our identity and are becoming marginalized and task focused* (p. 14); …*rhetoric does not match reality on the ground* (p. 14); …*we're at the bottom of the totem pole. We are pulled in a dozen directions, everyone wanting something different from us* (p. 15).

It is as if *Facing the Future*, in trying to be both candid and positive about the future of the profession, needs to find room for the voices of practising health visitors who work in the field, but can only fit their despondent views into speech bubble form, reminiscent of cartoon characters. In the main body of the text, the more 'positive' perspective is offered in a more authoritative, official, form, strangely amplifying the views of the health visitors about being at 'the bottom of the totem pole'.

Similarly, *The government response to Facing the Future* (DoH, 2007b) also finds itself in the position of both acknowledging failures as well as justifying its past actions. It acknowledges …*a lack of consistency in service provision* [of

health visitors] *and concerns in some parts of the country that the service was being undermined by a loss of health visitor posts* (p. 5). Yet the report also argues that this situation needs to be seen in …*the context of unprecedented*

investment in the NHS and services for children in the last 10 years [that has seen] …*significant investment, expansion and reform*, [and that] …*the lives of children have improved as a result of government investment and reform* (p. 5).

This theme of justifying the state of health visiting by situating it in a context of heavy investment in other areas is repeated in Section 4 of the document entitled '*Outstanding Issues'* (p. 17). The government response acknowledges that SHAs report …*reductions* [in the health visitor workforce] *were due to financial constraints in 2006/7… and the need to avoid newly qualified health visitors being unable to find employment* (p. 17). Yet it calls for such reductions to be viewed in the context of

> …*unprecedented investment …there are 79,000 more nurses in the NHS than in 1997 …£21 billion has been invested in early years and child care since 1997* (p. 5) …*the number of nurses working in the community increased by 29,543 (38%) between 1997 and 2006* (p. 17).

Whilst *The government response to Facing the Future* (DoH, 2007b) shows clear support for… *the coherent and relevant future for health visitors* (p. 21), as described by the health visiting review, it also appears to wish to widen the remit of the role. In the final conclusions of the document the government stated its desire for health visitors to also lead and deliver …*other public health programmes as determined by local commissioners* (p. 21). So such programmes are not to be decided by health visitors with a comprehensive awareness of the health and social needs of local children and families, but by those controlling the commissioning of the programmes.

Health Visiting Matters (UKPHA, 2009b) describes itself as a …*specific regeneration project, to renew and energise service provision, practice, and the health visiting profession* (p. 6). The findings of the project do not engage in describing or recommending what a renewed role and identity for health visiting should look like. Their recommendations focus upon - improving health visiting's professional leadership at local, regional and national level; establishing, demonstrating and strengthening its knowledge base and effectiveness to others; and improving the recruitment and development of the health visiting workforce. The report is particularly dedicated to influencing the creation of new provider organisational forms that will

…offer sufficient stability and expertise …for developing a dynamic and positive health visiting service (p. 4).

During the period of time covered by this study, much energy, debate and effort has been expended, both inside and outside the profession of health visiting, on determining its future role and identity. Many bodies have considered what should be 'normal', 'correct', or 'good' in terms of health visiting activity and meaning. Interestingly in all of the voices of the participants and the key documents investigated for this study, there is unanimous agreement on one thing – that the service of health visiting is 'valuable' and 'useful' and a particular form of social good.

Within *Health Visiting Matters* (UKPHA, 2009b) the point is made of the contradiction

> *… between evidence of the need for health visiting services in research and policy, and the apparent lack of value afforded to the service, as shown in the cutbacks and continual emphasis on describing the role instead, for example, of increasing funding and staff in post* (p. 22).

There is clear and consistent support for the profession of health visiting:

> *Health visitors do not assume (particularly in a recession or economic downturn) that they should be granted employment regardless of public service need. However, the consequences of the current recession will increase demand on health visitor resources* (p. 31).

In their view an increase in health visiting expertise is crucial in order to respond to the increasing numbers of a) children with special and complex needs, b) mothers experiencing post-natal depression or other mental health problems, c) teenage pregnancies, d) obese children, e) families experiencing social isolation, f) children and mothers needing protection/safeguarding. In their opinion "*the need for health visiting is clear*" (p. 32).

Whither health visiting?

The findings of this study indicate clearly the prime and significant influence that governmental and nursing regulatory bodies have had on the service, title, role and identity of health visiting. For a designated profession in its own right the population of health visiting would appear to have little professional control.

Foucault's (1991) interest in social order and discipline led him to consider the mechanisms for controlling and administering populations. These mechanisms he defined by coining the term 'governmentality'. Within his notion of governmentality lie the analysis of who could govern and who is governed, and the means by which that

shaping of someone else's activities is achieved. Inherent within the term 'governmentality' lies the concept of discipline, which for Foucault consists of,

> …a set of strategies, procedures and ways of behaving which are associated with certain institutional contexts and which then permeate ways of thinking and behaving in general. (Mills, 2003, p. 44)

From within such a Foucauldian approach, it can be clearly seen how discourses, emanating from certain ways of thinking and behaving about and towards health visiting, have been inextricably linked to governmental institutions. This is particularly evident in respect of the body the NMC that is charged with the surveillance and control of nursing, and organises, regularises and normalises the conduct and identity of those brought within the influence of its institution and governmentality.

Although these findings show overall health visiting emerging as a 'troubled' professional identity, troubled identities can come in many forms. Foucault (1979) reminds us that such identities can also be constructed as 'conditions of possibility' for who and what we might be or are likely not to become. The possibilities for health visiting, as will be seen in Chapter 6, are now receiving significant political attention.

Since the time my studies started many voices, speeches, texts, documents, journal articles, e-traffic, organisations and individuals have entered into the debate on health visiting, many have been asking, "What does health visiting now mean?" and, "What should/will it mean in the future?" Among the voices of the participants of this study, speaking at a time of considerable uncertainty for health visiting, we still see the resilience of a long-standing profession. The senior health visitors still talk of opportunities for health visiting in the future, yet also seek a greater clarity for their professional identity and a wider, national agreement on what is their distinctive role and identity. Being effectively led, represented and evidenced would be a significant starting point.

According to the insights provided by these findings the historical context, principles and endowments of the profession are still important. Foucault's interest in the genealogy and paradox of the human condition led him to produce some helpful insights. As this chapter concludes it is useful to reflect on the words he once said:

> I don't feel that it is necessary to know exactly what I am. The main interest in life and work is to become someone else that you were not in the beginning. If you knew when you began a book what you would say at the end, do you think that you would have the courage to write it? What is true for writing and

for a love relationship is true also for life. The game is worthwhile insofar as we don't know what will be the end. (Martin, 1988, p. 9)

CHAPTER 6

CONCLUDING THOUGHTS

Hughes, when writing in 1951 in the *American Journal of Nursing* observes:

> It takes courage to study one's own work, just as it does to take a good look at anything that is dear to one and of which one is proud. It is like looking hard in the glass to see if one has wrinkles. (1984, p. 311)

Hughes' remark has had considerable resonance for me whilst undertaking this study that set out to:

- consider the current state of the professional identity of health visiting;

- explore the historical context and meaning associated with health visiting;

- examine the range and influence of discourses currently debating the role and identity of health visiting;

- consider what changes these discourses may have on the professional identity of health visiting.

When coming to some concluding thoughts about the outcomes of this study I find myself resisting any sense of certainty, generalisation, explanation or closure. This study has felt increasingly like a collaborative process between the participants, the texts and myself, and the telling feels as if everything I have been studying for the past five years is still partial, contingent, and in flux. It has felt in many senses as if I have been researching an increasingly declining subject, located in a shifting and uncertain terrain. From the reading of the thesis it should be evident that recent times have witnessed a significantly turbulent era for health visiting, a situation that is still unfolding and developing today. If Murphy *et al.'s* proposition that the goal of much of qualitative research is concerned with description, rather than explanation (1998) is valid, then I hope to have described how knowledge of all sorts is thoroughly enmeshed in "the clash of petty dominations, as well as the larger battles, which constitute our world" (Rabinow, 1984, p. 6).

Methodological, personal and professional reflections

Undertaking this study has presented the significant challenge of exploring a topic as diverse, flexible and ambiguous as the role and identity of health visiting. Any cursory look at the relevant literature will illustrate an occupation that from its very inception has been occupied (preoccupied?) with forming, finding and confirming itself. This is

not to say that many authors have not tried to provide a clear and detailed definition for health visiting for, as demonstrated in these findings, many attempts have been forthcoming from many quarters, yet so has the absence of a consistent definition. Any investigation of health visiting since its inception will show that the core features, purpose and activities of health visiting have, however, remained remarkably consistent. They have achieved the development and maintenance of a strong internal professional identity through their specialised knowledge base, underpinning methodologies, historic independence and a capacity to speak and act autonomously.

I. Contribution of participants

I started my research journey interested in the impact of the NMC regulatory changes on the profession of health visiting but as time and events progressed the aims of the study grew and were adapted. Stage 1 of the research felt tentative and time-consuming, due to the lengthy processes of arranging access to a relatively small number of participants. However the choice of these participants, and the conversations I held with them, proved to be pivotal and invaluable. The findings at Stage 1 indicated a way forward and suggested an important source of informed knowledge and insight into health visiting.

Health visitor educators (HVEs) have proved an informed, interested and authoritative sample, and they have clearly and comprehensively expressed their thoughts and opinions. It is interesting that the words, values and feelings emanating from them has often seemed to be actively grappling to interpret, capture and make meaning of the number and variety of recent changes, as if they themselves are in the act of being and becoming. They demonstrate clearly how entwined the notion of professional identity is with the title, roles, meaning and values attached to an occupation. The participants in this study have been in the unique position of viewing events as they emerge from many different sites – governmental, political, professional, occupational and individual. They have demonstrated a shared cognitive and emotional connection with the wider community of health visiting, representing a sense of collective consciousness and identity (Poletta and Jasper, 2001). They have provided examples of the external, internal and inter-professional facets affecting health visiting, and have revealed how a professional identity can be externally, internally and/or subjectively ascribed. It is an indicator of how deep their involvement is, how high the stakes are, that they often serve up a caustic indictment of a variety of bodies/organisations influencing health visiting, including the government. Rather than read their views as 'biased' or 'just' emotional, I have taken this opportunity to consider seriously their insider perspective, especially as so few studies have done so in the past.

I wanted to spread my net wide by gaining the perspective of HVEs in locations throughout England, but perhaps this was rather ambitious. I achieved my aim but at the cost of no face-to-face contact. Without this I was unable to probe, challenge or seek clarification on some of their answers from the main questionnaire. This methodological tool was completed comprehensively by the participants, yet I wonder if I should have added more factors related to health visiting for consideration, such as the recruitment and retention of health visitors; the training of new health visitors; health visitor workforce number and caseloads; educational development of health visitors; and career opportunities. On the other hand, this may have been too prescriptive, too demanding and too restrictive.

This study was undertaken during a particularly stressful and busy period for HVEs, as universities disinvested in health visitor training programmes and personal careers looked very uncertain. It was, therefore, very gratifying to receive so many responses to the Stage 3 questionnaire. My 'insider' status as a fellow HVE proved advantageous to this outcome, as I knew many of the HVEs personally through professional meetings and forums. Conversely, such insider knowledge possibly affected the interpretation and analysis of the HVE comments. But within the 'small' world of health visiting this would have been hard to avoid. I accept that the opinions and perspectives expressed by these HVEs provide just one possible interpretation of what has been recently occurring for the role and identity of health visiting. They do however observe this form of practice from a very informed and knowledgeable vantage point.

It would have been useful and enlightening to have also sought the thoughts and opinions of some practising health visitors on the research topic from their position within the day-to-day reality of practice. However, gaining permission to access them would have been complicated, lengthy and time-consuming. However, this would be a potentially fruitful area of research for the future.

II. Concluding themes

Before this thesis concludes it is important to include two themes that have emerged from the participants as being of principal concern for the future of health visiting – showing/proving their effectiveness and the lack of leadership for health visiting. The following suggests a way forward.

<u>**a.**</u> <u>The effectiveness of health visiting</u>

The discourse associated with proving and defending the value, worth and effectiveness of health visiting practice within a market economy can be seen as a regular and enduring text within the literature of nursing, and particularly health visiting. The findings of this study echo this recurring concern for in the view of many of the participants, the current 'approved', 'scientific' discourse on performance had created a clinical, strategic, governmental, professional, economic and managerial emphasis on evidence-based practice with clear measurable outcomes – through performance indicators, league tables, targets, etc. Stronach *et al.* (2002) advocate that this "current rigid and coercive" 'economy of performance' (p.128) represents an attempt to re-articulate professional discourse as 'performances'. They suggest that polarities, and paradoxes, are being created between the practical and holistic 'ecologies of practice' (as art), and the technical and fragmented 'economies of performance' (as science), which represents an inherent problem for health visiting, as its practitioners are required to attend to both.

Many authors have highlighted the difficulty that 'evidence of effectiveness' and 'measurable outcomes' represent for health visiting with its fundamental preventative role and whose positive health outcomes are likely to be measurable only in the long term (Greenway *et al*, 2008), and are significantly intangible and often unpredictable in nature (Cowley, 1996). The CPHVA, and before it the HVA (see Glossary), have long realised these difficulties for health visiting and have produced a raft of publications aimed at providing a "a truly effective and efficient health visiting service" (HVA, 1994, p. 1; HVA. 1995; CPHVA 1997, CPHVA, 1998).

Many key documents examined for this thesis endorse the government's commitment to, and support for, more evidenced based interventions and call for the evidence base for health visiting to be developed, strengthened, co-ordinated and disseminated. Yet *Health Visiting Matters* (UKPHA, 2009b) states that evidence for **certain** interventions encompassed within health visiting services is more available now than it has ever been, and in a variety of forms e.g. evidence briefings (Bull *et al.*, 2004), meta-analyses (Macleod and Nelson, 2000), systematic reviews (Elkan *et al.*, 2000, Hannula *et al.,* 2008) and integrative reviews (Dowswell and Towner, 2002, Karoly *et al.*, 2005, National Institute for Health and Clinical Excellence (NICE) guidance, 2006, 2007a, 2007b, 2008, 2009) and the review of reviews (Barlow *et al.* 2008))(p. 41).

However, they admit that much of this information needs to be synthesised into readily useful information (for service commissioners, managers, practitioners, clients) and that there are…*very few people who have the skill, knowledge time or interest in doing this, and no funding is available to cover the time and cost* (p. 54). *Health Visiting Matters* raises the significant point that evidence on how to model, deliver, develop, and fund the remainder of the universal service of health visiting, and its infrastructure, is not available. They state the reason for this to be the existing vacuum in responsibility, and lack of leadership, for health visiting research. They are particularly concerned that there is no single point to which commissioners, managers and practitioners can look to for such information, and no organisation with specific responsibility to ensure that the evidence base for health visiting is developed, compiled or made available …*in a way that is accessible for these interested stakeholders* (p. 56).

Health Visiting Matters proposes exploring the feasibility for establishing a body, Institute, Faculty, College - of Health Visiting, responsible for undertaking and collating research knowledge relevant to health visiting, and in an accessible format for purposes of commissioning, quality assurance, practice and education. They do not however come to any conclusions as to who? or how? the necessary research be undertaken. They also acknowledge that taking forward this proposal faces the pressing problem of who will fund it, an issue that remains unsolved.

b. Leadership and health visiting

One particular challenge (and opportunity?) expressed within these findings is the clear conclusion that the profession of health visiting is lacking in leaders and leadership strategically, politically and in practice – not only within the wider nursing world but also within its main professional, regulatory body (the NMC) and the nursing division of the Department of Health.

The Labour government's modernisation agenda for health care focused firmly on strengthening nursing leadership generally (DoH, 2008c, Pollard *et al,* 2005), and a boost for the leadership potential of health visitors can be clearly witnessed in both the review of health visiting and the government's response to it (DoH, 2007a and 2007b). However both documents view this potential in a specific context, that of leading and delivering the Child Health Promotion Programme, and even this activity the government is keen to ensure …*is a 'hands on' role not a managerial one* (DoH, 2007b, p. 10).

Health visiting Matters (UKPHA, 2009b), however, considers the leadership potential of/for health visiting as an important and neglected factor for the profession and its service, … *the lack of positive health visiting leadership has had a direct impact on the form of service received by clients* (p. 25). It also expresses strongly the negative impact on health visiting leadership of the reduction in numbers, importance and support for the role of 'practice teacher', a situation that needs to be reversed particularly if the workforce is to be expanded.

Their conclusions identify and call for sufficiently skilled health visiting leaders at all levels of health care, local, regional and national. In their view it is very clear that the profession and its service needs more than one kind of leader - not just within clinical and professional areas, but within other specialist areas, for working in partnership across agencies, and for the successful commissioning of health visiting services. Their overall recommendation calls for the establishment of, and facilitated access to, national leadership programmes for health visiting practitioners and senior clinical leaders, which will lead to the development of clinical networks with clear leadership roles for practitioners, and a service delivery model that includes a reflection of the importance of leadership roles. For only with all these in place they believe can it be possible to …*embed leadership across the* [health visiting] *service* (p. 26).

III. Discourse and discourse analysis
This study looked at the meanings being given to health visiting during a span of time emanating from a variety of factors, influences, practices, actions, texts and language that have represented the various discourses participating, contributing to and constructing the 'truth' of what health visiting could and should mean. The use of the idea of 'discourse' has been of benefit to this study. It has assisted in understanding how discourses can enable and constrain – and how an individual is 'fabricated' into a particular social order (Foucault, 1979, p. 217). Any analysis of the discourses associated with nursing suggest that they have rarely been about wielding power; but more about its powerlessness and subjugation to the medical paradigm. Yet in the Foucauldian meaning 'power' is linked directly to discourse practices but in a diffuse, circulating mode, 'into the very grain' of those subjects involved in the prevailing discourses (Foucault 1980, p. 39). So power is embodied in day-to-day practices between people and existing within *relationships* and *sites* (Foucault, 1970).

This study has explored which organisations, factors, sites and relationships have the power and ability to influence the role and identity of health visiting. Many factors and associated multiple positions of power have been considered. The concentration of

power appears directly linked to the degree of authority and influence emanating from particular political, professional, managerial, regulatory and commissioning positions placed at the disposal of the government, Department of Health, NMC and other NHS bodies. For Kelly and Symonds (2003) the discourses flowing from such bodies makes certain knowledge about health visiting possible by creating a system of rules, statements and practices which then mediates the power to create a 'regime of truth' linked to the systems of power which constantly sustain, reproduce and extend it (p. 4).

The challenges and potential limitations, however, of applying discourse analysis to the primary data of this study are acknowledged. It has been testing to critique the discursive world and resources that the participants have themselves inhabited as well as analysing the wider reality and constructed subjectivities associated with the meaning of health visiting. When reflecting on some of the usefulness and difficulties of mining such discursive meaning, Gee's ideas on the use of discourse (Discourse) models as important tools of inquiry have been of considerable assistance. In his view they helpfully mediate between the ""micro" (small) level of interaction and the "macro" (large) level of institutions" (Gee, 2005, p. 71) and represent "the largely unconscious theories we hold that help us make sense of texts and the world" (p. 71). They aid the simplification of certain worlds (in this case health visiting) and as such can leave out many complexities and make many assumptions. They can, however, also be partial, diverse and inconsistent.

Gee (2005) depicts differing sorts of Discourse models. During the analysis of the data generated by this study is has been beneficial to be aware of the models of discourse that have been consciously espoused (espoused models), or consciously or unconsciously used to judge health visiting (evaluative models), as well as those that have consciously or unconsciously guided actual actions and interactions in the world of health and health visiting (models-in-(inter)action). These have helped to display certain ways of believing, talking, listening, reading, communicating and acting. Yet Gee also suggests that we should consistently question the relevance of certain Discourse models by asking ourselves:

> What must I, as an analyst, assume that people feel, value, and believe, consciously or not, in order to talk (write) act, and/or interact in this way?
> (p. 93)

The answer to this question can only be tentative. However to closely observe the texts, social and institutional interactions, context and situated meanings associated

with health visiting, as well as the words of the participants themselves, has helped provide substantive credence to the conclusions made in this final chapter.

Recent scenario − A rising interest in health visiting

This study started with the question "Whither health visiting?" and as I began to design and consider the third stage of this study, health visiting and health visitors started to become the topic of a much wider national conversation and media attention. This occurred with the launch of the Conservative party's (then in opposition) proposal and policy for *Helping new families. Support in the early years through universal health visiting* (2008). This highlighting of the value and importance of health visiting became one of the centre points of the Conservative party, Spring Conference in March 2008. Subsequent events and actions have placed health visitors and health visiting firmly back, once again, on the political and wider public agenda.

Present scenario

With the arrival of the new coalition government has come a robust political resolve to reduce significantly the national fiscal deficit. A context and discourse is being created and typified by a language of 'austerity', 'financial deficits' and 'public sector cuts'. Many of the coalition government's policies appear an extension of previous Labour government ideas but the additional 'financial pressures', required to achieve fiscal health, are impacting most on public services and their providers. The Prime Minister himself promised to protect the NHS from significant cuts to its budget, even promising a small, real-terms rise in NHS funding during the lifetime of this parliament. However the NHS is still required to make £20 billion of 'efficiency savings' over the four years from 2011-2015.

During such a frugal fiscal period the service of health visiting would normally be once again preparing itself to make a defence for greater, not lesser, investment in its role because of its impact upon longer term health returns. However the pre-election rhetoric of the Conservative Party to make Britain more "family friendly" is finally, and somewhat surprisingly, starting to become a reality. Their pledge to place health visiting at the cornerstone of this change has made tentative steps forward.

In February 2011 the Department of Health issued the *Health Visiting Implementation Plan 2011-15. A Call to Action* (DoH, 2011), that represents the government's conviction to "expand and strengthen health visiting services" (p. 4) and provide a new

service model and discourse for "reenergising" and "revitalising" health visiting. Their reasons are clear:

> The start of life is a crucial time for children and parents. Good, well resourced health visiting services can help ensure that families have a positive start …That is why the Coalition Government has made the challenging commitment to an extra 4,200 health visitors by 2015 (p. 4). In too many areas, there are just not enough health visitors …The lack of capacity means that health visitors are too often unable to perform the wider public health role that they have trained for, working with communities to improve health outcomes. Health visitors are frustrated by the gap between the role they have trained for and the amount they can do in practice. (p. 8)

The publication describes itself as a "living document that the profession and its partners will help shape" (p. 5). It admits that the Plan sets an ambitious pace and will require innovative approaches to health visitor training and development. It acknowledges that,

> …change will ultimately be delivered locally by commissioners and providers of service, and above all by health visitors and their partners working with families and their communities. (p. 4)

The government's vision for health visiting is detailed at length under the heading "Why health visiting matters" (p. 7) and a new service model (with associated terminology and language) for health visiting is provided and described. This is a model constituting five levels of service that all families will be able to access. These levels are:

- *Community* - "Interactions at community level" – building and using capacity to improve health outcomes and leading the Healthy Child Programme.
- *Universal* - "Universal services for all families" - working with midwives, building strong relationships in pregnancy and early weeks and planning future contacts with families.
- *Universal plus* - "Additional services that any family may need some of the time".
- *Universal partnership plus* - "Additional services for vulnerable families requiring ongoing additional support for a range of special needs".
- *Safeguarding and child protection* (p. 8).

The plan is presented as an opportunity for health visitors to reclaim the role which brought many into the profession, and to refresh and develop their public health skills in working with children, families and communities (p. 12). It offers new leadership challenges and opportunities to lead health visiting and wider skill-mix teams across early years settings. The Government describes the profession of health visiting as being "welcoming and enthusiastic of the proposed approaches", which in their view reaffirms health visitors as key professionals in public health delivery with their professional autonomy regained:

> Health visitors have responsibilities in promoting the profession, welcoming Return to Practice practitioners, taking part in new approaches to educating students, and working with providers and commissioners to embed the new service for families locally. (p.13)

Whilst the contents and implications of the *Health Visiting Implementation Plan* are now starting to be analysed and acted upon intial comments from the NMC, whilst expressing its desire to help meet the challenges of recruiting, preparing and keeping health visitors, state their view that:

> Health visiting has emerged, somewhat unexpectedly, as one of the government's top 10 priorities …This ambitious call to action is partly a response to *Facing the future* … that concluded that health visiting should focus where it can make the greatest impact: early intervention, prevention and health promotion for young children and families …a ring fenced budget of £577m is promised. (*NMC review* Issue 1, Spring 2011, p. 30)

The NMC is keen also to warn that the aim to grow the HV workforce from 8,092 (whilst "numbers continue to plummet in many areas" p. 30) to the target of 12,292 (Full Time Equivalents), a proposed 52% increase,

> … may not be achievable - indeed, the plan's small print concedes that the target may need to be 'refined and adjusted in the light of experience. (p. 30)

They take the opportunity in the first issue of their new magazine to rule out the possibility of direct entry to health visiting, stating that health visitors will remain as qualified nurses or midwives who have undertaken further training. In their opinion the SCPHN standards,

> …allow considerable scope for local interpretation and flexibility. For public protection, those standards – however broad – must continue to be met. (p. 31)

It is, however, this state of affairs that leads some commentators to already doubt the ability of health visiting to grow to the aspirational numbers laid down by the Government. Some voices warn, "that continuing barriers to [health visitor] entry might thwart its plan" (Higgs, 2011). Higgs in her article cites the views of several leading health visitors that any recruitment process would be hampered by the current removal of the title of health visitor from nursing statute (by the Nursing and Midwifery Order of 2001), with the pre-requisite of being a trained, and registered, nurse or midwife. Thus presenting not only a delay, whilst would be health visiting candidates achieve their first qualification, but also the difficulty of meeting the NMC requirement for practitioners to keep both qualifications (nursing <u>and</u> health visiting) current. Higgs comments that it is not that nursing is NOT a good base for health visiting but questioning why it should be the ONLY base.

At this very early stage the future achievements of the *Health Visiting Implementation Plan* (DoH, 2011a) cannot be known. For many health visitors it heralds a poignant symmetry to their careers - as they appear once more to be assured of their title, a specific role with children under fives and their families (particularly those that are vulnerable), whilst returning to their employment origins under the auspices of local authority systems rather than those of 'health'.

The questions being asked at this point are numerous:

- What of the role and identity of the SCPHN as prescribed by the NMC?
- How does the new service model for the health visitor impact upon it?
- What of the other occupations that share the same title and standards as SCPHNs?
- How will PCTs fund the employment of these additional health visitors whilst working towards their own known demise?
- How will enough trainees be found from the ranks of existing nurses and midwives?
- Whilst health visiting is predicated on nursing how much change can there be?
- How can health visitors influence and maintain the momentum, both as individuals and as a profession?
- How can health visitors be enabled to acquire the autonomy and authority to lead, provide and delegate services and teams?

- What is to attract those that have left health visiting back to the fold?

Overall the recent developments signal a time of potential hope for health visiting – for a clear and recognisable service model for all to follow – practitioners, PCTs, SHAs and commissioners. Yet whether these promises can actually be implemented within the current climate of hostility to the wider government proposals for the NHS as a whole remains to be seen.

Concluding thoughts

In compiling these concluding thoughts I am struck by the recurring thoughts of how interesting, and paradoxical, is the position held by health visiting. Its meaning and identity, from its earliest beginnings, have been prone to vulnerability and challenge, and yet at the same time both resilient and enduring. Health visiting appears to historically inhabit a landscape epitomised by the narratives of difference (foreignness?) and change. How much of the traditional meaning of health visiting has depended on, and is owed, to such difference?

The picture of health visiting presented within this thesis reflects an occupation which because of its distinct ontological and epistemological characteristics and flexibility (see Chapter 2) often finds itself at odds within the world of nursing and the pervading curative, medico-biological model and system of health care, with its requirement to show short-term effectiveness and value. The noted, and historic, flexibility and utility of health visiting would appear to represent a distinct disadvantage for the profession in times of a market-driven, performance-led health culture. For what cannot be specified, measured or demonstrated by way of short-term outcomes (i.e. be encased within a performance indicator) would appear vulnerable to disinvestment, and diminishing meaning and value. Perhaps the role of the health visitor is too multifaceted and is too willing to change and be reinterpreted to be realistically achieved? As Brocklehurst has stated:

> …health visiting, by its very nature, is a profession built on paradox. This may be both its greatest strength, because it allows considerable flexibility and responsiveness, and its greatest weakness because it guarantees internal strife and generates confusion. (2004, p. 137)

The identification and regulation of health visitors as Specialist community public health nurses appears an increasingly contested state of affairs. It is allied with a general 'dis'ease at the current regulatory position and training of new health visitors. It has challenged and provided a controversial account of the place of health visiting in

the nursing world and competes with the conventional knowing and meaning attributed to health visiting. The rebranding and re-titling of the health visitor appears to have offered the profession a potent and distinct signifier of inclusion rather than exclusion from the nursing world. It has offered the possibility of new interpretations on health visiting, which have been promoted as inevitable and presented as the only serious option for understanding and including such a complex and shifting form of practitioner. Health visiting would appear to have lost one identity without managing to find another. Such change would seem to have produced only further uncertainties rather than resolving them.

The regular reviewing and redefining of the meaning of health visiting moves from speaker to speaker as each lays claim to it. In some senses everything then changes (at regulatory, strategic level) yet in the reality of day-to-day practice little contextual difference is evident. The work of psychoanalyst Julia Kristeva on 'foreignness' (Strangers to Ourselves, 1997) looks at those who migrate to a different cultural and social context and her words resonate:

> You improve your skills in the new language, but it's never quite *yours*, and you lack the authority that goes with unthinking fluency. You are easy to ignore, and thus easily humiliated. Increasingly foreign to those you have left behind as well, you become a kind of cultural orphan, never *at one* with anyone anywhere. (p. 189)

The widespread confusion around the meaning, role and purpose of the SCPHN, and health visiting's role within it, is significant. As Belsey suggests clarity of a recognised meaning has benefits as "meanings control us, and inculcate obedience to the discipline inscribed in them" (2002, p. 4). The regulatory changes would appear to have significantly reduced - investment in the profession of health visiting; its influence within nursing, with employers and commissioners; and recruitment to its ranks. It would also appear to have ultimately led to a lack of leadership for health visiting at levels of practice, management, commissioning and government.

The programme of training student health visitors would also seem at odds, and disconnected, from the role and identity of the health visitor expected from employers, commissioners and consumers, all of which seem to have their own version of what health visiting should do and mean. The majority of these stakeholders would seem to prefer more professional specificity with an associated specific title, rather than the general community public health role ascribed to the SCPHN. A more focused (yet versatile and flexible) role within early years services, with a concentration on early

intervention, and the ability to responding to complex and individual circumstances and needs, seems the preferred option. Such a model of service echoes that being described within the Health Visiting Implementation Plan.

The ongoing tensions and debates about who should employ, organise and manage the service of health visiting only contributes to the further feelings of foreignness for health visitors, whose meaning and effectiveness are strongly associated with working across the divides of social, health and environmental concerns.

The identity of the 'health visitor' has always been closely linked with the relatively silent, and often hidden population of mothers and young children. It is of considerable interest that the least confusion and uncertainty about the role, identity, value and meaning of health visiting would seem to come principally from its consumers. How far are they aware of the current debate around the future purpose, sustainability and identity of health visitors? Many health visitors deem the regular consumers of their service to have relatively limited power to influence the political, and financial decisions associated with sustaining the service of health visiting. Yet perhaps, as these findings suggest, the profession of health visiting should show more intent and interest in garnering and advertising the support, validation and recognition they receive from many groups outside the statutory health umbrella.

As this study has demonstrated the role and meaning of health visiting has often been subject to being defined and decided by others, rather than by the profession itself. For the last fifty years it seems as if there has been a regular and recurring calls for renewal and clarification of its role. The sense of frustration of repeatedly being reviewed and redefined for the benefit of others, not necessarily themselves, are to be found in these findings. Such reviews have often been undertaken in isolation from the very stakeholders that are influencing the investment (or otherwise) in the health visiting workforce. Emerging out of this study is the realisation that it is not only health visitors themselves who need to understand and be able to define their role and particular identity, but even more importantly, perhaps even for their survival, that commissioners and providers of their service need to be able to do so as well. Health visitors have had to date limited power in influencing or challenging health commissioning decisions. Indeed this study highlights the unclear lines of accountability and governance for the decisions made by such commissioning bodies or the governmental bodies delegating the funds. Does this reflect governmental belief that local health bodies should make local decisions as they see fit? This is one nettle that requires grasping if health visiting is to survive and prosper.

It is therefore heartening that the Health Visiting Implementation Plan is being driven resolutely by central government as exampled by the recent NHS Operating Framework 2011/12, which contains clear and explicit requirements and expectations for providers and commissioners of health visiting services. It is equally pressing that designated local health visiting leaders are available to support and inform the commissioning process. As this thesis concludes even more change is afoot – the fortunes of health visiting appear increasingly secured, revived and enhanced. A new meaning and lexicon for health visiting is proposed and promised. Only time will tell whether on this occasion government rhetoric becomes a reality and health visiting is able to contribute to making its own future story. Again one wonders …whither health visiting?

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Recommendations

In concluding this thesis, it is worth reflecting on how this study has provided a valuable window into the world of health visiting during a significant and turbulent period of its professional journey. This window provides the evidence to make certain recommendations for the future of health visiting.

There is a pressing need, at this time of significant change, to investigate further the purpose, role and identity of health visiting from the perspective of health visitors in day-to-day practice. Exploring this viewpoint from an all-purpose, holistic perspective has been tried before. Yet the very utility and flexibility of health visiting activity requires, for such an exploration to be meaningful and useful, that it be linked to analysing a specific area of child health. The Healthy Child Programme initiative is one such area where the role content and leadership potential for health visitors/health visiting is signposted by successive government policy. An investigation of the responses of commissioners and provider organisations to this national programme, along with the comparative views from those delivering the programme, will demonstrate the nature, role and influence of health visitors from these three standpoints. Such research should also include an investigation of how the five levels of the new health visiting service model are being interpreted in practice by health visitors, providers and commissioners of child health services, and received by the consumers of the service. Such research should explore and identify explicit ways of demonstrating and measuring the impact, effectiveness and potential of health visiting.

The current SCPHN programmes are predicated on the SCPHN standards for proficiency produced by the NMC in 2004. Since then there have been a) significant

reviews of the health visitor's role and identity (DoH, 2007a; UKPHA 2009b) and b) significant new initiatives on the agenda (e.g; *Healthy Child Programme: pregnancy and the first five years of life*, DoH, 2009; *Health Visiting Implementation Plan*, DoH, 2011); c) the response to Lord Laming's safeguarding of children requirements (Department for Children, Schools and Families, 2009); and d) the national roll out of the Family Nurse Partnership (Olds *et al.*, 2002) scheme of targeting vulnerable young mums for intensive visiting. Surely such standards are now themselves in need of review.

This study has clearly demonstrated the significant effect that NMC decisions have had on the title, registration status and role of health visitors. It has also demonstrated the perceived marginalised position that many health visitors feel within the wider community of nursing. Perhaps a more cohesive position could be gained by the NMC acknowledging, and responding to, the growing concerns of various bodies and individuals that the statutory deregulation of health visiting should be revisited. As Seedhouse has pointed out,

> …meaning depends more on the ways in which a word is currently used than on an appeal to some ancient ruling. (1986, p. 20)

APPENDICES

APPENDIX I

<h2 align="center">Stage 1 Consent Form</h2>

Whither Health Visiting...Again!

Research activity undertaken as a student on the Doctorate in Education Programme at the University of East Anglia

Thank you for agreeing to take part in this research study about the impact of the 'new' professional Nursing and Midwifery Council register on the professional identity of health visiting. I am currently engaging in a small number of 'open conversations' with people whom I believe may be able to help me gain a better understanding of my main research subject area.

- It is my intention, unless you object, to record these conversations;
- It is expected that these conversations will inform and influence the next stage of the research process**.**
- All conversations will be kept confidential.
- The research is being funded by my employer XXXXXXXXX.

Name:	
Job title:	
Institution/organisation:	
Date:	

- I have been informed about the purpose and process of this research activity;
- I understand that my views as a participant will be treated confidentially and fed back anonymously;
- I understand that I have the right to withdraw my consent and to stop participating at any stage of the interview.

I agree to participate in this study.

Signature: _____ Date: _____

Whither Health Visiting … Again? – STUDY OUTLINE

RESEARCH ACTIVITY	DATE	QUESTIONS BEING CONSIDERED	RELATIONSHIP OF ACTIVITY TO AIMS OF STUDY
Stage 1 of the study Interviews of senior health visitors	2005 – 2006 Feb. 2006	How am I to gain insight into the current professional identity of health visiting? Who is aware of the recent changes to the NMC register? Who would be likely to have an understanding of the implications of this for health visiting generally and its professional identity particularly?	• To develop and clarify the main aims of the study by exploring the current state of the professional identity of health visiting. • To examine the range and influence of the various discourses currently debating the role and identity of health visiting, particularly that of the NMC. • To consider what changes these discourses may be having on the professional identity of health visiting.
Exploration and review of literature, both current and historical, that considers, comments on, concerns the role, purpose and meaning of health visiting. Exploration of key documents related specifically to the role and purpose of health visiting. Analysis undertaken by the application of Gee's (2005) ideas on analysing discourse by considering 7 particular building blocks (see Appendix A for worked example)	Sept. 2004 – Dec. 2009	Where, by whom, and to what degree has the professional identity of health visiting (current and future) been explored and considered? What particular facets of its identity have been debated? Which agencies have been parts of this debate? What is the current governmental, policy, nursing and health visiting interest in this subject? What does it say? What does it tell me? What are the key and significant documents particularly related to health visiting purpose, meaning and identity during this time? How can Gee's (2005) ideas on discourse analysis 'unpick' the meanings contained within them? What does the application of this model of analysis reveal? What is the nature, degree of influence and purpose of these texts?	• To explore the historical context and meaning associated with health visiting. • To examine the range and influence of discourses currently debating the role and identity of health visiting. • To consider what changes these discourses may have on the professional identity of health visiting.

<u>Stage 2 of the study</u> Consideration of findings from Stage 1. Establishment of the 4 main aims of the study	Jan. – August 2007	What have the findings of stage 1 shown/given me? • That few health visitors seem yet aware of the implications of the NMC register changes; • That there are a variety of significant influences affecting the current and future meaning and identity of health visiting. • That the context associated with health visiting is changing. • The clarification of the 4 key aims for my study.	The main four aims/questions for the study are established: • What is the current state of the professional identity of health visiting? • What is the historical context and meaning associated with health visiting? • What is the nature and degree of influence of the discourses currently debating the role and identity of health visiting? • What changes are these discourses having on the professional identity of health visiting?
Consideration of methods and tools in respect of the emerging questions – see column 3. Design of scoping questionnaire	Sept. 2007 - April 2008	From clarification of the aims emerge the following questions: • Where, and with whom can I seek insight and opinion into the range, nature and degree of the current influences on the professional identity of health visiting? • Will health visitor educators (HVEs) respond, find time, be interested in being part of my study? • How can I access them and encourage their participation? • In the light of the time and resource restraints, and differing national policies re health visiting, should I limit the sample to HVEs in England only?	
<u>Scoping exercise</u> to HVEs in England via UKSC membership list of 42 members (full and honorary members from England, Scotland, Wales and Northern Ireland). 15 replies received and analysed.	May – July 2008	At this time of significant change and disinvestment in health visitor training and HVEs will HVEs be willing to participate in my study? I wonder how many of my scoping questionnaires have gone to HVEs no longer employed in this role?	• What is the current state of HVE numbers, morale, role and identity in England? • What is their understanding of the current and future role and purpose of health visiting? • How is this impacting on the programmes they deliver?

<u>Stage 3 of the study</u>	2008 – 2009		
Questionnaire design and development.	May – Sept. 2008	How can the questionnaire be designed and written so that participants are encouraged and able to give their thoughts in relation to the 4 key questions being asked?	Questionnaire designed to facilitate and engender knowledge and insight in relation to the 4 key study questions and aims.
Piloting of questionnaire.	Sept. 2008		
Minor adjustments to questionnaire following feedback from pilot exercise.	Sept. 2008	How can questionnaire questions be reduced, adjusted, without jeopardising its intent and satisfactory completion?	
Despatch of final questionnaire.	Sep. 2008		
Return of completed questionnaires.	Oct. 2008 – Feb. 2009		How can I analyse the data and findings contained within these responses?
<u>Analysis of data</u> **Stage 1: Interviews** Transcribing of interviews into written text.	March – June 2006		
Text examined for perspectives on key questions/themes of stage 1(see right)	July – Dec 2006	• What is the individual participants familiarity with the recent NMC register changes? • What is their individual perspective on the intention, purpose, impact of these changes on health visiting? • How do they view the future of/for health visiting at this time? • How do they think I could explore the impact of the NMC register changes, and creation of the part3/SCPHN element, on health visiting? How do the findings of this data clarify the *why?*, *what?* and *how* ? of my study.	

Stage 2: Scoping Exercise Examination of 15 returned questionnaires for: • Expressed willingness to participate in the main part of my research study. • Details of their current involvement in the training of health visitors. • Their involvement in the development, delivery of existing HV training programmes and new SCPHN programmes.	July – Sept. 2008	• Have I a sufficient number of participants to proceed? • Are they still actively involved with the profession of health visiting? • Do they have sufficient, and current, involvement and expertise in the designing and delivering of health visitor training programmes to comment on the required NMC changes to HV training curricula?	
Stage 3: • Examination of 12 completed questionnaires. • Allocation of numerical code. • Transposition of individual responses related to specific questions for analysis (see Appendix B). • Text examined for emerging themes related to study aims (see colour coding exercise exampled in Appendix B). • Text examined for other emerging themes of interest.	Jan. – May 2009	• What do these responses say in respect of the 4 key study questions? • What other themes are emerging from the responses? • Is there similarity, constancy or variety in these themes? • Which themes are 'voiced' as being important, significant?	What? and how? is the data and findings showing in respect of the main four aims/questions of this study: • What is the current state of the professional identity of health visiting? • What is the historical context and meaning associated with health visiting? • What is the nature and degree of influence of the discourses currently debating the role and identity of health visiting?

		What do the responses show:	• What changes are these discourses having on the professional identity of health visiting?
• Text reviewed in relation to Gee's (2005) method of discourse analysis.		• Is significant for the participants? • Is under construction? • Is being used to enact? • Is politically important? • About connections/disconnections? • Is privileged? • About health visiting identity?	
• Numerical indication of factor influence examined (Question 1.2). • Weighting applied – high (10. 9. 8.); medium (7. 6. 5); low influence ((4. 3. 2. 1.) – to give segments of influence.		• What is the numerical value given to individual factors? What does it show? • Is there dissonance, or similarity between score and associated narrative? • Which themes have emerged? • What does it indicate?	

APPENDIX III

Stage 1 Interview Schedule

What is your current title and professional background?

What are your current links with health visiting?

How familiar are you with the recent changes to the NMC register – current/historical?

From your perspective what is the change intended to do – generally and specifically for health visiting?

Do you envisage a change to:

- the practice of health visitors?
- To their representation i.e. change their meaning, collective consciousness (responsibilities, role)?
- ➢ Within health visiting and health visitors themselves? and/or
- ➢ Within nursing generally? And/or
- ➢ Within the minds of the public?
- the professional identity and/or culture of health visiting? and/or
- the identity and culture of professional nursing?
- the structural relationship, positioning, location, demarcation, boundaries (more diffuse or more clear?) of what is health visiting?
- ➢ For nursing generally? And/or
- ➢ For health visitors? And/or
- ➢ For the general public?

- How currently do you view the future of health visiting?

If you were intending to explore in the near future what possible impact the changes to the NMC register might have had on health visiting how would you set about it?

Jane Sheen Senior Lecturer, XXXXXXXXX.

.

APPENDIX IV

Stage 2 Scoping Exercise and Letter

Whither Health Visiting …Again?

Dear UKSC Colleague,

I am just completing the third year of my Doctorate in Education studies at UEA, Norwich, Norfolk. Since the beginning of my studies I have been considering the potential impact of the NMC regulatory framework changes and the creation of the new third part of the register for Specialist Community Public Health Nurses. I have been exploring particularly the impact of such changes on the identity of health visiting.

During the recent initial stage of the study, it appears that within the practice arena (i.e. amongst practicing health visitors and/or clients) there is little awareness of the nature and purpose of these register changes. Consequently I have chosen as my sample members of the UKSC who are, or have been, involved in the training and education of health visitors in the United Kingdom.

My study is being conducted in two phases:

Phase one of the study – Scoping exercise
The first stage of my study is an investigation of the current situation regarding the development of 'new' programmes to produce Specialist Community Public Health Nurses. From this stage I hope to gain information concerning the experience of health visitor educators in the development of these programmes and receive notification of those wishing to participate in my main study. The response to this scoping stage of the study will be by way of a short questionnaire.

Phase two of the study – survey by questionnaire
During the second stage of the study I am intending to access the perceptions and knowledge of a sample of those health visitor educators who responded to stage one. These individual opinions and perceptions of the participants will be in relation to the NMC register changes, and other influences, that are impacting on health visitor training, role and identity. Opinions and perceptions will be gathered by way of an open structured questionnaire.

INVITATION TO PARTICIPATE

I would like to invite you to participate in this study by completing the short attached questionnaire. Please see below the 'principles of procedure' for this study.

Please either complete on line and e-mail back to me or, if you prefer, print off a copy and return the completed questionnaire directly to **Jane Sheen Senior Lecturer** at the XXXXXXXXX.

Thank you for taking time to read this.

Jane Sheen, Senior Lecturer, XXXXXXXXX.

Principles directing the research exercise

- Your participation in this research exercise is completely voluntary, and much appreciated. You may withdraw at any time.

- By your completion and return of this questionnaire, I will assume that you have given your informed consent to participate.

- During the course of the study any information or comment provided by participants will be securely stored and seen only by myself.

- Any words taken from completed questionnaires, interviews or documentation and used in the completed thesis or in any other medium will be treated as confidential. The identification of the participant will not be disclosed.

- Any data related to participants gathered during this research project will be destroyed at the end of the research project.

- Approval to send this letter and questionnaire to you has been given by the chair of the UKSC SCPHN.

Stage 2 Scoping Exercise Questionnaire

QUESTIONNAIRE – PHASE 1

Your Name

Your HE Institution

Contact details

e-mail   _____

Telephone number   _____

---

1. Are you currently involved in the education and training of new health visitors?
_____

If so in what capacity?

_____

_____

_____

---

2. Have you in the past been involved in designing and developing a pre-registration curriculum for health visitors?

                                 Yes/No

If yes when?

_____

_____

_____

3. Re: the Specialist Community Public Health programme.

Have you already developed a SCPHN programme for health visiting?

Yes/No

If yes, when did it start?

_____

_____

_____

4. If you have not yet developed a programme, are you currently involved in designing and developing such a programme for health visiting?

Yes/No

What date is the programme due to be validated?

_____

_____

_____

5. Would you be willing to participate in the second stage of my research study?

_____

6. Any other comments

_____

_____

_____

_____

_____

_____

_____

APPENDIX VI

Stage 3 Introductory Research Letter

Whither Health Visiting…Again?

Welcome to the Questionnaire!

Purpose of the questionnaire

I am presently researching the current influences on the professional identity of health visiting and their possible impact. In order to achieve this I am hoping to gain the perspective of educators involved with the training and development of health visitors. A simple questionnaire has been developed to realise this.

Who will see your responses and what will happen to the information you provide?

No one but me will see the completed questionnaires and your responses will be treated as confidential. The analysis of the data provided will be undertaken by me and will contribute to a thesis for a Doctorate in Education (University of East Anglia, Norfolk). If your comments are used within the thesis these will be anonymised. None of your personal details will appear in the thesis or in any written report or article. At the completion of my studies the completed questionnaires will be destroyed.

How long will it take to complete and where is it to be returned?

The questionnaire has been piloted and should take approximately thirty minutes to complete. As stated above, any answers you give will be treated as confidential.

If you would like to send any curriculum, or other, documents to illustrate your answers this would be welcome. Again these will remain confidential to this research exercise and will not be shared with anyone.

I would like to follow up some of the comments by way of e-mail correspondence.

This questionnaire can either be completed on line and returned to me or a hard copy can be sent to me at the address below

.

Jane Sheen, Senior Lecturer, XXXXXXXX.

I can be contacted by way of e-mail at jane_sheen@hotmail.com

Thank you very much indeed for your participation.

Jane Sheen, Senior Lecturer, XXXXXXXX.

Stage 3 Questionnaire

CODE: [   ]

Questionnaire

What is Professional identity?

Professional identity relates to how people compare and differentiate themselves from other professional groups. It can be described as the attitudes, values, knowledge, beliefs, skills and role content shared within a professional group (from Adams, Hean, Sturgis and Macleod Clark, 2006).

The questionnaire is in three parts:

Part 1 – Factors influencing health visiting and their degree of influence.

Part 2 – Specific influences

Part 3 – Individual comment

Should you wish to comment further on any of the questions, an additional comments section has been included at the end of the questionnaire.

PART 1 – FACTORS INFLUENCING HEALTH VISITING

1.1 Q. How do you currently view the professional identity of health visiting?

A.

1.2 Q. This question is in two parts and refers to the table overleaf.

Firstly, can you indicate and comment on the factors (listed in the left hand column) that you believe currently have an influence on health visiting?

Secondly, in the column marked Degree of Influence on health visiting *please give your view on the degree of influence that the factors currently have on health visiting.*

AND Please quantify the degree of influence of each factor by giving a numerical score from 1 to 10 (1 = not very influential and 10 = very influential).

Factor	Influence on health visiting?	Degree of influence on health visiting?	Score
NMC Register (particularly SCPHN element)			
Government policy, Reviews, actions/activities			
Government publications			
Strategic Health Authority decisions, actions/activities			
Provider Primary Care Organisations			
Commissioning bodies			
CPHVA influence and/or activities			
HV practice innovation			
Organisation and/or management of health visiting			
Organisations external to health care (e.g. LA's, other Agencies, etc.)			
Individual health visitors			
Individual GP practices			
Public/consumer opinion			
Higher Educational Institution decisions, actions			
Other:			
Other:			

(SCPHN = Specialist Community Public Health Nursing)

PART 2 – SPECIFIC INFLUENCES

This section of the questionnaire considers the specific impact of the creation and implementation of the SCPHN part of the NMC professional register (2004) and its associated principles and standards of proficiency. These new SCPHN principles and proficiencies necessitated the development of new programmes for the training of health visitors. I am interested in whether these changes have influenced the profession of health visiting and what it now means to be a health visitor.

When providing your responses it would be particularly interesting to receive detailed examples from you in respect of: -

▪   programme content (theoretical and practical)
▪   programme emphasis (theoretical and practical)
▪   models and frameworks for practice
▪   skills and competencies
▪   values, beliefs and behaviours
▪   relationship with clients
▪   professional and cultural expectations and responsibilities
▪   role content, function and delivery.

2 Q. From your personal experience of <u>developing</u> and/or <u>delivering</u> new SCPHN programmes, are there any changes you perceive to the role, purpose and construction of health visitors and Health Visiting?

A.

3.1 Q. In your opinion is health visiting currently in a stage of:-.

Reinvention?

Adaptation?

Evolution?

Extension (of 'traditional role')?

Stasis?

Decline?

Other?

Select and comment on which of the above you believe currently applies to health visiting and why:

A.

3.2 Q. What <u>opportunities</u> do you envisage the profession of health visiting may utilise in the future?

A.

3.3 Q. What <u>challenges</u> do you think the profession of health visiting may face in the future?

A.

194

Additional comments section.

Thank you very much for completing this. Now kindly send to Jane Sheen using the details included in the covering letter.

APPENDIX VIII

Gee's seven building tasks of language

Gee's suggested seven areas of reality and associated questions that can assist in creating or building the world of activities and institutions (*An Introduction to Discourse Analysis,* 2005, pp 11-13).

1. **Significance** – *How is this piece of language being used to make certain things significant or not and in what ways*? How is language used to make certain things significant and to give them meaning or value. What institutions produced these discourses and situation? Are they being transformed in the act?

2. **Activities** – *What activity or activities is this piece of language being used to enact (i.e. get others to recognise as going on)?*

3. **Identities** – *What identity or identities is this piece of language being used to enact (i.e. get others to recognise as operative)?* What are the relevant discourses, How are they made relevant? What identities are under construction? Which ones are taken for granted?

4. **Relationships** – *What sort of relationship is this piece of language seeking to enact with others?* What social relationships are relevant, taken for granted or under construction? How are oral, written texts quoted or alluded to so as to set up certain relationships to other texts, people, discourses?

5. **Politics** – *What perspective on social goods is this piece of language communicating? (i.e. what is normal, good, right, correct, proper, valuable, appropriate, the way things are, the way things ought to be, high/low status, like me or not like me).* What social goods are relevant, have status, power?

6. **Connections** – *How does this piece of language connect or disconnect things: how does it make one thing relevant or irrelevant to another.* How is intertextuality used to create connections? What sort of connections are made to previous/future interactions.

7. **Sign systems and knowledge** – *How does this piece of language privilege or disprivilege specific sign systems (i.e. language, words images) or different ways of knowing and believing or claims to knowledge and belief.* What sign systems are relevant? What systems of knowledge and ways of knowing are relevant?

A WORKED EXAMPLE OF A DISCOURSE ANALYSIS OF A KEY TEXT AFTER GEE (2005)

SEVEN BUILDING TASKS OF DISCOURSE ANALYSIS	TEXT; Facing the future. A review of the role of health visitors (Department of Health, June 2007, (actual text from **Facing the future** in *italics*)
Building significance *How is this piece of language being used to make certain things significant or not and in what ways?*	<u>**Significance for heath visiting**</u> Document the outcome of working party deliberation on future role of HV. Group funded and supported by government funding, meetings of working party hosted by DH. Degree of independence? Is their position and professional freedom transformed by these activities? Agents of government? Independent professional? The text makes significant the need to *review the future role of health visitors* and to *sharpen, clarify and revitalise the health visitors role* (Foreword). *The need has been identified to reform the existing health service* (p.5, by whom? – government, nursing, parents, health visiting?). *An overwhelming message has been the need for clarity and direction about the current role of health visitors for commissioners, health visitors, other professions, leaders and the public* (overwhelming message from whom? Does this document provide this? Is it talking about clarifying current role or initiating, signposting a future role? – appears to be the latter). Significance given to the review *not about more health visitors doing the same job they have always done* (Foreword). Language talks about health visiting being a *valued profession* and also talks about *the unseen work that health visitors are doing* [that] *has gone unrecognised and .. undervalued.* Although makes significant the fact that for some time now, there have been concerns that health visiting *has lost its focus, or rather, there seemed to be too many foci for anyone, even health visitors themselves, to be able to define what health visiting was about and what health visitors should be doing* (Foreword)*.* Document states *Yet throughout this review we have been faced with the question of why the profession seems lost and under pressure when the very issues where health visitors can make a positive difference have never had greater prominence in the public's mind and government policy* (p.9 – question raised but no answer, even partial, given). <u>**Significant Change Agenda**</u> Significance of need for, desire for change of health visiting activity, purpose, employment, commissioning, education, career path resounds throughout document. The word 'change' and its derivatives are used 17 times in a relatively short document. Also other words are used to signify the tone, expectations, and thrust of the review – e.g. *specify, clarify, reform, revitalise, sharpen, adapt, improve, redesign* (HV role, purpose and expected outcomes), in a *new, proactive* way. <u>**Intertextuality significance**</u> (significant themes mentioned in document that incorporate, echo, allude to other key government health policy emphasis and identity): • Need for reducing health inequalities and social exclusion – *Saving Lives: Our Healthier Nation* (DoH, 1999a) • Need for service redesign, allied to concepts of choice and contestability – *Making a Difference: Strengthening the nursing,*

	midwifery and health visiting contribution to health and healthcare (DoH, 1999b) • Emphasis on need for evidence based practice and programmes – *A First Class Service: Quality in the New NHS* (DoH, 1998b) • Demonstrating value for money – *The NHS Plan: A Plan for Investment, A Plan for Reform* (DoH, 2000) • Need to demonstrate measurable health outcomes – *Shifting the Balance of Power within the NHS: Securing Delivery* (DoH,2001c) • Importance of health commissioning system, choices and strategy – *Commissioning a patient-led NHS* (DoH, 2005) • Need for enhanced professional accountability – *Liberating the Talents: Helping Primary Care Trusts and Nurses to deliver the NHS Plan* (DoH, 2002) • National health policy direction importance, yet promotion of local decision making – *Our health, our care, our say: A new direction for community services* (DoH, 2006b) & *Modernising Nursing careers – setting the direction* (DoH, 2006c) How the language of this report makes certain things significant can be clearly seen also in other following sections.
Building activities What activity or activities is this piece of language being used to enact (i.e. get others to recognize as going on)?	Main activity - to describe the future role of the HV and make recommendations for developing and implementing the role in context of *Modernising Nursing Careers* (p.33). Building of HV role in context of governmental and professional policy and documents; evidence base for parenting and child health. To identify levers for change. To attract a new generation to the profession. The new focus, core elements and priorities for health visitors (p.6). P. 29 getting health visiting to move *from here to there.* MacLure's binary construction? Moving *Coming from > Going towards.* Page full table concerned with transition of health visiting practice, workload, workforce, beliefs, career path, employer, training, individualism, model of practice. Starting on p.19 more detail is provided on reasons for described future ***Priorities*** for health visitors. Supporting examples come mainly from epidemiological data and messages from research. Although stating the need for priorities for HVs to have greater focus and clarity the stated priorities are couched in very broad terms and do not address how they might be achieved!
Building identities What identity or identities is this piece of language being used to enact (i.e get others to recognize as operative)?	**Text creates a proposed new future identity for health visitors and health visiting** -Giving the health visiting profession *a real opportunity* to *renew role for health visitors* (p.5), Under construction in the language are what the core elements of health visiting should be (p.6). Identity stabilised or transformed? Renewed/redesigned? Knowledge and beliefs about **current health visiting** – stated as too many foci; *have lost their focus,* doing the same job they have always done*; defined as public health nurses working with young children (p.7); a key part of an integrated children's service (p.8); *has a long and proud tradition in this country .. a valued resource and .. positive influence on health and wellbeing of families and young children* (p.9) Document represents a strong attempt to influence, and create a change (adaptation? Evolution? Transformation?) in the values, activities, meaning and purpose of the profession of health visiting and the role of the health visitor. As stated *the review was asked to*

	describe a renewed role for health visitors (p.5). The report is described as providing *an analysis of health visiting today and setting out a vision for the future* (p.9). The document puts forward 9 recommendations in respect of this mission: • Defines/recommends a future for health visiting by describing what health visiting's core elements, focus and priorities *should be,* and the priorities in which health visitors *will need to play a lead role* (p.6); • Introduces the idea of *level of practice* that health visitors are working at and what they *should be responsible for* i.e. *the 'difficult things'* (p. 7); • Defines/recommends what the primary role of the health visitor should be – one of two options (see p.7); • Defines/recommends additional areas of practice – two further packages of services *that health visitors ..can provide depending on local circumstances* (see p. 7); • Defines/recommends commissioning strategy (p.7) and organisational options for health visitors – which is as a key part of integrated children's service – which *should be determined locally* (p. 8).
Building relationships What sort of relationship or relationships is this piece of language seeking to enact with others (present or not)?	**Relationship with HV profession/health service** Generally unclear **–** *this report does not tell the service what to do, neither does it make recommendations on numbers and resources. Rather it describes a role for the future that focuses on the needs of children and families and on what commissioners, providers and the health visiting profession need to do to implement that role* (p.10). *Facing the future* states its wish to build relationship with *the health visiting profession and the health service as a whole* (p. Foreword) by providing a real opportunity to *sharpen, clarify and revitalise the health visitor's role* (Foreword). Yet see 'Building connections'. **Building, creating, strengthening relationship with commissioners, commissioning**? These words feature often in report (pp. 5, 7, 8, 9,10, 12, 13,15, 16, 21,24, 27,28, 29, 30, 31, 33). Commissioning has its own recommendation number 4 *Commissioners should commission early intervention, preventive and health promotion services for all young children and families* (p.7). **Power/influence of relationship building?** So many of stated key relationships cited by the review in respect of - commissioning of health visiting services, core activities of health visitors, organisational options for health visitors and national policy suggestions to *support the implementation of the review* (p.8) - feature the word '**should'** - what influence and power does the review have to really influence – government policy? Commissioners of services? Provider organisations? The NMC? The profession of health visiting? **Relationship building with parents** in report is seen as a priority in the report - described as *Supporting the capacity for better parenting.* Better parenting is described in relation to outcomes, self-sufficiency and supporting parental relationships. Fathers are mentioned – if briefly. Focus particularly on genes, bio-chemistry, early neurological development and attachment. **Relationship building with wider stakeholders** – see review party membership – see building connections section.
	The current and future 'social good' of and for health visiting - P29 of document, **Getting from here to there**, indicates the central beliefs of the working party and a synopsis of the thrust of the overall document, and communicates these beliefs as to where health

| Building politics

What perspective on social goods is this piece of language communicating? | visiting is going and what should be conserved as 'good',' normal', 'right', 'correct', 'proper', 'appropriate' and 'valuable' for future health visiting's 'way of being'. It clearly displays the way the working party think things are <u>and</u> the way things ought to be for health visiting in respect of 20 areas. The ***Going towards*** column (reflected and discussed further within the document) is stated as the right and favoured way for health visiting to develop/proceed and is consequently ascribed a higher status than the existing **C*oming from*** situation/position of health visiting which appears afforded a lower status.
Language in **G*oing towards*** column illustrative of what the working party appears to wish to achieve, is the good and correct and valuable way forward:
• Words *focus, focused* feature in 2 main areas – *on young children and families; on priorities and delivering outcomes.* Other words used reflect a desired health visiting approach that is *planned, more self-directed, systematic and professionally accountable.*
• Nature of future health visiting activities and practice described to become – an *integrated child and family health service from conception to 19 years* involving *public health at both individual and population level;* with health visitors as members of *universal, integrated, preventative, multi-skilled children's teams in a range of settings.* Very much a *team player and community leader, engaging fathers as well;* undertaking *more self-directed and professionally accountable planned, systematic* provision delivering commissioned services.
• The essence of future models/philosophy of practice for health visitors and health visiting emerge from certain key words - *pluralism, alternate, new, different, commissioned, flexible, more, outcomes, diversity, integrated, focus.*
• Words associated with looked-for future nature of health visiting workforce – *ethnic and gender mix to reflect diversity in population; younger generation of health visitors; flexible workforce to meet public needs/demands;*
• Career pathways for health visitors and employers of health visitors (i.e. providers of service) follow supported model/philosophy of pluralism – *option of several career paths; plurality of provision offering alternate employers and employment models; commissioners contracting from new providers with competetion.*
• Training of health visitors in the future to – *equip all health visitors to do the job on the ground; modular learning, flexible curriculum with national standards.*
The column headed ***Coming from*** is described in terms that have the tone of being a 'way of being' for health visitors/health visiting that is rigid, inflexible, outdated, confused and too universal i.e.
• Health visiting practice - *9 to 5, undifferentiated workload, inconsistent service provision with individual interpretation, stand alone, doing everything,* possessiveness of caseload '*my caseload',* resistant to change '*we've always done it this way'.* A service from *'cradle to grave',* providing a *universal health visitor,* where *all health visitors are equal* (meaning of this statement not clear?), viewed *as a separate service.*
• Use of words *one, single, 'one size fits all'* a recurring theme in this column *used* to describe health visitor career pathway; the employment of health visitors by *a single employer; one service provider with no competition;* one model of health visitor training programme where *'one size fits all'* and practical skills are acquired *after qualifying as a health visitor..*
• Nature of health visiting workforce described as *older workforce, largely female and white.* |

Building connections How does this piece of language connect or disconnect things; how does it make one thing relevant or irrelevant to another?	**Things that are connected in the findings**: • Health visiting and its need for reform; • Achievement of reform written as if connected with certain factors: a) Facing the future describes *the road we think should be taken by the profession. However, showing the way is not enough to make it happen …the levers for change reside at every level and with many individuals and organisations …commissioners, providers, the profession, educationalists and the regulatory body* (p.30); b) *It is clear that the solution to the problems facing health visitors today does not necessarily lie in the profession but in the commissioning of child and family health services* (p.21) !. c) The implementation of the review findings *will depend on strengthening the commissioning of preventive services for children, modernising nursing careers and change by the health visiting profession itself* (p. 10); *This report does not tell the services what to do, neither, does it make recommendations on numbers and resources. Rather, it describes a role for the future that focuses on the needs of children and families and what commissioners, providers and the health visiting profession need to do to implement the role.* **Mixed messages, appear at times disconnected – does the Report just describe and analyse or lay out a blue print for reform? What teeth does it have to influence such a variety of organisations – many with quite different purposes, agendas and desired outcomes? See b) – if solution to HV problem does not lie with HV profession what does the Working Party suggest should happen. How widespread has the knowledge, reading and recommendations of the review been to reach the stakeholders that CAN provide a solution to the HV problems?** • Stated connection between the review and final report with an ambitious programme of engagement over a short period ..*over 1,000 health visitors and local leaders contributed to the debate through 10 regional 'Let's talk about health visiting workshops .. 400 responses through the Chief Nursing \officer email box … one-off events and meetings .. to gather the views of other stakeholders ..the expertise of the Health Visiting Review Group .. a small survey of PCT commissioners and practice based commissioners* (p.13). **Things that are disconnected in the findings** – the stated importance of undertaking the review of health visiting yet use often of word 'should'. 9 recommendations but what real connection/impact/influence does the report have with NMC and its Modernising Nursing Careers strategy? Commissioners? Provider organisations? Government policy, **a recurring theme in this analysis.** **The NMC proficiencies for SCPHNs, or <u>the actual name of specialist community public health nurse</u>, achieves not one mention or consideration – they appear irrelevant to the review and report – yet they must be highly relevant as they define the competencies, knowledge and beliefs required for training of new health visitors – if the role is to be renewed then so must their professional requirements from their professional governing body! No mention of part 3 of the NMC register at all. Does this report and review only consider existing health visitors? What of future training of health visitors? This report is published only 3 years after creation of new title, role and register part for health visitors.** **Connections with a range of organisation to make up Review Working group** Interestingly membership of Health Visitor Review Working Group (of 34 members) come from many 'bodies' CPHVA and UNISON (x 3 members); PCT staff (x 9 members, with nurse in their title (6); University staff (x 5 members); independent bodies – Queen's Nursing

	Institute (x 2), National Children's Bureau (x 1), Kings Fund (x 1), From government related bodies – Department of Health x 1 (Deputy CNO), The Performance Support Team DH x 1 (Director of Nursing), Department for Education and Skills x 1 (nurse adviser), SHA x 1 (Director of Nursing), NHS Confederation x 1 (Deputy Policy Director). From official professional nursing bodies – RCM x 1 member, RCN x 1, **NMC x 1** **(title given as Professional Adviser, Specialist Community Public Health),** UKSC x 1 (Chair) **Only one member has title Health Visitor**. Consumer reps. Netmums x 1 (Director), Parentline Plus x 1 (Chief Executive), One Plus One x 1 (Director). **Does nursing dominate membership** **Comnnection with** training **of new health visitors –** an important area that is rarely mentioned or addressed – p. 29 review wishes to move from a *'52 week course 'one size fits all'* to *modular learning, flexible curriculum with national standards.* What of national professional regulatory standards? Yet on p. 15 under title Review findings on what needs to happen – point no.13 is *attract a new generation of nurses who want to make a difference.* Also on p.14 under heading *Review findings on where profession is now* – Point 10 *states there is a mismatch between training and the service requirements.*
Building significance for sign systems and knowledge How does this piece of language privilege or disprivilege specific sign systems or different ways of knowing and believing or claims to knowledge and belief ?	**Specific signs and systems strongly related to words v. images of old health visiting versus 'new' health visiting – see building politics** Report supports and suggests certain ways of knowing and believing to help create the 'new' health visiting – a new Discourse model (storyline, connected images, communication system, theories "shared by people belonging to a specific group" (Gee, 2005, p.95) of and for health visiting. Particularly relevant to the creation of the new Discourse model for health visiting are two key ideas put forward by the working party: 1. the underpinning (widely suggested and supported) NHS national (labour govt.) policy concept/philosophy of **progressive universalim –** *a universal service that is systematically planned and delivered to give a continuum of support according to need at neighbourhood and individual level in order to achieve greater equity of outcomes for all children. Those with greatest risks and needs receive more intensive support* (p.25). 2. the level of practice for future health visitors – that of *highly trained professionals … responsible for the 'difficult things'* (p.7). For 'difficult things' see p.7 – managing, deciding, leading in respect of conditions of complexity, uncertainty, difficulty and vulnerability for populations that are hidden, mulit-skilled, individual and population wide. Out of this decision the review recommends the central two packages that *should make up their* [health visitors] *primary role in the future* (p.23) – a role for such practitioners *with high level responsibilities that require high level skills* (p.22). Two packages - *Leading and delivering the Child Health Promotion Programme using a family focused public health approach* and *Delivering intensive programmes for the most vulnerable children and families* (p.23) The words '**progressive universalism'** achieve a situated meaning – an image or pattern that is assembled "on the spot" as we communicate in a given context "based on our construal of that context and on our past experience" Gee, 2005, p.94).

APPENDIX X

MacLure's General Questions

MacLure's suggested general questions to 'open up' a research text (2003, p. 82):

- How do politics and poetics intertwine in this text?

- Does this text carry the 'scent' of an institution?

- How are knowledge claims established and defended?

- How does this text make its bid for believability?

- Where does this text get its authority?

- How does the text persuade?

- Where does the power reside in this text?

- What other kind of texts is this text 'like'?

- What might be so taken for granted in this text that it is almost impossible to 'see' it?

- Whose voices are privileged in this text? Who gets agency?

- What kind of reader is this text 'hailing'?

- What are the questions that this text cannot pose to itself?

- Where are the gaps, silences and inconsistencies in this text?

Stage 3 Questionnaire – Quantitative data from Question 1.2

- indicates no reply

Factor	CODE	01	02	03	04	05	06	07	08	09	10	11	12
	NAME	MARY	PAM	JEAN	LUCY	JOHN	ANNE	JANE	RUTH	GILL	EMMA	KATY	RITA
NMC Register (particularly SCPHN element)		4	9	7	8	9	8	10	10	8	5	10	10
Government policy, Reviews, actions/activities		5	10	7	10	8	8	8	10	7	8	8	7
Government publications		5	7	7	7	7	8	10	6	7	4	8	7
Strategic Health Authority decisions, actions/activities		9	9	5	9	9	7	5	5	9	8	9	10
Provider Primary Care Organisations		9	7	5	7	9	7	-	8	9	5	10	9
Commissioning bodies		9	-	5	-	9	6	10	7	9	7	-	7
CPHVA influence and/or activities		6	5	6	5	4	6	2	6	7	5	8	7
HV practice innovation		9	5	2	3	4	5	2	7	4	4	-	3
Organisation and/or management of health visiting		10	2	5	2	8	7	4	9	9	8	10	9
Organisations external to health care (e.g. LA's, other Agencies, etc.)		5	2	4	2	7	4	2	2	5	7	-	8
Individual health visitors		9	1	3	1	5	4	2	-	7	4	1	8
Individual GP practices		5	3	2	-	7	5	5	-	4	5	4	7
Public/consumer opinion		9	6	4	-	-	4	1	-	5	4	3	2
Higher Educational Institution decisions, actions		5	5	4	5	-	5	-	-	7	7	-	8
Other: Political comments Laming Report recommendations Netmums				5								-	5

Stage 3 Questionnaire – Analysis of Quantitative data related to Degree of Influence on health visiting

Factor	Degree of influence on health visiting (Scores from 12 participants – 1 = not very influential and 10 = very influential)			Overall degree of influence (Position)
NMC Register (particularly SCPHN element)	No. of 10s - **4** No. of 9s - **2** No. of 8s - **3** No. of 7s - **1**	No. of 6s - **0** No. of 5s - **1** No. of 4s - **1** No. of 3s - **0**	No. of 2s - **0** No. of 1s - **0** No. of no reply - **0**	1st
Government policy, Reviews, actions/activities	No. of 10s - **3** No. of 9s - **0** No. of 8s - **5** No. of 7s - **3**	No. of 6s - **0** No. of 5s - **1** No. of 4s - **0** No. of 3s - **0**	No. of 2s - **0** No. of 1s - **0** No. of no reply - **0**	2nd
Government publications	No. of 10s - **1** No. of 9s - **0** No. of 8s - **2** No. of 7s - **6**	No. of 6s - **1** No. of 5s - **1** No. of 4s - **1** No. of 3s - **0**	No. of 2s - **0** No. of 1s - **0** No. of no reply - **0**	7th
Strategic Health Authority decisions, actions/activities	No. of 10s - **1** No. of 9s - **6** No. of 8s - **1** No. of 7s - **1**	No. of 6s - **0** No. of 5s - **3** No. of 4s - **0** No. of 3s - **0**	No. of 2s - **0** No. of 1s - **0** No. of no reply - **0**	2nd
Provider Primary Care Organisations	No. of 10s - **1** No. of 9s - **4** No. of 8s - **1** No. of 7s - **3**	No. of 6s - **0** No. of 5s - **2** No. of 4s - **0** No. of 3s - **0**	No. of 2s - **0** No. of 1s - **0** No. of no reply - **1**	5th
Commissioning bodies	No. of 10s - **1** No. of 9s - **3** No. of 8s - **0** No. of 7s - **3**	No. of 6s - **1** No. of 5s - **1** No. of 4s - **0** No. of 3s - **0**	No. of 2s - **0** No. of 1s - **0** No. of no reply - **3**	6th
CPHVA influence and/or activities	No. of 10s - **0** No. of 9s - **0** No. of 8s - **1** No. of 7s - **2**	No. of 6s - **4** No. of 5s - **3** No. of 4s - **1** No. of 3s - **0**	No. of 2s - **1** No. of 1s - **0** No. of no reply - **0**	9th
HV practice innovation	No. of 10s - **0** No. of 9s - **1** No. of 8s - **0** No. of 7s - **1**	No. of 6s - **0** No. of 5s - **2** No. of 4s - **3** No. of 3s - **2**	No. of 2s - **2** No. of 1s - **0** No. of no reply - **1**	12th

Factor	Degree of influence on Health Visiting (Scores from 12 participants – 1 = not very influential and 10 = very influential)			Overall degree of influence (Position)
Organisation and/or management of health visiting	No. of 10s - **2** No. of 9s - **3** No. of 8s - **2** No. of 7s - **1**	No. of 6s - **0** No. of 5s - **1** No. of 4s - **1** No. of 3s - **0**	No. of 2s - **2** No. of 1s - **0** No. of no reply - **0**	4th
Organisations external to health care (e.g. LA's, other Agencies, etc.)	No. of 10s - **0** No. of 9s - **0** No. of 8s - **1** No. of 7s - **2**	No. of 6s - **0** No. of 5s - **2** No. of 4s - **2** No. of 3s - **0**	No. of 2s - **4** No. of 1s - **0** No. of no reply - **1**	11th
Individual health visitors	No. of 10s - **0** No. of 9s - **1** No. of 8s - **1** No. of 7s - **1**	No. of 6s - **0** No. of 5s - **1** No. of 4s - **2** No. of 3s - **1**	No. of 2s - **1** No. of 1s - **3** No. of no reply - **1**	8th
Individual GP practices	No. of 10s - **0** No. of 9s - **0** No. of 8s - **0** No. of 7s - **2**	No. of 6s - **0** No. of 5s - **4** No. of 4s - **2** No. of 3s - **1**	No. of 2s - **1** No. of 1s - **0** No. of no reply - **2**	14th
Public/consumer opinion	No. of 10s - **0** No. of 9s - **1** No. of 8s - **0** No. of 7s - **0**	No. of 6s - **1** No. of 5s - **1** No. of 4s - **3** No. of 3s - **1**	No. of 2s - **1** No. of 1s - **1** No. of no reply - **3**	13th
Higher Educational Institution decisions, actions	No. of 10s - **0** No. of 9s - **0** No. of 8s - **1** No. of 7s - **2**	No. of 6s - **0** No. of 5s - **4** No. of 4s - **1** No. of 3s - **0**	No. of 2s - **0** No. of 1s - **0** No. of no reply - **4**	10th
Other:	No. of 5s - **2**			

APPENDIX XIII

Stage 3 – Example of initial questionnaire data analysis in respect of main research questions

What is the current state of the professional identity of health visiting?
What is the historical context and meaning associated with health visiting?
What is the nature and degree of influence of the discourse currently debating the role and identity of health visiting?
What changes are these discourses having on the professional identity of health visiting?
Other themes emerging?

PART 1 – FACTORS INFLUENCING HEALTH VISITING?
1.1   Q. How do you currently view the professional identity of Health Visiting?

Code	Response
01	At the moment there is a definite gap between what we teach academically and then what the student is exposed to in practice. I don't view this as a traditional practice/theory gap. More a case of students entering practice fired up and ready to trail blaze new policies and initiative and being met by some practitioners who are reluctant to change, feel disempowered and have become cynical as result.
02	Serious risk of any identity being eroded, particularly if/when the CHN role is being fully implemented. However, a positive aspect remains in that HVs are still widely recognised as sources of expert help by families and communities.
03	In crisis. There are reduced numbers of health visitors in post and being trained. Staff are aware that others are undertaking roles they once did e.g. parenting, identification of developmental difficulties, group work and more. Health visitors are not a confident group and they are not making their voice heard within the PCTs or at national level. Until recently we have been missing in the government documents, though that at least seemed to be changing, see documents related to the Darzi review. Overall health visiting seems passive, just waiting to see what will happen next.
04	Serious risk of any identity being eroded, particularly in Scotland if/when the CHN role is being fully implemented.
05	The professional identity of health visiting is somewhat blurred at the moment. Health visitors have *been* (and still are in some quarters) regarded as providing to support to families with new born children, with a fairly limited professional identity linked to the skills associated with weighing babies, advising on weaning and safeguarding children. There is a struggle between this identity and the wider public health identity. Perhaps this is because (among other things) public health is considered from population approach and health visiting is considered from an individual family approach. Health visiting sees skills in building relationships as essential while P. H. work requires population-based skills.

06	Somewhat confused at present due to a number of issues. Firstly over the past few years the role of the HV has become blurred with a shift towards a more medical model of practice due to government policy relating to targets. Also other professions coming into the community more so squeezing the traditional role of the HV e.g. nursery nurses; Surestart etc. I also think that the general reduction in whole time equivalent HVs across trusts have led HV to feel undermined and more crisis driven thereby the Public Health remit has been eroded away. I also think that Agenda for Change did the profession no favours and tried to reduce the profession down to measurable components which again led to discontentment and finally the NMC have demonstrated time and again a pre-reg slant which has again undermined the specialisms.
07	I think this is in a state of flux – I think there has been a great deal of confusion in relation to the identity of HVs that has become undifferentiated in many ways from other community nurses, children's centres, public health workers – I think this is now turning and the recent CHPP has clearly laid out the leadership role for HVs. HV is different from others in that they have specific skills of HNA, implementation of initiatives, health promotion, partnership working with an emphasis on family working. The key for me is the relationship they develop with the family and the interactions that then follow.
08	A. Since the deregulation of health visiting in 2002 by the NMC health visiting is no longer a profession in its own right. Any one can now call themselves a health visitor and the public are not protected from people who do so and who do not hold any qualification in health visiting. B. The protected title is now specialist community public health nurse (health visitor), yet this is not seen on identity cards held by practitioners. Health visiting is now a role title only. C. There is now no body of knowledge, attitudes and values identified for the role of health visitor, these are now embedded in the standards for specialist community public health nursing and predicated on nursing or midwifery.
09	Over the last year following the HV review and subsequent policy documents and reports including the Laming Review there has been an elevation of the health visiting profile. However, I think there is still some confusion between the professional identity of a Health Visitor and health visiting service provided by a skill mix team.
10	Health visiting is struggling to secure a professional identity. This is due, in my opinion, to a multitude of historical elements. There has continually been a lack of understanding by society in general of the role of health visiting and more latterly the role of the 'public health' nurse within the concept of health visiting. There has been a notable lack of leadership to secure a health visiting strategy for the UK – there have been notable commentators but this has led the academic drive, rather than leading practice. Parenting is high on the national agenda, now, but rather than re-emphasising the importance of health visiting in this (to date) there has been greater investment in other agencies (such as local authority) to address parenting issues.
11	In practice – an experienced community nurse who has got specialist skills to work with children and families and other vulnerable groups of people to promote and protect their health through public health activities, this is what HVs and their clients know. However, within the public arena the identity is lost under the SCPHN title.
12	Health visiting has a unique public health role (in whatever form that might be) in that it has access to the family 'unit' in a way that no other professional group has. It demands a set of skills based on the establishment of relationships with parents.

APPENDIX XIV

Wither health visiting? - Data on the statistical position of health visiting

- "The number of health visitors has dropped by 10% in the last three" years (Unite/Community Practitioners' and Health Visitors' Association Omnibus Survey 2008).

- Whilst – the population has grown by 4.65%; the number of live births has increased by 8.51%; the number of midwives has grown by 8.10%; and the number of nursery nurses employed in the NHS has risen by 99.03% (Unite/CPHVA, 2009a).

- "Health visitor caseloads are significantly higher than the recommended 300 families or 400 children, with 40% of health visitors handling case-loads of over 500 children and 20% over 1,000 children" (Lord Laming 2009, section 5.22, citing the Unite/Cpractitioners HVA Omnibus Survey, 2008).

- "In 2008, 253 new health visitors were registered; in 2004, 717 new health visitors were registered ('Health Visiting: A career in crisis?' *Children and Young People Now,* September 2009).

- "40% axe in health visitor training places 'sabotages' government public health goals: ministers told to stop acting like Pontius Pilate" (Amicus/CPHVA Press Release following release of NHS workforce statistics for year ending September 2006, *One Health Visitor Job a day is Being 'Lost' – its Official,* 2007).

- "The number of health visitors working within English Primary Care Trusts is around 7,800 WTE, approximately 1000 fewer than the 8,764 reported in the Department of Health workforce statistics" (*Health Visiting Matters,* UKPH A, 2009a, p. 5).

- "1 in 5 health visitors are already over retirement age" (The NHS Information Centre for Health and Social Care, 2009).

- "The annual spend on health visiting service provision ranges from £60 to £386 for each pre-school child across the 143 Primary care Trusts" (Family and Parenting Institute, 2009).

- December 2008, CPHVA survey by way of a telephone interview of a random sample (n=829) of health visitor members (by C. Adams and I. Craig). Results portray "a health visitor service in crisis and children put at risk" due to rising health visitor workloads, reduction in numbers of health visitors; rising skill mix teams; gaps in support services; poor access to education and training, in all "a depleted health visiting service". "There has been encouraging remarks from ministers…it will take some time to rebuild the health visiting profession in England".

GLOSSARY

CETHV -The Council for the Education and Training of Health visitors.

A Council set up in 1977 to define the principles of health visiting practice, and requirements for the training and education of health visitors. These principles emphasised the requirement for health visiting to search for health needs, as well as their educative function and work with 'the family'.

The Child Health Programme (CHPP)

A national a programme of screening tests, immunisations and guidance to support parenting and health choices to assist every family in England achieve their optimum health and wellbeing (*The Child Health Programme, Pregnancy and the first five years of life,* DoH, 2008b).

Commissioning

- The process of specifying, securing and monitoring services to meet people's needs at a strategic level. This applies to all services, whether they are provided by the local authority, NHS, other public agencies or by private and voluntary sector organisations (*Making Ends Meet,* Audit commission, October 2003).

- The full set of activities that local authorities and Primary Care Trusts undertake to make sure that services meet the health and social care needs of individuals and communities (*Commissioning Framework for Health and Well-being,* DoH, 2007c).

Community Practitioners and Health Visitors Association (CPHVA)

The CPHVA is the United Kingdom's leading professional organisation for health visitors, school nurses, nursery nurses and other community nurses working in primary care. The CPHVA was affiliated before 2007 with the union Amicus and therefore some of the CPHVA publications are recorded as Amicus/CPHVA. In May 2007 Amicus amalgamated with the Transport and General Workers' Union – forming the union Unite. Consequently the CPHVA changed its nature and title to Unite/CPHVA – becoming a section of the Unite trade union, the largest trade union in the United Kingdom across the private and public sectors.

The Community Practitioners and Health Visitors Association is one of the seven professional groups and associations in Unite Health Sector which is the third largest health union for nurses. For clarity and ease of use, the term CPHVA is used within the text.

Facing the Future (DoH, 2007a) suggested future roles for the health visitor

<u>Primary role</u>:

– Leading and delivering the Child Health Promotion Programme using a family focused public health approach;

– Delivering intensive programmes for the most vulnerable children and families.

<u>Additional areas of practice</u>:

– Providing wider public health packages;

– Providing primary care nursing service for children and families.

Health Visitor Educators (HVEs)

Educators/lecturers working within Higher Educational Institutions (HEIs) who are qualified teachers and health visitors who design, deliver and lead programmes of education to train nurses and midwives to become health visitors.

Netmums

Founded in 2000, Netmums is the United Kingdom's fastest-growing online parenting organisation with over half a million members, mostly mums. Netmums is a family of local sites that cover the United Kingdom, each site offering information to mothers on everything from where to find playgroups and how to eat healthily to where to meet other mothers. The local sites are backed by a wealth of parenting articles that start with pregnancy and follow through each stage of chilhood helping mums to enjoy a happy and healthy family life. Netmums is also available offline too with the publication of five books.

Practice Teachers

Qualified, experienced health visitors who have completed further education and training in the facilitation of learning in practice and assessment of practice in order to undertake their role as Practice Teachers. Each student health visitor is 'attached' to a named Practice Teacher for the duration of his/her training. Practice Teachers monitor and facilitate their learning and development and assess their progress in the practice of health visiting skills, knowledge and competence. At the end of the course it is the decision of the Practice Teacher as to whether the student health visitor is fit for practice and subsequently registration as a qualified health visitor.

Primary Care Trust (PCT)

A semi-autonomous NHS organisation that initially purchased and provided health care services for a defined population, in its new form it is the purchaser and commissioner of care services for a defined population.

Primary Care Organisation (PCO)

A semi-autonomous NHS organisation that provides primary care, community services and practitioners for a defined population. Their role as employer is primarily in respect of community nurses, and professionals allied to health who provide other community services. They are therefore the managers and employers of health visitors, student health visitors and Practice Teachers.

Principles of health visiting

Health visiting principles are defined as:

- The search for health needs
- The stimulation of an awareness of health needs
- Influencing the policies affecting health
- The facilitation of health enhancing activities.

(CETHV, 1977; Twinn and Cowley, 1992;)

SENATE For Health Visiting and School Nursing (SENATE)

SENATE defines itself as an Egroup that is an enabling mechanism for health visitors and school nurses for interactive involvement and networking. Membership is free – health visitors and school nurses are actively encouraged to participate and other interested parties are welcome.

SENATE aims:

- To be a voice in the development of, and influence on, policy affecting health for health visiting and school nursing;
- To provide an interactive discussion group where policy and practice issues can be debated and explored;
- To influence policies affecting health with particular reference to health visiting and school nursing;
- To provide clarity of purpose for health visiting and school nursing through professional leadership (www.egroups.com/SENATE-HVSN).

Skill mix teams

Teams consisting of a range of staff - community staff nurses, nursery nurses, family support workers etc. Skill mix has been defined as "a mix of differing grades of staff in a particular working environment, their costs and activities" (*Skill Mix Fact Sheet,* CPHVA, 2007, p. 1).

Specialist Community Public Health Nurse(ing) (SCPHN)

The title and Part (3) of the Nursing and Midwifery Council register. The definition for Specialist Community Pubic Health Nursing, as provided by the Nursing and Midwifery Council:

"Specialist Community Public Health nursing aims to reduce health inequalities by working with individuals, families, and communities promoting health, preventing ill health and in the protection of health. The emphasis is on partnership working that cuts across disciplinary, professional and organisational boundaries that impact on organised social and political policy to influence the determinants of health and promote the health of the whole population" (NMC www.nmc-uk.org 13.2.06).

Specialist Community Public Health Nurse Programme (SCPHN)

The NMC prescribed programme (NMC, 2004b) for the training of Specialist Community Public Health Nurses (i.e. health visitors, school nurses and occupational health nurses. The standards of proficiency for SCPHNs require programmes:

- To have an overall length of 52 weeks (of which 45 are programmed weeks) (p.13);

- To balance between practice and theory in the programme, i.e. to be 50% practice and 50% practice (p.14);

- To provide the opportunity for students to experience practice in a range of different settings and areas of practice, to enable the student to develop a breadth of understanding in Specialist Community Public Health Nursing (p.14);

- Where a particular practice route is required (i.e. health visiting, school nursing or occupational health nursing) students must have completed their consolidated practice experience (minimum of 10 weeks) and at least half the remaining practice time (minimum of 6.3 weeks) in settings and with clients that are central to the responsibilities for that defined area of practice (p. 15);

- To enable students to gain a broad understanding, and the context for practice, in all community public health settings (p.15);

- Where students must, additionally, spend at least three weeks gaining experience in the settings, and with clients, considered either important or that may be a potential area of responsibility, even if not central to the defined area of practice (p.15);

- The minimum academic standard of Specialist Community Public Health Nursing programmes is that of a first degree (p.16);

- Programme leaders are expected by the NMC to be registered with the NMC on that part of the register and to have a teaching qualification recorded with the NMC, together with relevant academic qualifications appropriate to the level of the programme (p. 16) (*Standards of proficiency for specialist community public health nurses*, NMC, 2004b).

The Health Visitors' Association (HVA) - the forerunner of the CPHVA. Defining itself as a professional association and a trade union (HVA, 1992). Formed in 1896 as the Women's Sanitary Inspectors' Association. It was one of the first health unions to affiliate to the TUC in 1924.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) - The body created under *The Nurses, Midwives and Health Visitors Act* of 1979 to record and regulate all nurses employed both within and without the NHS.

United Kingdom Standing Committee on Specialist Community Public Health Nurse Education (UKSC); formerly the United Kingdom Standing Committee for Health Visiting (UKSC)

A body representing all health visitor education and training centres in the United Kingdom, with links to Nursing and Midwifery Council and the Department of Health. It acts as a forum for discussion and exchange of information and ideas. It describes itself as being " in a unique position to contribute authoritative insights regarding the nature and purpose of health visiting – past, present and future" (www.uksc.org Dec. 2005). The Forum holds meetings four times each year, with representatives from the NMC and Department of Health (Nursing Division) attending.

The United Kingdom Public Health Alliance (UKPHA)

The UKPHA is an independent, UK-wide voluntary association, which brings together through its membership individuals and organisations from all sectors, sharing a common commitment to promoting the public's health. The organisation seeks to promote the development of health public policy at all levels of government and across all sectors. It acts as an information platform and aims to support those working in public health both professionally or in a voluntary capacity. The UKPHA works closely with government bodies from England, Scotland and Wales and with colleagues in Europe.

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