

# National Nursing RESEARCH UNIT



## **Start and Stay: The Recruitment and Retention of Health Visitors**

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## Executive summary

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### Introduction

The *Health Visitor Implementation Plan 2011-15: A Call to Action* (Department of Health 2011a) sets out a new vision for the future of health visiting in England including plans to expand the health visitor workforce by around 50% (4200 additional health visitors by 2015).

The research presented in this report was commissioned by the Department of Health and undertaken by the National Nursing Research Unit (NNRU) to inform and support the implementation of the new implementation plan and to provide evidence for further developments in health visiting policy and practice. The programme of research (2011-2012) consisted of three separate, but linked, pieces of work: a scoping study and narrative review of the literature, an empirical study about service users' views and experience of the health visiting service and the present study, which examines the recruitment and retention of health visitors.

### Background

The turn of the new century saw the beginnings of a growth in political interest in supporting families and investment in early years programmes, such as Sure Start, to target the most disadvantaged communities. This interest and investment was paralleled by a decline in numbers of health visitors available to deliver public health initiatives and family focused care. In 2010 NHS workforce census data showed that large proportions of younger health visitors were leaving the profession and that 1 in 5 health visitors were over 55 years of age. Unite/CPHVA drew attention to the impact of this workforce decline reporting that large proportions of health visitors did not believe they had adequate resource within their teams to meet the needs of the most vulnerable children.

The United Kingdom (UK) Coalition Government<sup>1</sup> has since committed a substantial investment in the health visitor workforce as part of the Healthy Child Programme (Department of Health 2009). The new vision is for health visiting to provide four levels of 'the family offer' – *Community, Universal, Universal Plus, and Universal Partnership Plus*.

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<sup>1</sup> Conservative-Liberal Democrats coalition, under the leadership of Prime Minister David Cameron and Deputy Prime Minister Nick Clegg.

The rapid expansion of the health visitor workforce and changes to health visiting services mean that there is a need for clarity about the required skills and capabilities of health visitors, and strategies to promote recruitment and retention of new staff.

In 2011-2012, we undertook an extensive scoping study and narrative review of the literature about health visiting practice 'Why Health Visiting?' We argued for the importance of preserving and consolidating certain core dimensions of health visiting practice and also made clear recommendations for research, practice, education and policy.

## Aims

The overall purpose of the study presented in this report is to provide an in-depth analysis of recruitment and retention issues specific to health visiting to inform the on-going delivery and sustainability of the *Health Visitor Implementation Plan*. The specific aims were:

1. To identify factors important to the successful recruitment of health visitors.
2. To develop an understanding of workforce retention issues pertinent to health visitors.

The study objectives were to:

- Examine what people want from their job as a health visitor and how it links with their aspirations.
- Identify what attracts new recruits and returners to the health visitor profession.
- Identify what factors help retain health visitors.
- Seek insights into the organisational characteristics and approaches (including working practices and professional culture) that promote job satisfaction.

## Current knowledge

In England and the wider UK, health visitors are primarily employed by service providers within the National Health Service (NHS). Smaller numbers of health visitors are employed in organisations outside the NHS, such as local authorities and social enterprises which now provide health visiting services under Transforming Community Services. Under the Government's new plan, growth is expected to come primarily from an increase in the number of training places - with the intention to train over 6,000 new health visitors by 2015 - as well as improving retention of the current health visitor workforce and encouraging ex-health visitors to return to practice.

Whilst health visitor students come from diverse backgrounds (in terms of age, cultural background, and ethnicity) health visiting generally has not been perceived as an attractive career choice. Historically, negative perceptions of the profession, issues of gender, status and work/life priorities and the type of work environments that health visitors occupy (e.g. largely autonomous community-based posts) have been identified as preventing some individuals from entering the profession. Pay scale downgrading as well as concerns about the lack of job prospects and career progression on qualification, have also contributed to reduced numbers of applicants. More recently recruitment has, to some extent, been supported by development of tailored health visitor Return to Practice (RtP) schemes which provide opportunities for health visitors to re-register with the Nursing and Midwifery Council (NMC) after their registration has lapsed.

Low morale and job satisfaction within health visiting is a longstanding problem. For many years health visitors have expressed concerns about their own careers and the ability of the profession to respond to the needs of the most vulnerable children. A history of inadequate investment in health visiting has occurred alongside a rise in demand for health visitor time: there is a rising birth rate (22% increase between 2001 and 2011) (Office for National Statistics 2012); growing numbers of mothers and fathers with different types of cultural and linguistic needs; increasing numbers of women presenting with postnatal depression; and a rise in reported numbers of infants with physical and learning disabilities requiring more complex care.

Going forward it is important to understand what attracts new recruits to a career in health visiting and to take steps to retain the new health visitor workforce, protecting the investment that is being made. Research has shown that 'perceived availability of development opportunities', 'being able to achieve a good work/life balance' and 'prevalence of work pressures' are important factors for retaining staff. It is also likely that health visitors who are psychologically engaged with their jobs are less likely to consider leaving. Initiatives to improve employee engagement, where staff are more fully involved in running organisations, and feel their voices are heard, may increase retention. To support health visitor retention there is a need for information about employment relationships including health visitors' expectations and hopes for their development and careers.

## **Methodology and methods**

This study of health visitor students', practitioners', lecturers' and managers' views and experiences of recruitment and retention includes:

- a review of the academic literature on recruitment and retention in health visiting (presented in section 4.2)

- a selective literature review on NHS and other workforces (presented in section 4.3 & 4.4)
- qualitative empirical work with staff and students at two study sites in England (findings presented in section 6)

An interpretive approach was used to guide the overall design of the empirical element of the study and choice of data collection methods. This approach enabled us to explore the issues associated with recruitment and retention as expressed through the recounted experiences and perceptions of health visitor students, practitioners and managers.

The approach drew upon Appreciative Inquiry (AI) to actively seek out good practice and experiences, focusing on what participants value or find motivating and how these aspects of practice could be enhanced. Qualitative research methods were used to support in-depth exploration of individual experiences, views, intentions and aspirations regarding health visitor work and perceptions of the wider organisational context.

Full ethical approval for the study was granted from the Psychiatry, Nursing & Midwifery Research Ethics Subcommittee of King's College London (PNM/11/12-55).

To select study sites we undertook a national scoping exercise of arrangements for recruiting health visitor students within Strategic Health Authorities. Two (HEI/NHS trust) study sites were selected purposively on the basis of being in different SHAs and willingness to participate in the research.

The two study sites were selected according to the following criteria:

1. The HEI had an established SCPHN health visiting course running, with an intake of health visitor students in the academic year beginning September 2011.
2. The NHS Trusts currently employed health visitors and were taking students from the partner HEI for their practice placements.

At each site semi-structured interviews were carried out with lecturers in the HEI and managers in the NHS trust, who also facilitated access for the research team to health visitor students at the HEI and health visitors employed by the trust. Groups of practising health visitors (22 people in total) and student health visitors (17 people in total) took part in separate two-hour long workshops which included AI exercises. Following the group interviews, semi-structured telephone interviews were carried out by the researchers with participants from the group interviews (n=8) to further explore expectations and experiences of being a health visitor.



We used the framework approach to ensure the analysis was 'grounded' in participants' accounts as well as specifically focused on issues of health visitor recruitment and retention. All team members, and especially those directly involved in the generation of data, adopted a reflexive approach to their work, exploring personal views and assumptions and reflecting on the impact these may have on conversations with participants and the analytical process.

## Findings

The findings are presented in two main sections related to the following themes:

- Motivations and aspirations
- Organisational context: supporting job satisfaction

### Motivations and aspirations

The first section of the findings draws on data from the AI exercises, in which participants (students and qualified health visitors) discussed work experiences they found motivating, and focuses on their frequently-expressed aspirations to *make a difference* to children and families.

Participants used the phrase *making a difference* to signify their understanding of the purpose of health visiting and associated it with a set of values and work practices that were seen as essential for effective health visiting practice. Together, these beliefs, values and work practices form part of a distinctive professional ideology of health visiting held by both qualified health visitors and students that influences how they define worthwhile work that provides professional and personal reward.

Four key aspects of health visiting practice were consistently perceived to contribute to *making a difference*, these were:

- connecting with families and communities
- working in collaboration with others
- using knowledge, skills and experience
- professional autonomy to respond appropriately and flexibly to needs

These aspects of health visiting practice were seen by students as being interconnected and important for providing worthwhile and rewarding work experiences and as essential for achieving the goal of *making a difference* to families. However, it was not always easy for students in training to fulfil their aspirations of health visiting practice, although this did not seem to affect their motivation to become health visitors. Their experiences –

positive and negative – tended to reinforce their expectations about health visiting and their commitment to *making a difference*.

Experienced health visitors typically talked about complex scenarios that featured long-term involvement with families, often over many years. Examples of rewarding practice included working with family members seeking asylum; experiencing post-natal depression and domestic violence; or other forms of abuse. They emphasised that although these cases were the most demanding, they derived the greatest sense of achievement and personal privilege from them. Health visitors' narratives about their work tend to reinforce their professional identity and contribute to the broader discourse of professionalism in health visiting. The health visitors' accounts also give some indications of the tensions and constraints they experience in their work which may inhibit them from working in ways that are congruent with their ideology of practice.

### Organisational context: supporting job satisfaction

The second section in the findings, drawn from the full range of stakeholders contributing to the study, provides insight into the organisational characteristics and approaches that promote job satisfaction and help retain health visitors. These are the:

- nature of work
- organisation of recruitment and training
- being valued and respected

The extent to which health visitors believed they were able to provide a service that *made a difference* depended on the practice conditions created by the surrounding culture and resources. What health visitors and new recruits were concerned about for now and the future was an ability to practice what they understood to be health visiting.

*Nature of work:* The organisation of the health visiting team impacted upon the delivery of health visiting practice and job satisfaction; some new working arrangements and large workloads were identified as unhelpful for achieving the aspiration to *make a difference*. The approaches taken by managers when working with organisational rules and guidance impacted on the way health visiting teams operated. When the work felt as if it was just '*more of the same*', health visitors could lose sight of their original aspirations. The absence of career progression opportunities posed a real threat to retention.

*Organisation of recruitment and training:* Potential applicants need to be sufficiently informed about the role; they were more able to make informed decisions about a health visiting career when they had had direct contact with existing students and practising health visitors. Practice teachers had a pivotal role in helping maintain students' enthusiasm for a career in health visiting, important because during the course students

encountered a range of experiences that either challenged or reaffirmed their decisions. Students had high expectations of support and where managers were able to provide greater detail about preceptorship arrangements, students felt reassured.

*Being valued and respected:* health visitors need to feel that their work is worthwhile and valued. Feedback received directly from clients; views expressed by friends, family and colleagues; and interactions with managers give practitioners a sense of whether their work, and health visiting more widely, is or is not valued. Positive feedback reaffirmed their commitment to their professional ideology and desire to *make a difference*. Negative feedback provoked them to question whether their contribution was sufficiently valued. The approaches adopted by managers influenced staff perceptions. Helpful approaches included acknowledging staff as individuals, recognising knowledge and inviting contributions when decisions were required. Unhelpful management approaches included failing to involve staff in decisions, not listening and delivering instructions without negotiation, which negatively impacted on morale and reduced job satisfaction.

## Discussion

The findings indicate that health visitor recruitment should be thought of as an on-going process that is linked to longer-term workforce retention. Health visitors' decisions about their career extend beyond initial application and entry onto a programme of study, into the period of 'training' when the organisational context continues to influence their thoughts about health visiting work and their career.

New recruits are motivated to join the health visiting profession by an aspiration to *make a difference* to children and families and, in particular, to prevent illness. Salary on qualification was not inconsequential, as those who realised during 'training' that their eventual banding was unlikely to equate to a pay rise were prompted to question their purpose in pursuing the qualification.

Health visitors value particular aspects of their work. These aspects are: autonomous practice, close contact with clients, working as part of multi-professional teams and being able to use their knowledge and skills to promote health and enable families to make healthy choices.

Health visitors themselves play a part in supporting recruitment and retention to the profession. Practice teachers in particular can help students or newly-qualified health visitors to make positive decisions about their work and careers.

The findings from this study, whilst not generalisable, do resonate with existing literature and with the broader human resources literature, which suggests we have captured a range of important issues that can inform future policy, research and practice.

## Conclusions

Health visitors' and students' aspirations for practice are summarised by the statement *making a difference*. We have discussed the features of the practice environment as 'organisational context' that health visitors believed impacted on their ability to fulfil their role, support their job satisfaction and desire to stay as a health visitor as well as factors students identified as informing their education and recruitment to the profession.

## Implications

The study findings have implications for policy, research and practice. Our recommendations are summarised below:

- 1) Policy recommendation: Commissioners and providers of children's services should be required to identify, work with and regularly review strategies for maintaining health visitor numbers and sustaining the on-going recruitment and retention of health visitors as part of plans for improving child and family health.
- 2) Policy recommendation: Strategies for retaining health visitors should address how health visiting services are organised to ensure health visitors are able to work autonomously to use their knowledge and skills to develop relationships with families and link with multi-professional teams.
- 3) Policy recommendation: Employing trusts should regularly review, and develop as necessary, arrangements for health visitor service delivery in line with the Call to Action.
- 4) Practice recommendation: Managers should regularly appraise health visitor knowledge and expertise in public health practice and make available development and education opportunities to equip health visitors to fulfil the breadth of their public health role.
- 5) Policy recommendation: Employers reviewing service needs should consider whether health visitors adopting specialist or advanced practice roles could be a valuable addition to the workforce, whilst also introducing career progression opportunities that ensure health visitors' skills are retained for direct service delivery.
- 6) Practice and education recommendation: NHS Trusts and HEIs should work together to map out the process of recruitment to the profession and ensure systems include opportunities for applicant contact with practising health visitors offering experiences that support informed decision making.

- 7) Research recommendation: Research is needed to examine the quality of practice learning for students undertaking an educational programme in health visiting, including in particular the contribution of the practice teacher role (in comparison with that of the mentor), and the impact of 'long-arm' models on student learning.
- 8) Research recommendation: Focused research is needed to assess the barriers and facilitators for former health visitors who consider returning to practice.
- 9) Practice recommendation: Senior leaders and managers should follow the lead of the Department of Health in demonstrating the high value placed on the health visiting contribution. They should visibly convey that health visitors' work is valued by their employing organisations through routinely involving them in organisational decisions that may affect them or their work.
- 10) Practice recommendation: Those appointed to directly line manage health visitor teams should be able to demonstrate a clear understanding of health visiting professional practice and adopt styles of working and management strategies that support both teams and individuals to deliver a high quality health visiting service.
- 11) Practice recommendation: Senior leaders and managers should review how new service developments are implemented to ensure health visitors gain sufficient support in managing change whilst still being able to deliver a quality health visiting service that provides continuity of care and that values: client relationship building, autonomous practice, application of knowledge and involvement of multi-disciplinary expertise.
- 12) Practice recommendation: during student recruitment to educational programmes and health visitor recruitment to employment, managers should establish each applicant's expectations of the post / programme and provide up to date and accurate information about: salaries, terms and conditions, role requirements and the availability of support with career and professional development.

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## 1. Introduction

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In *The Health Visitor Implementation Plan 2011-15: A Call to Action* (Department of Health 2011a) the Coalition Government set out a new vision for the future of health visiting in England. The document sets out plans for expanding the health visitor workforce by around 50% (4200 additional health visitors by 2015), to mobilise the profession and to align delivery systems with new NHS architecture and local government children's services (including Sure Start Children's Centres). The expansion of the workforce is taking place across all health regions in England, and as a large undertaking, requires co-ordinated action across numerous NHS service providers and Higher Education Institutions (HEIs) with the capability and capacity to support and deliver professional education programmes approved by the UK Nursing and Midwifery Council (NMC). The challenge is to recruit new talent to the workforce and retain existing expertise to ensure delivery of a family specific service that promotes health early in life and is able to accommodate the different family circumstances present within all communities. This refocused service is articulated within the '*Call to Action*' (Department of Health 2011a) as providing four different levels of 'family offer', with health visitors coordinating and contributing to provision of 'Community' and 'Universal' levels of service to all families, whilst tailoring additional support for those who need it through offers described as 'Universal Plus' and 'Universal Partnership Plus.'

To inform and support the implementation of the new service organisation and to provide useful input for further development in health visiting policy and practice, in 2011 the Department of Health also commissioned, through their Policy Research Programme, a broad programme of research to be carried out by a dedicated team at the National Nursing Research Unit, King's College London. This programme consists of three main strands of research: a scoping review of the literature on health visiting (Cowley et al. 2013) an empirical study exploring service users' views on their experience of engaging with the health visiting services (Donetto et al. 2013) and an empirical study focusing on issues of recruitment and retention in health visiting, reported here.

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## 2. Background

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### 2.1 Policy context

The turn of the new century saw the beginnings of a growth in political interest in supporting families and the development of the Sure Start Local Programmes (Department for Education and Employment 1999) targeted at the most disadvantaged communities. There was some attempt to rejuvenate health visiting with the publication of health visitor development packs (Department of Health 2001), but the steady growth in the early years sector, particularly spearheaded after the publication of The Victoria Climbié Inquiry (Lord Laming 2003) and Every Child Matters (Department for Education and Skills 2003) consultation, was paralleled by a decline in numbers of health visitors available to deliver public health initiatives and family focused care. The decline in the size of the health visitor workforce continued to be apparent (UKPHA 2009), so much so that it gained the attention of organisations representing families who began to express their concern at the lack of support and preventive health advice important for raising healthy happy children (Family Parenting Institute (FPI) 2007; Russell and Drennan 2007). Specifically parents were requesting that they wanted this advice from a trained knowledgeable health visitor (FPI 2007).

The NHS workforce census data showed large proportions of younger health visitors (e.g. less than 45 years of age) leaving the profession and that 1 in 5 health visitors were over 55 years of age (The NHS Information Centre 2010). Such statistics have highlighted the seriousness of the steady decline in the overall health visitor workforce that has occurred over the last decade (The NHS Information Centre 2009a; The NHS Information Centre 2009b). Indeed in 2008 the annual omnibus survey conducted for Unite/CPHVA drew attention to the impact of this workforce decline, reporting findings that large proportions of health visitors did not believe they had adequate resource within their teams to meet the needs of the most vulnerable children (Adams and Craig 2008). To reverse this trend, the UK Coalition Government has since published the *Health Visitor Implementation Plan 2011-2015: A Call to Action* (Department of Health 2011a), which detailed a substantial investment in the health visitor workforce. The overall intention is to strengthen services operating as part of the Healthy Child Programme (Department of Health 2009). The strategy, detailed in the document, envisages in particular: a strengthening of the workforce with 4,200 new health visitors in post by 2015; a new vision for the organisation of services articulated through four levels of 'family offer' – *Community, Universal, Universal Plus, and Universal Partnership Plus* - and a fast-paced progressive implementation of the new service operating through three

main mechanisms: growing the workforce; professional mobilisation; and alignment of delivery systems. This plan has been established as part of the NHS Operating Frameworks for 2011-12 and 2012/13, to which all Primary Care Trusts in England must adhere (Department of Health 2010; Department of Health 2011b). Its implementation started immediately after the publication of the *Health Visitor Implementation Plan 2011-2015* in 2011 (Department of Health 2011a), with student numbers expanded across regions and selected NHS Trusts appointed as Early Implementer Sites (EIS) (see various reports charting developments of EIS and workforce mobilisation events, Department of Health 2011c; Department of Health 2012b; Department of Health 2012c; Department of Health 2012d). This rapid expansion and injection of new talent into the workforce has drawn attention to the need for clarity about the skills and capabilities needed by health visitors, as well as for strategies required to promote recruitment and retention of these staff.

Within this policy context, a programme of research was commissioned at the National Nursing Research Unit, King's College London to support development of the *Call to Action and Implementation Plan* (Department of Health 2011a). This research consisted of three separate, but linked, pieces of work: a scoping study and narrative review of the literature, an empirical study about service users' views and experience of health visiting and the present study, about recruitment and retention of health visitors. Overall, the programme aims to produce evidence that is directly relevant to current thinking and future developments in policy, as well as in professional practice. In the following section, we describe the programme in a little more detail so as to provide a more complete backdrop to the study this report describes.

## **2.2 The health visiting research programme at the NNRU**

In 2011-2012, we undertook an extensive scoping study and narrative review of the literature about health visiting practice (Cowley et al. 2013). This review brought together key seminal literature from health visiting research as well as more recent studies exploring the health visiting contribution to different areas of intervention outlined in the Healthy Child Programme. Our review analysed and organised the literature under the headings provided by the levels of the 'family offer' set out in the Implementation Plan. In this extensive review, we argued for the importance of preserving and consolidating certain core dimensions of health visiting practice and also made clear recommendations for research, practice, education and policy. We drew on some classic studies as well as more recent research to describe how this operates, which gave some insights into health visitors' activities and the skills they used.



In particular, our report (Cowley et al. 2013) suggested that some forms of practice are particularly well-suited to the unsolicited, proactive and health promoting focus of health visiting, which means that in the early phases of pregnancy and having a new baby, services need to reach out to parents who have not initially requested a service. Our analysis revealed an 'orientation to practice' grounded in salutogenic (health creating), person-centred (human valuing), and context-sensitive (human ecology-based) approaches, which could enable parents to have a better experience of their 'journey' through this service. This orientation to practice is given expression through three core practices, being: relationship formation, visiting parents at home and assessing their health needs, which have all been researched as separate processes. However, our analysis suggests that all three core practices are interconnected and operate together in delivering the whole health visiting service. Research about each core practice describes similar skills and attributes, and cross-references the other two in explaining how they operate.

Most families do not ask for their first home visit by a health visitor but rather receive this as part of a programme of health care, which is provided for all families (Cowley et al. 2004). Faced with the dual challenge of gaining access to the private space of the home and to the psychological space of the family's health beliefs and health practices, health visitors have developed patterns of communication, skills and professional qualities which are core skills of health visiting practice (Chalmers and Luker 1991; Cowley 1995a; Dixon et al. 2005). In her review of the literature and empirical qualitative research, Bidmead (2013) identifies features that reflect the concepts of 'keeping in mind' and elements of human valuing, which are reciprocal between the family and the health visitor. A non-judgemental approach to the difficulties of family life, reliability and ability to give sound advice, along with a willingness to 'reach out' to all families and 'not give up' on any family are key to enabling health visitor-client relationships and effective health visiting.

Bidmead (2013) also identified practical aspects of service provision, such as having one health visitor over a period of time and receiving visits at home, as contributing to a successful relationship. Home visiting appears central to the delivery of health promotion for families with young infants, being both the most frequent form of health visitor activity (Cowley et al. 2007) and a form of contact that is popular with parents and families from all walks of life (Elkan et al. 2000; Austerberry et al. 2004).

A number of studies have described the general process of searching for and assessing health needs (Chalmers 1993), identifying the on-going nature of health visitor assessments (Collinson and Cowley 1998; McIntosh and Shute 2007; Wilson et al. 2008; Appleton and Cowley 2008a) and the different fields of knowledge used by health visitors to deal with the complexity and uncertainty of family life (Cowley 1995b; Appleton and Cowley 2008b).

To facilitate a positive experience for parents, services need to be organised in a way that enables expression of the health visitors' 'orientation to practice,' through the fostering of health visitor-parent relationships, health visitor home visiting and health visitor needs assessments, which we dubbed 'a triad of core practices.' The combination of the 'orientation to practice' and the 'triad of core practices' appears to provide a platform from which to deliver interventions and programmes that have been formally evaluated. Amongst the specific areas of health visiting practice, we, in the *Why Health Visiting?* report (Cowley et al. 2013), considered studies that evaluated breastfeeding support, diagnosis of and support for postnatal depression, assistance and help for domestic violence and abuse, and a number of other aspects emphasised within the Department of Health (2009) Healthy Child Programme. Although there was no strong research evidence for any particular intervention or programme, we were able to outline the main issues and open questions for each level of service provision. We noted that implementing proven approaches and programmes into a service organised and delivered in a way that is known to enhance uptake and use of provision would increase the likelihood of positive health outcomes.

The ideal is not always the reality, however, and we also identified studies indicating difficulties and barriers that might arise. If resources are inadequate, this might cause health visitors to limit health awareness-raising action to avoid creating client demands that cannot be met (Pearson 1991; Chalmers 1993). Health visitors may miss cues or communicate in unhelpful or insensitive ways (Kendall 1993; Mitcheson and Cowley 2003; Cowley and Houston 2003) such as inadequate (Pearson 1991) or hasty advice-giving, before exploring the parent's perspective (Foster and Mayall 1990; Kendall 1993) or priorities (Bloomfield et al. 2005), or appear judgemental and not open to partnership working (Roche et al. 2005), or services may be organised in ways that inhibit relationship-formation (Bidmead 2013). Much of the evidence that we identified in our scoping review (Cowley et al. 2013) offered professional perspectives only. There was a paucity of work from a user perspective, for example about the effect of skill mix or team-based provision on parents, and very limited research about child health clinics or other centre-based provision delivered by health visitors alone or in conjunction with other colleagues (such as in Children's Centres) in the community. The second of the NNRU health visitor studies (Donetto et al. 2013) aims to address some of these deficits and is published concurrently with this report.

In our recommendations, we suggested – amongst other things – that health visiting services should be commissioned and organised in a way that preserves the holistic combination of approaches identified, including the orientation to practice and the triad of core practices. We note that there is a potential conflict between the need to preserve the family-focused, individualised and relational approach, which appears to be the key to promoting use of services and take-up of health promoting messages, and some of

the public health imperatives, such as promoting breast feeding or smoking cessation services. The solution appears to lie partly in improved education, not only for managers and commissioners, who need to understand how the health visiting process operates, but also to ensure health visitors develop the finely honed professional skills required to navigate any tensions arising from such conflicts in practice.

We draw attention to these findings and suggestions from our earlier work as we return to them later in the report, when we discuss how findings add to our scoping review and this empirical work contribute to health visiting understanding of workforce recruitment and retention.

### 2.3 Section Summary

The turn of the new century saw the beginnings of a growth in political interest in supporting families and investment in early years programmes, such as Sure Start, to target the most disadvantaged communities. This interest and investment was paralleled by a decline in numbers of health visitors available to deliver public health initiatives and family focused care. In 2010 NHS workforce census data showed that large proportions of younger health visitors were leaving the profession and that 1 in 5 health visitors were over 55 years of age. Unite/CPHVA drew attention to the impact of this workforce decline reporting that large proportions of health visitors did not believe they had adequate resource within their teams to meet the needs of the most vulnerable children.

The UK Coalition Government has since committed a substantial investment in the health visitor workforce as part of the Healthy Child Programme. The plans include: a strengthening of the workforce with 4,200 new health visitors in post by 2015; a new vision for the organisation of services articulated through four levels of 'family offer' – *Community, Universal, Universal Plus, and Universal Partnership Plus* - and a fast-paced progressive implementation of the new service operating through three main mechanisms: growing the workforce; professional mobilisation; and alignment of delivery systems.

The rapid expansion and injection of new talent into the health visitor workforce has drawn attention to the need for clarity about the skills and capabilities needed by health visitors, as well as for strategies required to promote recruitment and retention of these staff.

In 2011-2012, we undertook an extensive scoping study and narrative review of the literature about health visiting practice, 'Why Health Visiting?' We argued for the importance of preserving and consolidating certain core dimensions of health visiting practice and also made clear recommendations for research, practice, education and policy.

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### 3. Aims and Objectives

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The overall aim of this study is to provide an in-depth analysis of recruitment and retention issues specific to health visiting to inform the on-going delivery and sustainability of the *Health Visitor Implementation Plan* (Department of Health 2011a).

The specific aims are as follows:

1. To identify factors important to the successful recruitment of health visitors.
2. To develop an understanding of workforce retention issues pertinent to health visitors.

To meet these aims we commence with an initial narrative review of published academic literature on recruitment and retention related to health visiting, to identify what was already known and identify any gaps in the existing research. This was also used to formulate specific objectives for meeting the broader aims and designing an empirical study that will add to an understanding of what keeps health visitors practising and what motivates them in the first place and will therefore provide contemporary evidence on health visitor workforce recruitment and retention.

#### Our research objectives are to:

1. Examine what people want from their job as a health visitor and how it links with their aspirations.
2. Identify what attracts new recruits and returners to the health visitor profession.
3. Identify what factors help retain health visitors.
4. Seek insights into the organisational characteristics and approaches (including working practices and professional culture) that promote job satisfaction.

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## 4. Recruitment and retention in health visiting: what is understood from existing research

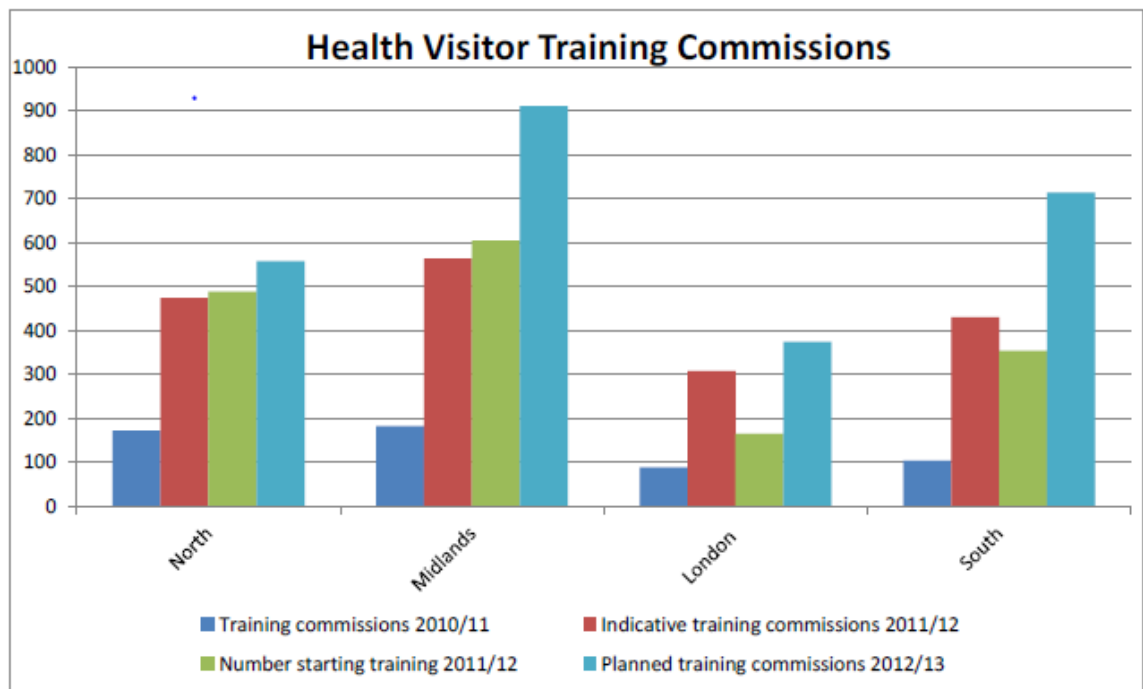
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In this literature review we outline changes in the current context of the National Health Service health visitor workforce in England in light of recent investments as part of the 2011-2015 Health Visitor Implementation Plan. We use the existing health visitor literature to outline what is currently known about health visitor recruitment and retention. We also draw on a selection of the more extensive literature on nursing workforce issues as well as on the wider human resources literature to identify relevant concepts for health visitor recruitment and retention. In this section we also explain the notion of the psychological contract, which we use later in this report to frame the findings of our empirical research with practitioners and students. Finally we draw together these insights and perspectives to summarise areas for further research to inform future investment and development of the health visitor workforce.

### 4.1 Current context of the health visitor workforce

In England and the wider United Kingdom health visitors are primarily employed by service providers within the National Health Service (NHS). Smaller numbers of health visitors are employed in organisations outside the NHS, such as local authorities and social enterprises which now provide health visiting services under Transforming Community Services (Centre for Workforce Intelligence (CfWI) 2012). These service providers work alongside service commissioners, education providers and Strategic Health Authorities (SHAs) to assess workforce requirements and decide on education commissioning plans in each Health Authority region (CfWI 2012). Health visiting commissioning plans have been the subject to recent changes as a result of the *Health Visitor Implementation Plan 2011-15* (Department of Health 2011a). A key part of the plan is to recruit an extra 4,200 Full Time Equivalent (FTE) health visitors (from a baseline of 8,092 FTE health visitors recorded in May 2010 to 12,292 FTE health visitors in April 2015). The growth is expected to come primarily from an increase in the number of training places - with the intention to train over 6,000 new health visitors by 2015 - as well as improving retention of the current health visitor workforce and encouraging ex-health visitors to return to practice (Department of Health 2012b). According to the *Health Visitor Implementation Plan* quarterly progress report for April-June 2012 (Department of Health 2012c), strategies for promoting health visiting as a career option have included: mailing a recruitment flyer to 400,000 nurses, provision of events and conferences across all ten strategic health authority regions and delivery of careers road shows. These strategies have supported the recruitment of 1,642 people to 2011/12

educational programmes leading to qualification as a health visitor. This cohort of recruits began to enter the workforce in autumn 2012 (Department of Health 2012d). Recruits to the degree and masters level health visitor education programmes are required to have a nursing or midwifery qualification to undertake the year-long specialist community public health nurse (SCPHN) training. The content of courses is set by local SHAs and education institutions with guidance regarding standards from the Nursing and Midwifery Council (CfWI 2012).



Source: Health Visiting Minimum Data Set

Taken from: Department of Health, Health Visitor programme (2012c) quarterly progress report April-June 2012.

At the present time, newly-qualified health visitors or those returning to practice enter a work environment that is characterised by a workforce approaching retirement age (CfWI 2012). The Centre for Workforce Intelligence caution that, as approximately half the health visiting workforce will be newly or recently qualified in April 2015, there may be a relative loss of professional knowledge and experience within the health visitor workforce when these current practitioners retire. However, changes in the workforce also offer an opportunity to establish new ways of working and review the types of services that are provided. The increase in health visitor student numbers and the steps being taken to improve retention of the existing workforce have meant that recruitment and retention within health visiting have become political and professional priorities. In particular, given the opportunity to significantly expand the health visitor workforce, there is a need to identify which recruitment and retention initiatives are most successful and to plan for

sustainable and effective integration of thousands of new recruits into the NHS in England and the profession.

## 4.2 What is known about health visitor recruitment and retention

Despite much being written about recruitment and retention in nursing generally, less is known about recruitment and retention issues in health visiting. One known issue is that health visiting has a relatively narrow recruitment base as entrants are required to be existing UK Nursing and Midwifery Council (NMC) registrants (UKPHA 2009; NHS Careers 2012). The type of work environments that health visitors occupy (e.g. largely autonomous community-based posts) may also be a barrier to recruitment to the profession for some people. Perceptions of the profession, issues of gender, status and work/life priorities are also factors associated with recruitment and we discuss these further below. Variations in the organisational and management structures in health visiting in the UK (UKPHA 2009), are also important. For example numbers of health visitors locally and the way services are configured (e.g. individual caseloads or team-based health visiting) differ significantly across the UK (Cowley et al. 2007).

### Health visitor retention

Prior to the health visitor implementation plan, the health visiting workforce was characterised by inadequate recruitment and poor retention with high turnover and difficulties in recruiting to vacant posts (see for example Stinson et al. 2004; Chalmers et al. 2011). Financial restrictions placed on community NHS organisations over many years have resulted in low investment in training and insufficient supply of health visitors to meet demand (Amin et al. 2010). This history of inadequate investment is highlighted by Lindley et al (2010) as occurring alongside a rise in demand for health visitor time, which has resulted from factors such as an increase in mothers with different types of cultural and linguistic needs, increasing numbers of women presenting with postnatal depression (4Children 2011) and a rise in reported numbers of infants with physical and learning disabilities requiring more complex care (Prime Minister's Strategy Unit 2005).

Low morale and job satisfaction within health visiting is a longstanding problem. In 1993, Wade reported a qualitative analysis of three annual surveys of the job satisfaction of health visitors, district nurses and practice nurses working in four UK trusts. She found that health visitors were considerably less satisfied with their work compared to district nurses and practice nurses. Health visitors expressed concerns about their own careers and the future of the profession. Wade's explanation for low rates of job satisfaction was that the long term nature of health promotion, with little immediate feedback, contributed to health visitors and their managers doubting the value of what they did. These findings

are consistent with studies from the 1970s which also reported low job satisfaction amongst health visitors (Wade 1993).

More recently, Craig and Adams (2007) reported on the annual survey of 1000 Unite/CPHVA health visitor members. They also found that morale amongst health visitors was low and that the majority (77%) of participants had experienced a rise in workload over the last year and felt unable to respond to the needs of the most vulnerable children. Sixty-three per cent also felt very or somewhat pessimistic about the future of the health visiting profession. It is important to note that the annual survey was conducted and published prior to the implementation plan (in 2007), so the findings may not accurately reflect the current views of practicing health visitors. As part of an Institute of Leadership and Management (ILM) report, Sadler (2010) assessed the motivation and morale of staff within the health visiting teams of Sutton and Merton Community Services using a questionnaire. Similar to the Craig and Adams report, Sadler also found low levels of morale; 65% of staff reported feeling demotivated or highly demotivated. The main reasons identified by practicing health visitors were: reduced opportunity for personal development; reduced staffing levels; and low senior management visibility. Additionally, Sadler found that staff felt they were not consulted, listened to or valued. Insufficient management support and lack of recognition of staff contributions are issues that are identified elsewhere within the wider recruitment and retention literature, discussed further below.

An evaluation of an induction programme for newly-qualified health visitors by Honey and Walton (2008) aimed to identify which elements of the induction programme were deemed to be successful and why. The study found that health visitors often felt they had a backlog of work as well as limited time and energy to help colleagues. These factors combined with insufficient management support, structure and guidance, contributed to poor retention amongst health visitors in the study (Honey and Walton 2008). The authors describe how, prior to receiving the induction programme, health visitors reported feeling isolated, stressed and inadequate but that after its introduction new staff felt that they were able to adjust to their new roles. The provision of peer support and opportunities for reflection, were particularly important aspects of the programme.

Developing the confidence of newly-qualified health visitors and students - and thus improving their retention - could also be facilitated by students having access to adequately trained practice teachers (PTs) during their training. Lindley et al.'s (2010) discussion paper highlights the importance of strengthening the practice teacher workforce to facilitate the development of student confidence and how this depends on PTs themselves being confident and adequately trained. Poulton et al. (2008) conducted a quantitative study comparing the self-perceived public health competences of SCPHN students (n=35) with those of practice teachers (n=31) and found that although PTs felt



more confident than students in leadership and management, they were less confident than the students were in applying key public health knowledge and skills. A concern was that this student knowledge would be lost soon after qualifying when working in teams focused mainly on individuals and families with little attention to community based public health activities. The authors suggest that the triennial review that PTs are required to complete to maintain professional registration, should include knowledge and skills of public health practice, as well as their educational skills, which would in turn enhance the development of health visitor students and a public health focused workforce.

## Health visitor recruitment

The issues highlighted above, including high workload and inadequate support structures, may deter students from pursuing health visiting careers. The literature also points to additional reasons why, in the past, health visiting has been an unattractive career choice. A discussion paper by Cowley and Bidmead (2009) details some potential disincentives, including a relative downgrade in the pay scale, confusing and onerous re-accreditation requirements, and the unflattering myth that health visitors are 'surrogate grannies functioning as a substitute for the extended family'. More recently, a 2012 article for the Nursing Times explored the professional identity of health visitors and reported that the NHS pay system, Agenda for Change, impacted negatively on the profession's image by lowering salaries during health visitor training (Band 5) thus discouraging qualified and senior staff from considering a move to health visiting (Baldwin 2012). It noted that health visitor training is further undermined by the fact that midwives in many areas are generally paid at a higher grade (Band 7) than health visitors (Band 6). Lindley et al.'s (2010) discussion paper further supports Baldwin's assertion that pay scale downgrading, as well as concerns about the lack of job prospects and career progression on qualification, have contributed to reduced numbers of applicants to the profession and a need to re-establish the value and contribution of health visiting in the NHS (UKPHA 2009) (this describes the situation prior to the implementation plan).

A small number of studies have examined factors influencing students' decisions about entry into health visiting. Muldoon and Reilly (2003), in a study to establish nurses' career aspirations and whether career options were perceived to be gendered, found that within nursing, health visiting is a popular career choice and was identified by nursing students as an especially appropriate career for women (the authors did not explore the reasons behind the students' choices). As a choice, health visiting ranked sixth out of the 17 most popular nursing specialities. Like the findings regarding job satisfaction reported by Wade (1993), student nurses generally perceived health visiting

less favourably when compared to other community nursing roles (including practice nursing, district nursing and midwifery).

Thurtle (2005) explains that there is little information available on community nurses' (including health visitors') career trajectories or why they choose to work in the community. To explore this issue, Thurtle conducted a survey with 85 community specialist practice students, of whom a third (n=28) were health visitor students, attending a single, central London Higher Education Institution. Although the study largely reflected students' views across a number of community nursing roles, some health visitor specific insights are gleaned. These include feedback that the key reason for entering health visiting was autonomy or independence, followed closely by scope for using initiative. A preference for working in the community was also ranked highly along with perceived better promotion opportunities. Other important influencing factors were the perception of better pay and ability to balance work with personal life. Thurtle cautions that the small size of the study does not allow for wider conclusions to be drawn. However, similar findings were reported by Ridley (2012) who, in a study of placement experiences for pre-registration nursing students, found that the community setting appealed to many participants, who favoured the less hierarchical structure, team work and professional autonomy. The appeal of autonomy echoes the finding of Thurtle (2005) and highlights the possibility that the flexibility of health visiting work is a key motivator for potential recruits. The study supported the value of having placements with health visitors during adult nursing programmes, and supported findings of previous nursing studies that mentors play a vital role in promoting the profession to student nurses. The possibility of student nurse community placements having a positive influence on future recruitment to community nursing posts has been previously suggested by Marsland and Hickey (2003). However, it seemed from Ridley's study the opportunity to properly 'market' a health visiting career to student nurses on placement was not always taken, as few students even after their placement, had a full understanding of the health visitor role, and saw it as largely limited to responsibility for children under three. Although Ridley's study was only reporting the experiences of a small sample of students in one part of the country, the suggestion that student nurses can have limited expectations about the scope of the health visitor role suggests health visitors themselves (mentors) may not be 'selling' the full opportunities of the health visitor role available to students.

A study of health visitor students (as opposed to generic nursing or community nursing students) by Poulton et al. (2009) surveyed 35 students starting a SCPHN programme to examine factors influencing their decision to train for this part of the register, and whether these factors differed according to previous experience or chosen pathway. The health visitor students came from diverse backgrounds (in terms of age, cultural background, ethnicity) compared to the school nurses and occupational health nurses.

They saw being involved in health promotion as a key driver for embarking on the SCPHN programme, although paradoxically health promotion activities may not aid workforce retention, given that, as outlined above, results are slow to be realised which can limit immediate job satisfaction (Wade 1993). Other motivators for health visitor students included factors intrinsic to the health visitor role: community work, involvement in social aspects of health; multi-disciplinary practice, working with families and professional autonomy and extrinsic factors such as career progression, pay and family-friendly hours of work (Poulton et al 2009).

Expansion of and recruitment to the health visitor workforce has also been supported by development of tailored health visitor Return to Practice (RtP) schemes which provide opportunities for health visitors to re-register with the NMC after their registration has lapsed (Amin et al. 2010; Ly 2011; Abbott et al. 2012). A difficulty of researching health visitor RtP specific issues is that the numbers of students entering these programmes are small and the available evidence is limited to localised case reports (Chalmers et al. 2011; Miller 2011; Goredema-Braid 2012) and descriptive evaluations (Amin et al. 2010; Abbott et al. 2012). It is known that RtP courses attract students, like those joining as pre-registration health visitor students in Poulton's et al (2009) study, from diverse backgrounds who have the potential to enrich health visiting teams by bringing a wide range of professional, personal and life experience (Amin et al. 2010; Abbott et al. 2012). This diversity of transferable experience, combined with the fact that the students join RtP programmes with complementary prior education, make RtP courses seem economical, however if cohorts are small (as in Amin et al.'s (2010) study of the Leicestershire programme) then in reality delivering such courses can be cost intensive because of the relatively small number of students attending them.

In the case of the Leicestershire programme, the reasons students cited for returning to practice as a health visitor were largely to do with factors extrinsic to health visiting practice. These reasons included: a need for flexible employment, to accommodate domestic circumstances and relocation needs, and personal life changes after having children. Factors intrinsic to health visiting were also cited and included: increased opportunities due to publication of the Healthy Child Programme, personal and professional interest, and local advertising campaigns to recruit more health visitors. The reasons cited by these students differed slightly to those given by the students starting the SCPHN programme in Poulton et al.'s study, illustrating how individuals' work/life priorities change over time and that the need for flexible working may eventually take precedence over the desire for autonomy and independence. However, further research is needed to understand the motivations of students and how work/life priorities change over the life course and between diverse groups of people entering or re-entering the profession. It is also noted in the research literature that given the relatively small numbers of students who take up RtP opportunities, energies might be better spent

investing in recruiting to 'grow your own' type programmes (Stinson et al. 2004; Chalmers et al. 2011) or rotational schemes (Abbott et al. 2005) where staff nurses are given opportunities to work within health visitor teams and gain experience with a view to preparing them for a health visitor career.

### **4.3 Recruitment and retention within the wider nursing field**

Recent studies of the nursing workforce have identified a number of key factors that contribute to improved nurse retention and these have relevance to health visiting. From their survey of 16,707 nurses from 167 healthcare organisations in England (registered nurses and midwives), Carter and Tourangeau (2012) found that 'perceived availability of development opportunities', 'being able to achieve a good work/life balance' and 'prevalence of work pressures' influenced nurse intention to remain employed. Nurses who were psychologically engaged with their jobs were less likely to consider leaving nursing. The authors suggest that initiatives to improve employee engagement, where staff are more fully involved in running organisations, and feel their voices are heard, may increase retention. Research by Tourangeau et al. (2010) found that trusting and respectful relationships with colleagues and managers were important for retention, although Carter and Tourangeau (2012) reported only a small association between intention to leave and relationships with colleagues and patients. Tourangeau et al. (2010) proposed a model of eight areas which impact on nurses' intention to stay in a role, including the relationship factors mentioned above and: organisational support and practices; conditions of work; environment; and work rewards. More specifically, Tourangeau et al.'s model highlights the important role of workload pressure, career advancement opportunities and psychological engagement in nurse's decisions to stay in, or leave the profession. Tourangeau also proposes that characteristics of individual nurses, for example, age and time spent in the organisation, also influence intention to stay.

Cowden and Cummings' (2012) systematic review identified a wide range of factors which affected nurses' intentions to stay in their workplace. The authors derived key predictors of staff nurses' intention to stay from the literature which included: organisational commitment (defined as the strength of the individual's commitment to the employer); job satisfaction; leadership practices (for enabling shared decision, supervisors support, praise and recognition); work environment (including the collegiate nature of teams, the sense empowerment and autonomy as well as workplace conditions enabling access to adequate information and resources); individual nurse characteristics and career development opportunities. These predicting factors were organised into a theoretical model of staff nurses' 'intent to stay', which details how the combined characteristics of: manager, work, organisation and nurse, inform an individual's cognitive and affective response to work and influence a person's intent to stay. A

limitation of the model is that it is derived from a heterogeneous body of published research, which, in the main, include non-experimental correlational design studies and so the model is unable to offer confident predictions on the causal nature of factors. However, the model does highlight the potential breadth and complex interplay of factors associated with workforce retention, which serves to emphasise that addressing retention requires multiple strategies that include increasing workforce size and reducing workload pressure.

In examining recruitment as well as retention, Meadows et al. (2000) published a report on the key issues affecting the UK nursing workforce. The report drew on a literature review, focus groups with nurses and interviews with stakeholders. They found that nurses joined the profession for many reasons, including wishing to work with and care for people, and the perception of nursing as a secure career, although for some, nursing had been the only alternative to unemployment (suggesting the importance of practical considerations in career choice). The authors highlight some of the reasons nurses remained in the profession. Key factors were a flexible and family friendly work environment, and control and autonomy, which resonate with the health visitor literature. An examination of nurses' reasons for leaving the profession, like the more recent work of Tourangeau et al. (2010), revealed a complex inter-relationship between 'small issues', which in combination exerted a cumulative effect of dissatisfaction that drove nurses away. Similarly, Shields and Ward (2001) noted, that those expressing job dissatisfaction showed an increased probability of leaving, but this was strongest for dissatisfaction with training and promotion prospects rather than pay. Dissatisfaction with pay, although noted, was recognised as only part of the problem by Meadows et al (2000), and other features such as poor working conditions, not feeling listened to and a feeling that nurses were unable to fulfil their roles, all contributed to unfulfilled expectations and stress. The latter point, Meadows et al. (2000) explained specifically contributed to a feeling of poor control over one's role and ability to work according to personal and professional expectations. These factors in combination appeared to contribute to nurses leaving because of cumulative effects, which became in some instances 'the last straw' rather than a response to one major event. The damaging consequence of the cumulative impact of work difficulties faced by nurses, was also highlighted by Maben (2008) who explained such events as individual breaches of the psychological contract (discussed below) which threatened the individual's sense of relationship with the employing organisation.

In drawing attention to positive practice Meadows et al. (2000) refer to the American 'Magnet hospitals' programme (McClure et al. 1983) which identified hospitals that could attract and retain nurses. Nurses from 'Magnet hospitals' reported higher satisfaction with organisational structure, professional practice, management style, quality of leadership and professional development, with management style being a key factor. Of

particular note was the importance of adequate staffing, which was understood to be critical to nurses job satisfaction and 'pride at being part of the institution' (McClure et al. 1983: p8). Meadows et al. (2000) concluded that to attract and retain staff management needs to be facilitative, empowering and good at listening.

#### **4.4 Insights from the wider human resources literature**

The wider human resources literature offers insights into what motivates individuals to enter and remain in a job or profession and provides explanatory frameworks that draw on psychological and sociological theories. Two ideas that have influenced academic work and HR practice are the psychological contract, based on social exchange theory (Guest 1998) and organisational justice, based on equity theory (Greenberg and Cropanzano 2001). Both frameworks propose that the employment relationship is based on reciprocity, and focus on the employee's perceptions and expectations of the employer (or organisation); their appraisal of how fairly they are treated; and how this influences their feelings, attitudes and behaviour at work. The psychological contract in particular has generated a rich seam of research that is helpful in understanding health visitors' relationships with their employing organisation and factors impacting on recruitment and retention.

##### **The psychological contract**

The psychological contract can be simply defined as the obligations employees and employers believe they have towards each other, which are seen as part of the 'deal' each should commit to and honour. These obligations are informal and unwritten (unlike the legal contract of employment); they are based on the employee's sense of fairness and trust; and may be revised over time and in the light of continuing interaction (Guest 1998). Some obligations may be seen as 'promises' and some as 'expectations'; but most importantly they are perceived by the employee as part of the employment relationship (Chartered Institute of Personnel and Development (CIPD) 2012). Maben (2008) has shown how unmet expectations and perceived breaches of the psychological contract can have a negative impact on nurses' job satisfaction, motivation, commitment and engagement. Other studies have shown how early in their careers nurse graduates (Robinson et al. 2006), like graduates generally (Sturges and Guest 2001), have high expectations of their employing organisations with respect to career management support and appropriate training opportunities, which if not met, become a source of dissatisfaction. Sturges and Guest (2001) explain that the psychological contract is violated when reality does not match up to the graduate's pre-joining expectations, and commitment to stay is undermined.

This research examining graduates' expectations of work provides compelling evidence for employer proactivity with regard to understanding and even shaping future employee expectations (Sturges et al. 2000; Sturges and Guest 2001; Robinson et al. 2006). Specifically, employers can reinforce a positive reciprocal psychological contract by providing training and development opportunities relevant to assisting the graduate's existing job performance and future career progression (Sturges and Guest 2001) and thereby aim to make the most of the potential offered by a workforce with career ambition (Robinson et al. 2006).

Studies informed by the psychological contract typically investigate employee perceptions, focus on shortcomings of organisation and management, and suggest managerial strategies to help fulfil organisational obligations and improve employee motivation and job satisfaction. These include two-way communication to give expression to employee voice; transparency of process and employee involvement in decision making; adopting management styles that are responsive and supportive; and creating opportunities for learning and development (CIPD 2012). The organisational and managerial perspective on the psychological contract was explored by Guest and Conway (2002) who confirmed that effective communication was seen as the primary way of managing employee expectations, although they found managers admitted that their organisations often failed to keep their promises and commitments. The psychological contract may therefore help to interpret and integrate the research findings reported above that link unmet expectations with dissatisfaction and stress (for example Meadows et al. 2000; Sadler 2010).

Research into the psychological contract often differentiates two types of contract: transactional and relational, which are based on exchanges using different 'currencies'. Transactional contracts are usually clear-cut, instrumental and have a financial basis, while relational contracts require longer-term investment of socio-emotional currency and promote organisational commitment (Makin et al. 2000). The types of contract can also be linked to motivation, and the distinction between extrinsic and intrinsic rewards. Extrinsic rewards such as pay and career progression are important to most employees but for professionals, such as nurses and health visitors, commitment over the long term may be more strongly linked to intrinsic rewards from meaningful work, seeing progress and improvements, good working relationships and feeling valued (Thomas 2000). Maben's (2008) research into nursing engagement and retention in one London hospital trust explored nurses' expectations and experiences of employment over time. She found that nurses began with high hopes for good teamwork, support and feedback, adequate staffing levels, personal development, supportive management, feeling valued and appreciated, and being able to give good quality care. These expectations were not always met. Feeling valued was particularly important to most nurses, and they made nuanced assessments about whether they as individuals, and their work, were

appreciated based on a variety of experiences in the organisation, including the feedback they received from patients, managers and colleagues. Qualitative studies in many workplaces and with different staff groups report that job satisfaction is strongly associated with a sense of 'feeling valued' or being respected in the organisation. It has been argued that feeling valued is one of the strongest drivers of employee engagement, which in turn improves performance because engaged employees are willing to invest discretionary effort (Robinson et al. 2004). In Maben's (2008) study there was a perception among nurses that they were not valued; inadequate management support for nurses and nursing was seen as a significant problem; and nurses felt they were marginalised and lacked voice in the organisation. This raises questions about how membership of a professional group shapes psychological contracts, in terms of forming expectations and assessing fairness and trust, and influences organisational behaviour and commitment.

### The psychological contract and professional practice

Bunderson (2001) suggested that since distinctive and complex professional ideologies determine how professional employees define fulfilling and worthwhile employment, the psychological contract should be modified to encompass commitment to a principle or a cause that goes beyond self-interest and contextualises the relationship between an individual and an organisation. Thompson and Bunderson (2003) proposed adding a third, ideological dimension to the psychological contract, allowing for it to become 'ideology-infused' for individuals who bring with them ideological commitments and expect the organisation to provide an environment that supports them to fulfil these commitments. This development allows the purpose and meaning of professional work, and its alignment with professional identities, to be foregrounded in the psychological contract in a way that resonates with research findings of nurses' and health visitors' disillusionment and distress when they are not able to practise in ways that match their professional aspirations, ideals or training. Interviews with nurses working in an Australian public hospital found evidence of perceptions of the psychological contract that included a distinctive ideological currency, the core components of which were professional expertise and excellence, client focus, and making a contribution to the public good (O'Donohue and Nelson 2007). All the nurses looked for, but did not find, relationships with their employing hospital in which they were cared about, treated with respect and their professional contribution was supported. Thus they expressed more commitment to their profession than to their employer, but little intention to leave. Another Australian study of research scientists working in the public sector produced similar findings of disenchantment with the organisation but a strong sense of personal commitment to their work (O'Donohue et al. 2007).



Employee tolerance of perceived breaches of ideological obligations by the organisation was predicted by Thompson and Bunderson (2003). Similarly, a study of employee expectations in the NHS, by Hyde et al. (2009), found that 'public service values' exerted a powerful influence on employees' work, moderating and sometimes overriding the impact of unmet expectations (organisations providing appropriate infrastructure and support) on performance and patient care. Even when they were disaffected enough to withdraw effort, staff did so in ways that did not adversely affect patient care and, counter intuitively, clinicians' public service values seemed to drive them to intensify their efforts in the short term, despite lack of organisational support. These findings support ideas of ideology-infused psychological contracts that may influence how professionals practice and want to be treated, although it seems their response to unfulfilled ideological expectations is to 'work to rule' (therefore maintain some level of control over their working day) rather than leave, unless other dimensions of the contract are also violated.

Some researchers have begun to explore how workplace relationships can buffer the negative effects of unmet expectations or breached psychological contracts, although the findings are specific to particular professional groups and contexts and may not be generalisable. For example, Zagenczyk et al. (2009) found that mentoring and supportive supervisory relationships may help white collar employees to feel valued and cared for by the organisation even if their psychological contracts are not fulfilled. In some contexts team relationships play an important part in moderating the effects of unfulfilled expectations, although the influence of colleague relationships depends on the type of psychological contract individuals hold (Bal and Vink 2011).

A limitation of many employee retention studies is that they rely on single cross-sectional questionnaire surveys to produce correlations between multiple factors, which fail to show the relative importance of factors for individual participants or identify causality. Qualitative research from other traditions may be more effective in illuminating how organisational culture and relationships influence occupational values and behaviour at work, and could potentially address the problem of the psychological contract existing in a seemingly socio-political vacuum. For example, an ethnographic study of district nursing teams demonstrated how informal interaction between colleagues played a role in sustaining professional identities, establishing tacit work values and maintaining job satisfaction (Adams et al. 2012). The researchers described how the informal practice of 'catching up' could create very local communities of practice that provide space for informal learning and development of specific nursing ideals and values, which influenced quality of nursing practice and enhanced its intrinsic rewards.

## 4.5 Summary of what is known and remains to be understood

The major challenge when establishing a picture of health visitor workforce recruitment and retention is that there are few studies involving health visitors, and those that do include health visitors tend to focus on wider nursing workforce issues. Even for those studies that are community specific, evidence concerning health visiting still needs to be separated from findings reflecting other modes of SCPHN practice (for example Poulton et al. 2009) or community practice (Thurtle 2005). The limited health visiting literature paints a picture of a difficult work environment with staff shortages, increased focus on 'high need' cases and a professional concern that practitioners are unable to consistently meet the needs of families, provide a universal service (Adams and Craig 2008) or practice public health preventive work (Brocklehurst 2004).

The generic nursing literature, although providing useful insights into the wide range of factors implicated in workforce retention in particular (Meadows et al. 2000; Tourangeau et al. 2010; Cowden and Cummings 2012), is only of limited value as the circumstances for practice between acute nursing in particular and health visiting are vastly different. The body of nursing research available highlights relevant factors, brought together in theoretical models to support explanation (Tourangeau et al. 2010; Cowden and Cummings 2012), however these theoretical models still need empirical testing to establish their predictive capabilities.

The nursing literature seems to suggest that increasing workforce size alone is not going to be a solution to workforce difficulties. Other action is likely to be necessary if all factors that threaten retention and limit recruitment are to be addressed. A handful of disparate studies touching on issues relevant to health visitor recruitment and retention, suggest some of the intrinsic and extrinsic factors motivating health visitors.

The nursing literature does however introduce the relevance of the psychological contract to support interpretation of recruitment and retention study issues (Maben 2008). In the main though, this body of nursing and human resources research is motivated by understanding risks to retention.

What is not known is what those who continue to practice get from their job and role as a health visitor. It is unclear why there would be a desire to become a health visitor and stay with a role when the conditions for practice as indicated by annual surveys (Craig and Adams 2007; Adams and Craig 2008) are apparently so poor. This study is therefore informed by the need to consider an appreciative standpoint and prioritise an understanding of what health visitors' value about their professional role and why those who are still practicing stay.

## 4.6 Section Summary

In England and the wider United Kingdom health visitors are primarily employed by service providers within the National Health Service (NHS). Smaller numbers of health visitors are employed in organisations outside the NHS, such as local authorities and social enterprises which now provide health visiting services under Transforming Community Services. Under the Government's new plan, growth is expected to come primarily from an increase in the number of training places - with the intention to train over 6,000 new health visitors by 2015 - as well as improving retention of the current health visitor workforce and encouraging ex-health visitors to return to practice.

In 2011/12 there were 1,642 recruits to health visitor education programmes, who began to enter the workforce in autumn 2012. The massive recruitment drive is changing the character of the workforce from one that is largely approaching retirement, to one where, by 2015 approximately half will be newly or recently qualified. These rapid changes to the health visitor workforce mean there is a need to identify which recruitment and retention initiatives are most successful and to plan for sustainable and effective integration of thousands of new recruits into the NHS in England and the profession. Despite much being written about recruitment and retention in nursing generally, less is known about recruitment and retention issues in health visiting. The type of work environments that health visitors occupy (e.g. largely autonomous community-based posts) may also be a barrier to recruitment to the profession for some people. Perceptions of the profession, issues of gender, status and work/life priorities are also important factors associated with recruitment.

A history of inadequate investment in health visiting has occurred alongside a rise in demand for health visitor time: there are growing numbers of mothers and fathers with different types of cultural and linguistic needs; increasing numbers of women presenting with postnatal depression; and a rise in reported numbers of infants with physical and learning disabilities requiring more complex care. Low morale and job satisfaction within health visiting is a longstanding problem. For many years health visitors have expressed concerns about their own careers and the future of the profession. Surveys of Unite/CPHVA health visitor members have found that health visitors have experienced a rise in workload in recent years and felt unable to respond to the needs of the most vulnerable children.

Other research with health visitors has shown that they do not feel they have sufficient opportunity for personal development; that staffing levels and senior management visibility need to be addressed; and that they do not feel listened too or valued. Induction programmes for newly-qualified health visitors - together with opportunities for peer support and reflection - are known to help health visitors to feel less isolated, stressed

and inadequate and able to adjust to their new roles. Access to adequately trained practice teachers (PTs) during their training is important for helping to build newly-qualified health visitor's confidence.

In the past, health visiting has been an unattractive career choice, and pay scale downgrading as well as concerns about the lack of job prospects and career progression on qualification, have contributed to reduced numbers of applicants to the profession. Those entering the profession say it offers the potential for more autonomy or independence; the chance to use their initiative; to work in the community; and promotion opportunities. Pay and the ability to balance work with personal life are also important deciding factors cited by recruits.

Mentors can play a vital role in promoting the profession to student nurses and encouraging them to consider becoming a health visitor. Expansion of and recruitment to the health visitor workforce has also been supported by development of tailored health visitor Return to Practice (RtP) schemes which provide opportunities for health visitors to re-register with the NMC after their registration has lapsed. However, RtP schemes are potentially expensive to run. Therefore investment in 'grow your own' programmes or rotational schemes in which staff nurses are given opportunities to work in health visitor teams and gain pre-recruitment experience may be more effective ways to equip qualified nurses for a health visitor career.

Going forward it is important to take steps to retain the existing experienced workforce and those newly-qualified to protect the investment that is being made. Research has shown that 'perceived availability of development opportunities', 'being able to achieve a good work/life balance' and 'managing work pressures' are important factors for retaining staff. It is also likely that health visitors who are psychologically engaged with their jobs are less likely to consider leaving. Initiatives to improve employee engagement, where staff are more fully involved in running organisations, and feel their voices are heard, may increase retention. However, more needs to be known about employment relationships, including how the characteristics of management, health visiting work, the organisation, and individual person, can support health visitor retention.

It is also important to understand health visitor's perceptions and expectations of the employer or organisation; their appraisal of how fairly they are treated, and how this influences their feelings, attitudes and behaviour at work as these factors influence their decisions to stay.

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## 5. Methodology and methods

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### 5.1 Introduction

This study of health visitor students', practitioners', lecturers' and managers' views and experiences of recruitment and retention includes a review of the academic literature and qualitative empirical work. The literature review examines existing writing on recruitment and retention in health visiting and selective literature on NHS and other workforces (presented in section 4). The qualitative empirical work involved group and individual interviews at two study sites and individual interviews with representatives from 4 SHAs in England. The study sites each included an NHS Trust and single HEI working together to provide health visitor education programmes (findings presented in section 6). The following sections provide details of our chosen methodology and methods.

### 5.2 Literature review

The literature review presented in Section 4 draws together background information about what is already known about recruitment and retention in health visiting. Using a narrative approach we examined the health visiting literature to contextualise our empirical research (Pope et al. 2006). The review informs our overall aim of gaining in-depth understanding of health visitor students', practitioners' and managers' views and experiences of recruitment and retention. In order to focus the literature review on the most relevant sources of information (Mays et al. 2005), we limited its scope by focusing on publications that: i) related to UK health visiting context; ii) reported on health visitors or students' views; iii) related to perceptions of health visiting, health visiting services, interventions or care delivered by health visitors, health visitors working as part of primary care teams, or contributing to education programmes.

We began the search process by drawing together references on recruitment and retention issues identified by our earlier scoping review (Cowley et al. 2013) but we also undertook a more focused search. We searched both specific and general databases (Medline, Embase, British Nursing Index, Web of Knowledge, and GoogleScholar) and used keywords in combination (e.g. recruitment/retention/intention to stay in combination with health visiting/health visitor) to search the titles and abstracts of papers, tracking references of papers and reports. We aimed to identify key sources, including both qualitative and quantitative research studies, relating to recruitment and retention issues in health visiting. Searches revealed a relatively limited amount of research on health visitor recruitment and retention, so the search was broadened to include related areas of nursing and human resource research.

Our quality assessment was based on the relevance to the overall study questions and the inclusion criteria outlined above, rather than the method of the research (Mays et al. 2005); though we did exclude opinion pieces and commentaries (Mays & Pope, 2000).

## 5.3 Empirical research methodology

### Interpretive approach

An interpretive approach (Mason 2002) was used to guide the overall design of the empirical element of the study and choice of data collection methods. This approach enabled us to gain understanding of the issues associated with recruitment and retention as expressed through the recounted experiences and perceptions of health visitor students, practitioners and managers. Qualitative research methods were used for this study to allow in-depth exploration of individual experiences, views, intentions and aspirations regarding work and perceptions of the wider organisational context. Three methods for obtaining data were appreciative inquiry (AI) exercises (Kinni 2003); group interviews informed by the appreciative inquiry exercise; and semi-structured interviews.

### Appreciative Inquiry

Appreciative Inquiry (AI) is primarily an approach to organisational and staff development that seeks to engage participants to renew, change and improve performance. It is based on the assumption that the questions we ask tend to focus our attention in a particular direction (Kinni 2003) and begins by defining and 'appreciating' what participants perceive is working well. In contrast, research often sets out to identify problems or deficiencies and find solutions to them; it can thus be experienced by participants as negative and debilitating; and may encourage attribution of blame rather than emphasising collective responsibility for change. Appreciative Inquiry takes an asset-based approach, in the belief that every organisation, and every person in that organisation, has positive aspects that can be built upon (Eaton 2010). It actively seeks out good practice and experiences which participants valued or found motivating, by asking questions such 'What's working well?', 'What's good about what you are currently doing?', and focuses on how these aspects of practice could be enhanced. Appreciative Enquiry is reported to be a positive, stimulating and morale-boosting process for participants (Carter 2006).

Methods developed in Appreciative Inquiry have been adopted by nursing researchers to reframe traditional research designs to acknowledge existing good practice and explore how it can be supported and spread (Carter et al. 2007). Carter (2006) has described

how research informed by Appreciative Inquiry starts with open-ended exploration of experiences through story telling:

*Prescriptive interview agendas or schedules are avoided as the aim is to follow the individuals' experiences and discover their own stories. Specific examples of real experiences are elicited, thus allowing each individual to explore these experiences without stripping them of the context that helps the individual make sense of them.*

Carter (2006, p56)

In designing the present study, the research team considered that use of selected AI approaches to underpin aspects of the data collection offered an attractive, creative, novel and appropriate addition to traditional methods of investigating experiences of recruitment and retention. The focus on sharing positive experiences in a peer group setting was thought likely to stimulate wide-ranging discussion and generate rich qualitative information about participants' perceptions of their professional role and the aspects of their work they found rewarding. By starting with participants' primary motivations and aspirations for health visiting, that can ordinarily become lost or unacknowledged in day-to-day practice, the discussions in the subsequent group interviews did proceed unconstrained by participants' or researchers' preconceived ideas about factors influencing decisions to join or leave the workforce. Data generated in this way complemented information gathered by individual semi-structured interviews. The group interviews that followed the AI exercises used ideas from the 'appreciative' discussions to inform reflections on current experiences of health visiting practice. Interviewing participants in a group, provided the opportunity to expand the dialogue on topics by involving a number of participants in the same conversation. This enabled different perspectives to be shared and to some extent debated which assisted the interviewer in determining the significance of the issue being discussed (Krueger and Casey 2009). The group interviews also provided an efficient way of obtaining the perspectives of a larger number of participants than would be possible if only individual interviews had been employed (Flick 2009).

## 5.4 Ethics

Full ethical approval for the study was granted from the Psychiatry, Nursing & Midwifery Research Ethics Subcommittee of King's College London (PNM/11/12-55). Permission letters were also gained from the NHS and HEI partners at each of the two research sites. Information sheets (Appendix 2) and consent forms (Appendix 3) were provided to all participants, who were asked to give written consent (for face to face interviews) or verbal consent (for telephone interviews) to participate. Original signed consent forms were stored securely by the research team. Additional documentation associated with

the project, such as documented correspondence with participants, was also stored securely.

As part of the information-giving process to support informed consent, research team members (AG and KW) visited HEI and NHS sites at least one week prior to the data collection exercises to explain about the study, the AI exercise and invitation to participate in a group interview. It was explained that all those participating would be invited to share their reflections on practice and that participants would be asked to respect the anonymity of others sharing stories and joining group interviews. At the information session and again immediately prior to the AI exercise it was stated that whilst the research team could not guarantee that anonymity would not be breached by group members, assurances were made that the research reports and publication would not divulge the names of any participants or the names and locations of the organisations from which they came. To honour this assurance and to support maintenance of anonymity beyond the individual groups we purposely provide very little organisational detail about the NHS Trusts and HEIs, the particular courses or services they provide and any identifiable aspects of participants' experiences. Group members were also asked to respect the anonymity and confidentiality of others and therefore not share any of the discussions when outside of the group.

## 5.5 Data Collection

The study involved several stages (see Figure 1) building on insights from our literature review of health visitor recruitment and retention to provide background to the empirical work. Data collection began with a scoping exercise of arrangements for recruiting health visitor students within Strategic Health Authorities (SHAs)<sup>2</sup>, followed by telephone or email conversations with the lead for the health visitor implementation plan in four SHAs, two of which included the selected (HEI/NHS trust) research sites, to provide contextual information about health visitor recruitment. At each site semi-structured interviews were carried out with lecturers in the HEI and managers in the NHS trust, who also facilitated access for the research team to health visitor students at the HEI and health visitors employed by the trust. Groups of practising health visitors and student health visitors took part in separate two-hour long workshops that included Appreciative Inquiry exercises. Details of each of these stages of data collection are provided below.

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<sup>2</sup> It was important to collect this data because SHAs were at the time responsible for commissioning student places and recruitment of health visitors in the NHS.



## SHA Scoping Exercise

A scoping exercise with SHAs was carried out to identify whether centralised or local recruitment<sup>3</sup> of students had taken place for the 2011 September Specialist Community Public Health Nursing (SCPHN) health visiting course. We established that of the 10 Strategic Health Authorities (SHAs) in England, eight had used a local system for recruiting health visitor students (e.g. Trusts recruited locally and separately) and two had a centralised system (e.g. all the Trusts in the SHA recruited students from a centralised pool of applicants). This information helped us to plan the selection of study sites (described below) which was based on the geographical spread of SHAs and the local HEIs partnered with single NHS Trusts. The intention was to recruit one research site serving a large conurbation and a second serving a mixed urban/rural community.

Lead members of staff for the health visitor implementation plan in four of the SHAs were contacted by telephone or email to provide more information about the arrangements for recruitment to health visitor training, for example systems in place for facilitating advertising; and application and interview processes. This convenience sample of SHAs provided contextual information about the research sites, which were located in two of the four SHAs.

## Appreciative Inquiry exercises and group interviews

Health visitors and students who agreed to participate in the study were contacted several weeks in advance of the dates scheduled for a workshop when the AI exercises would be completed. They were provided with further details about the processes and a pro forma on which to write a short account of a positive experience to bring with them. Students were asked for a practice experience that they particularly valued, felt excited and motivated by, and to briefly describe the factors they believed contributed to this (see Appendix 4). The health visitors were also asked to recall a time when they felt happiest working as a health visitor and briefly describe the factors that contributed to this (see Appendix 5). They brought these written sheets with them to the workshops. The handwritten original documents were later scanned and the originals returned to participants with signed evidence of having taken part in the workshop, which they could, if they wished, include in their professional portfolios.<sup>4</sup>

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<sup>3</sup> With central recruitment all applications for an education programme within a single SHA are managed at a central point. A number of HEIs and NHS Trusts work together to select successful candidates who are then allocated to a HEI and NHS Trust place. By contrast local recruitment requires applications to be made directly to a single NHS Trust or HEI, who liaise with the other to manage the selection process.

<sup>4</sup> Professional portfolios are required for NMC registration. Mentors and practice teachers are required to submit portfolios for triennial review.

The workshops began with the researchers explaining the process, and confirming participants' consent to audio taping the proceedings. Initially, participants were asked to discuss the AI stories they had written about with one other person in the group, then after a few minutes to form two small groups to present features of the stories they had exchanged. After about an hour there was a break, during which the researchers identified themes emerging from the groups' stories. After the break, the full group convened to discuss the themes and more general experiences of working as a health visitor or being a student. The second half of the workshop was facilitated by the researchers as a group interview that was guided by topics previously identified by the research team, but also allowed questions emerging from the earlier discussion to be explored further (see Appendix 6 topic guide and Appendix 7 workshop schedule).

Separate student and health visitor workshops were held at each research site; a total of five workshops across the two sites. The AI exercises were completed by 17 student health visitors (joining one of two workshops) and 22 qualified health visitors (joining one of three workshops). Each workshop involved between four to ten participants and was facilitated by two members of the research team (KW and AG). On one occasion Mary Malone (MM) and Caroline Nicholson (CN) joined KW in AG's absence. Each workshop lasted approximately two hours, with a short break in the middle. All workshop discussions were audio taped and transcribed in full. The researchers' field notes captured their observations and reflections on the process of each workshop.

### Semi-structured interviews

Following the group interviews, semi-structured telephone interviews were carried out by the researchers (KW and AG) with participants indicating a willingness to be followed-up (n=8). The interviews were informed by an interview topic guide (Appendix 6).

For students, topics covered included:

- what motivated them to enter the profession and the factors that impacted on their decision
- their perceptions of health visiting as a profession
- their aspirations for the future and plans for career development

For health visitors, topics covered included:

- which organisational characteristics, such as supervision procedures, were important to maintaining their morale

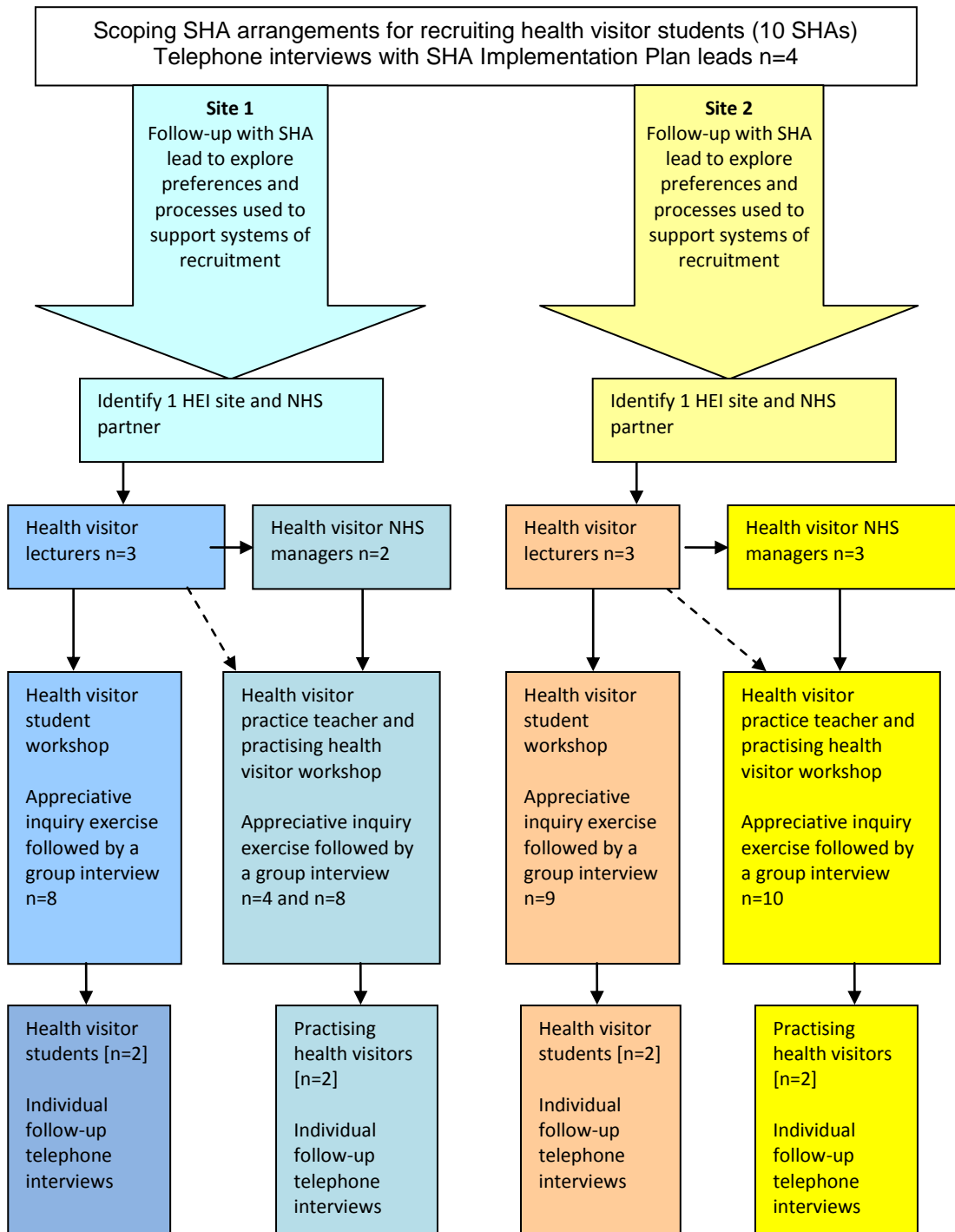
- their aspirations for the future
- how expectations about their role matched their current experience

HEI lecturers and health visitor managers: Semi-structured key informant interviews informed by a topic guide (Appendix 6) were undertaken by KW and AG either in person or by telephone with the six HEI lecturers and five NHS Trust health visitor managers to provide contextual information. Lecturers were selected on the basis of their involvement in the recruitment process and delivery of the educational programme. Likewise, all the health visitor district managers involved in student health visitor selection and recruitment were approached for interview. Lecturers, were asked about recruitment processes and criteria used in selection of students. Managers were asked about current recruitment and retention issues; organisation and management of health visiting teams, measures to support staff, e.g. supervision procedures, and education and training opportunities.

SHA leads for the health visitor implementation plan: Semi-structured key informant interviews informed by a topic guide (Appendix 6) were undertaken by KW by telephone to provide context information about the arrangements for supporting recruitment and workforce development. SHA leads were selected on a geographical basis (see page 46)

The 19 individual semi-structured interviews and 5 group interviews lasted between 29 minutes and 84 minutes (the majority were around one hour long) and all were audio taped for transcription.

**Figure 1: Process of data collection involving 54 participants**



## Selection of study sites

The two (HEI/NHS trust) study sites were selected purposively on the basis of being in different SHAs and willingness to participate in the research. The demography of the populations to which the NHS Trusts provided services was also considered: one trust included a large conurbation and the other a mixed urban/rural area bordering on a large conurbation. The HEI and NHS Trust at each site had to have an existing connection for delivering health visitor training. Those selected fulfilled the following criteria:

- The HEIs had an established SCPHN health visiting course running, with an intake of health visitor students in the academic year beginning September 2011.
- The NHS Trusts currently employed health visitors and were taking students from the partner HEI for their practice placements.

## Site access

Contacts were made initially with the Head of School in two HEIs, who both agreed to participate in the study. The heads, along with SCPHN health visiting course leaders, advised the research team which NHS trusts they worked with that best met the criteria above. One HEI took students sponsored and on placement in three different NHS Trusts; the other had students from five NHS Trusts. A prospective 'partner' NHS Trust was selected for each HEI and the service lead for health visiting services were approached about collaborating with the study. Both agreed to take part and the study proposal was approved as compliant with the trusts' research governance requirements.

## Recruitment and Sampling

At each study site, the research team discussed the study with two individuals in senior positions - one at the HEI and one in the NHS Trust - who agreed to be 'local leads' for the study and assist the research team with recruiting participants and making practical arrangements for the workshops and interviews. Potential student and health visitor participants were identified through discussions between the local lead, field researchers and other relevant SCPHN health visiting course lead/lecturers and managers in the NHS Trust.

## Students

All students (full-time or part-time) enrolled on the SCPHN health visiting course in the two HEIs were invited to participate in the study. There were no exclusion criteria. The HEI local leads found an appropriate time for the researchers to meet potential participants, for example at the end of a lecture, explain the study and hand out the

information sheet. Examples of the study information sheets are given in Appendix 2. This initial engagement meeting was followed up with a circular email to all students asking whether they would take part in the study, and giving full details of what this involved. Students who responded positively and provided informed consent were contacted by telephone, by email or in person to learn more about the arrangements, timing and location of the AI exercises. After the group interview had taken place, students were invited to take part in an individual telephone interview and asked to contact AG if they were willing to participate further. Two students took up this invitation.

### Health visitors

All health visitors who worked in the two NHS trusts were invited to participate in the study. This included health visitors working part-time and full-time and in any capacity, for example as practice teachers and in specialist posts. The NHS Trust local leads helped the research team use management systems for cascading information about the study to health visiting teams, and found suitable times for the researchers to meet potential health visitor participants. To avoid disrupting their working day, this was usually when they were meeting as a group for another purpose, for example a regular team meeting or a practice teacher meeting at the HEI. The researchers explained the study and gave out an information sheet, (example included in Appendix 2) which made clear that participation was voluntary. Health visitors who replied positively to emails about the study (circulated by managers and team leaders) were contacted by telephone or in person to explain about the arrangements, timing and location of the workshop/ group interview. After the group interviews had taken place, health visitors were invited to take part in an individual telephone interview. These individuals (n=2) were selected on the basis of their employment history and their willingness to discuss their experiences in more depth.

### Lecturers

The selection criterion for lecturers was that they were lecturers/course leads on the SCPHN health visiting course at the HEI. Those who consented to take part in the study were contacted to arrange a convenient time to be interviewed, either in person or by telephone.

### Managers

Health visitor managers were selected on the basis that they were currently employed in a health visiting management role in the NHS Trust. The local leads identified potential manager and lecturer participants and contacted them or introduced them in person to the research team, who explained the study to them and provided information sheets.

Managers who consented to take part in the study were contacted to arrange a convenient time to be interviewed, either in person or by telephone.

### SHA leads

Leads for the Implementation Plan were contacted from 4 SHAs. The SHAs were selected on the basis of the geographical location to cover the north, south, west and east of the country. The SHA leads had a strategic role for ensuring delivery of the implementation plan across NHS Trusts.

They were contacted by e-mail in the first instance to provide study information and seek recruitment. Those consenting to participate were interviewed by telephone at a time suiting themselves.

## 5.6 Study participants

A total of 54 participants took part in the study. The numbers of participants in each organisation and in each occupational group, and how they contributed to the data collected for the study, are given in table 1 below.

**Table 1 Participants and their contribution to the study (n=54)**

<b>SHA HV Lead</b> interviews				4
<b>HEI/NHS Trust sites</b>		<b>Site 1</b>	<b>Site 2</b>	
<b>Lecturers</b> interviews		3	3	6
<b>Managers</b> interviews		2	3	5
<b>Health Visitors</b>	AI exercises	10	12	22
	Follow-up interviews*	[2]	[2]	
<b>Student Health Visitors</b>	AI exercises	8	9	17
	Follow-up interviews*	[2]	[2]	
				54

*\*these interviewees were selected from participants in the data collection workshops*

## Demographic data

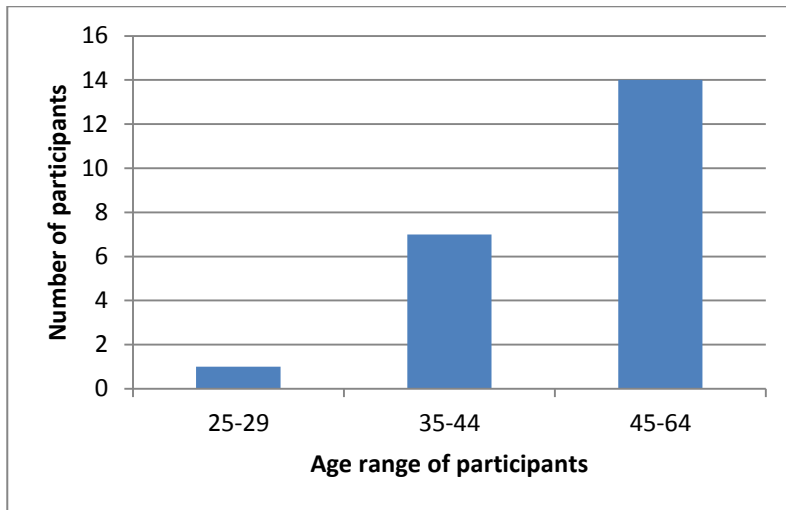
Brief demographic data was collected for health visitor and student participants to provide some context to the data directly relating to recruitment and retention experiences. The profiles for participating health visitors and students were very similar in each site, therefore the data has been aggregated and presented in single graphs. This information was not collected for teachers and managers who were interviewed as informants with information that was understood to supplement the main body of data from students and health visitors.

### Health Visitors

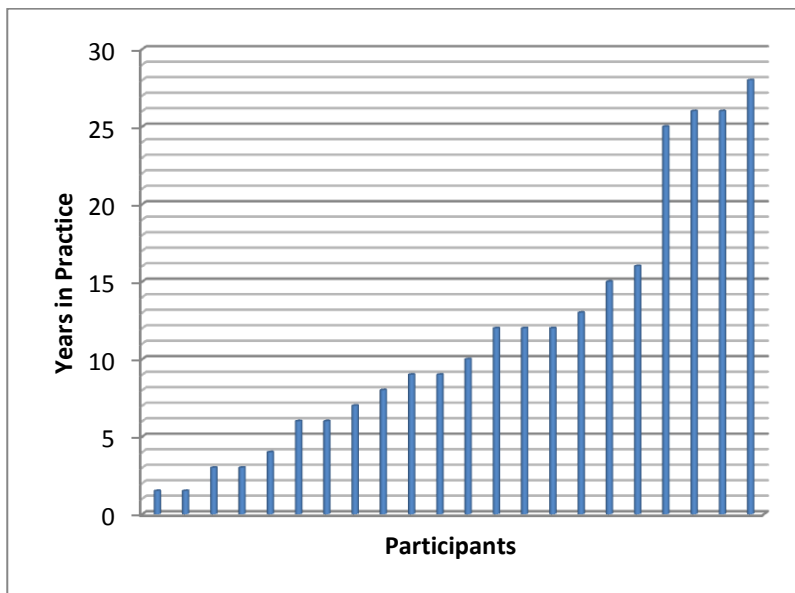
The practising health visitors were asked to indicate their age group; the number of years they had been qualified and working as a health visitor; and the job they held before entering health visiting. The age distribution of the sample is shown in figure 2. There was a wide range of health visiting experience in the sample, which included practitioners with as little as 1.5 to as many as 28 years' experience. The mean number of years qualified was 11.5 and there was a fairly even spread of experience, as shown in figure 3. Before entering health visiting, about half the health visitors had been working in midwifery or community nursing roles and fewer had come directly from adult nursing posts, as shown in figure 4.



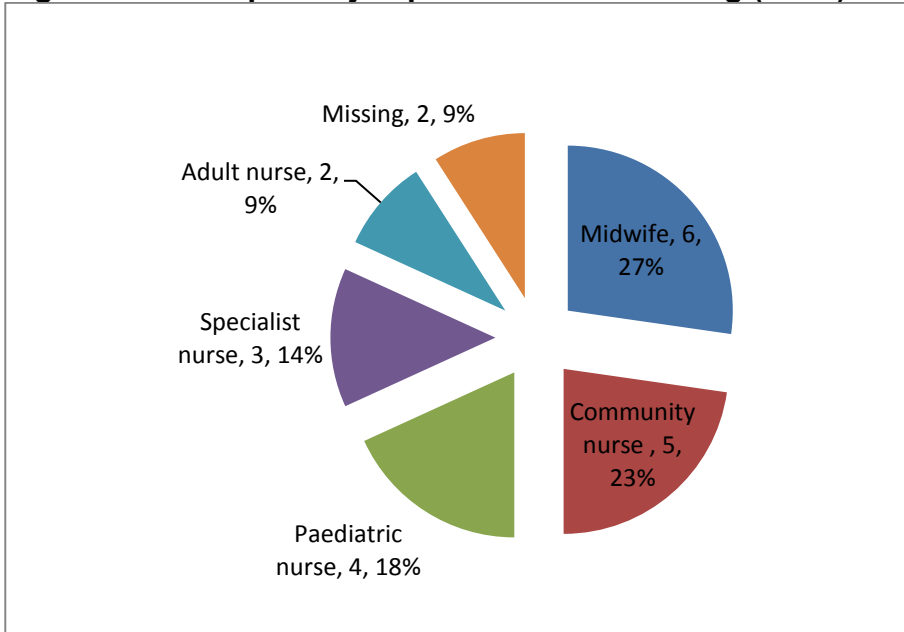
**Figure 2: Age distribution of health visitors participating in the study (n=22)**



**Figure 3: Participants' number of years in health visiting (n=22)**



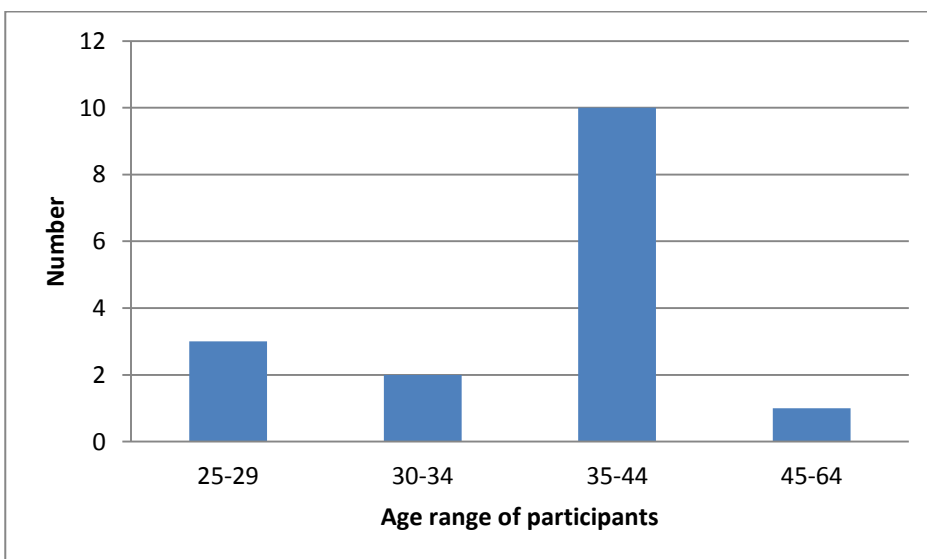
**Figure 4: Participants' job prior to health visiting (n=22)**



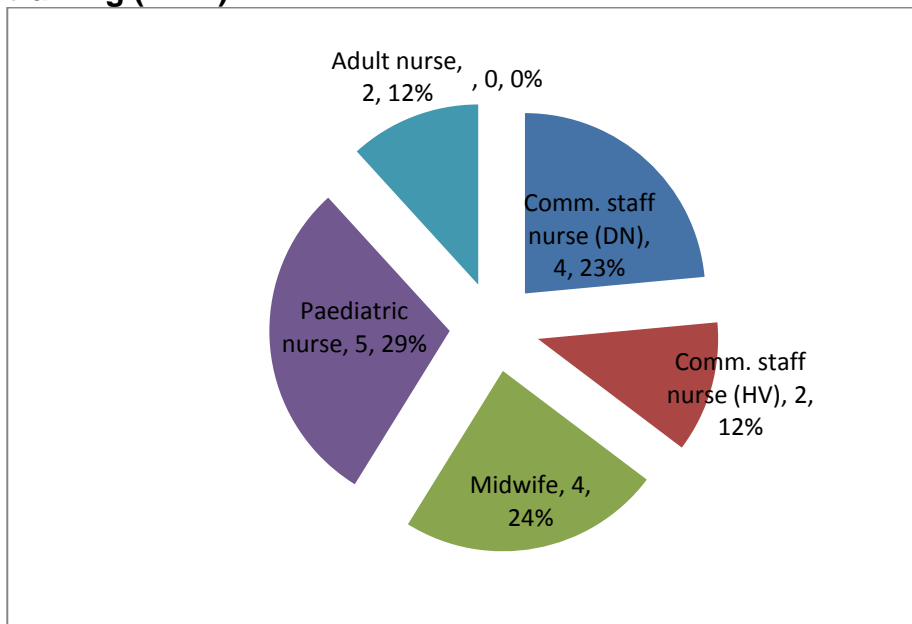
### Student health visitors

The students were also asked to indicate their age group and the job they had held immediately before starting the health visiting course. The age range of 16 participating students, as data missing for one participant, is shown in figure 5. More than half of the students (59%) had been working in midwifery or community nursing roles; 29% had come from paediatric nursing; and only 12% from adult nursing roles, as shown in figure 6.

**Figure 5: Age distribution of student health visitors participating in the study (n=16)**



**Figure 6: Student health visitors – post held immediately before training (n=17)**



## 5.7 Data Analysis

In this study the processes of data collection and analysis ran concurrently. Data collection at the two research sites and with the various groups of participants took place over several months (March–August 2012). During this time the research team discussed the issues being raised by participants and their own impressions and ideas, to get an early sense of how participants framed their experiences. This helped with maintaining alertness to emerging issues and similarities and differences between students and experienced staff.

The audio taped interviews were transcribed and anonymised for analysis. The AI stories in their original written form provided another data set. In total there were 31 transcripts, numbered 1-31 for reference and 39 AI stories also numbered for reference. We used the well-established approach of Framework Analysis (Ritchie and Spencer 1994) to analyse all the qualitative data, broadly following the five steps outlined by Pope, Ziebland and Mays (2000). Using framework analysis allowed the analysis to be 'grounded' and inductive, as well as maintaining a specific focus on health visitor recruitment and retention.

Familiarisation with the data involved two researchers, KW and Jane Hughes [JH], reading a selection of transcripts and making notes on key themes, then discussing the material and their ideas with other team members (AG and Jill Maben [JM]) some of whom also read the same transcripts. This process was repeated several times, with

additional transcripts and themes being considered each time. Some similarities were found between groups of respondents, but distinctive themes also emerged from each group, therefore the data from different groups of respondents was analysed separately. To ensure that new themes could emerge from the data we firstly engaged in open coding of transcripts to generate framework categories. Framework were then refined using *a priori* categories derived from the literature. Development of thematic frameworks allowed us to index the data using Microsoft Word and create charts for each theme or groups of themes (Ritchie and Spencer 1994; Lacey and Luff 2007). This was an iterative process, involving discussion and flexibility to refine themes and linkages, and was supported by aide memoires, such as flowcharts, tables and visual maps of themes in the data and their interrelationships, that captured developing ideas. These 'visuals' were presented, contested, defended and amended within the research team as part of the process of analysis. The research team met regularly to discuss ideas and interpretations, and these were further refined through drafting and redrafting sections of the report.

## Reflexivity

All team members, and especially those directly involved in the generation of data, adopted a reflexive approach to their work, exploring personal views and assumptions and reflecting on the impact these may have on conversations with participants and the analytical process. Alternative perspectives within the team (e.g. practice, research, education) were explored during team meetings (these took place at regular intervals that varied according to the stage of the project, from monthly during data generation to fortnightly and then weekly during data analysis and report drafting) and were brought into the analysis and interpretation of the data. AG and JH are social scientists with experience of qualitative research in healthcare. AG joined the Health Visiting Research Programme's team with relatively limited knowledge of the health visiting context and developed a more grounded understanding of health visiting policy, practice, and research through her involvement as a researcher working on the scoping review of the literature on health visiting. KW is a registered health visitor, has previously researched health visitor practice and has led educational programmes for student health visitors. She has knowledge and experience of recruiting students to health visiting undergraduate and post-graduate courses and Practice Teacher courses. These different viewpoints produced rich discussions in the analysis. Further analytical lenses were provided by JH's experience of research and development work with a variety of healthcare professions, EM's insights into the wider policy and healthcare research literature, and JM's expertise in nursing workforce research and policy.

## 5.8 Section Summary

This study of health visitor students', practitioners', lecturers' and managers' views and experiences of recruitment and retention includes:

- a review of the academic literature on recruitment and retention in health visiting (presented in section 3)
- a selective literature on NHS and other workforces (presented in section 4)
- qualitative empirical work with groups and individual interviews at two study sites in England (findings presented in section 6)

An interpretive approach was used to guide the overall design of the empirical element of the study and choice of data collection methods. This approach enabled us to gain understanding of the issues associated with recruitment and retention as expressed through the recounted experiences and perceptions of health visitor students, practitioners and managers.

The approach drew upon AI to actively seek out good practice and experiences, focusing on what participants value or find motivating and how these aspects of practice could be enhanced. Appreciative Inquiry is reported to be a positive, stimulating and morale-boosting process for participants.

Qualitative research methods were used for this study to allow in-depth exploration of individual experiences, views, intentions and aspirations regarding work and perceptions of the wider organisational context. Three methods for obtaining data were appreciative inquiry exercises; group interviews informed by the appreciative inquiry exercise and semi-structured interviews. Framework Analysis was used to analyse the data.

The two (HEI/NHS trust) study sites were selected purposively on the basis of being in different SHAs and willingness to participate in the research. At each site semi-structured interviews were carried out with lecturers (n=6) in the HEI and managers (n=5) in the NHS trust. Groups of practising health visitors (22 people in total) and student health visitors (17 people in total) took part in separate two-hour long workshops involving Appreciative Inquiry exercises. Semi-structured telephone interviews were undertaken with participants from each workshop (n=8) to further explore expectations and experiences of being a health visitor. In addition, short telephone interviews were conducted with SHA health visitor implementation plan leads (n=4) to collect contextual information about arrangements for supporting recruitment and or retention.

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## 6. Empirical findings

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### 6.1 Introduction

Findings are presented thematically in two parts. Part one (motivations and aspirations) draws on data from the AI exercises, in which participants discussed work experiences they found motivating, and focuses on their frequently expressed aspiration of *making a difference* to children and families. We suggest that participants used the phrase *making a difference* to signify their understanding of the purpose of health visiting and associated it with a set of values and work practices that were seen as essential for effective health visiting practice. Together these beliefs, values and work practices form part of a distinctive professional ideology of health visiting held by both qualified health visitors and students that influences how they define worthwhile and rewarding work. We explore this ideology of practice to understand participants' aspirations and the intrinsic rewards their work provided.

The second part (organisational context: supporting job satisfaction) considers the circumstances and situations within which health visitors work that have an influence on the 'nature of work', the 'organisation of recruitment and training' and beliefs about 'being valued and respected'. These findings, drawn from the full range of stakeholders contributing to the study, provide insight into the organisational characteristics (including structures and culture) and approaches that promote job satisfaction and hence help retain health visitors.

In this report we use quotes from participants to illustrate our analysis and have adopted the following conventions for quotation: participants' own words are in italics and we have tried to keep editing to a minimum. When we quote a participant speaking, hesitation is indicated by ..... Where dialogue or written text has been edited by us for brevity, clarity or to protect anonymity, this is indicated by [...] for omission of words or sentences; or [*with words inserted*] when we have altered or summarised what was said. When editing quotes, we have endeavoured to be faithful to the meaning intended by the participant. Against each participant quote is a code noting the transcription number, participant type and group (grp) or individual interview (int) e.g. (3-HV-grpA) = transcription 3, health visitors, group A. The participant type is abbreviated as follows: HV=health visitor, S=student, M=manager, L=lecturer, SHA=SHA stakeholder. The AI sheets are similarly coded noting the type of participant and participant number, e.g. (S-AI5) = student, AI sheet, number 5.

## 6.2 Motivations and aspirations

In the AI exercises participants shared stories about work experiences they particularly valued and felt motivated by, which encouraged exploration of what health visiting meant to them: the purpose of their work; the values that underpinned it; and how these values were expressed in everyday work practices. Thus the AI exercises surfaced beliefs and values that influence professional identities and behaviour, and which form a distinctive 'ideology of health visiting practice'. In the discussions, a phrase that was reiterated frequently encapsulated participants' perceptions of the main purpose of health visiting and what they were striving to accomplish: *making a difference to children and families*. We go on to consider what this meant to study participants, before exploring the four key aspects of health visiting practice that were perceived to contribute to *making a difference* first for students then for experienced health visitors. These were:

- connecting with families and communities
- working in collaboration with others
- using knowledge skills and experience
- professional autonomy to respond appropriately and flexibly to needs

### What does *making a difference* mean?

Health visitors and students often referred to *making a difference* to children and families as an ambition or a goal, and as something they had experienced in practice, e.g. a personal and professional achievement, and occasionally as a way of signifying the effectiveness of their work. Similarly, lecturers identified that they were looking for new recruits applying for health visiting courses to show evidence that they were: *passionate about making a difference to children and families and want to understand that it's about addressing the inequality we've got in this country and being very non-judgmental* (17-L-int). Researchers have reported that other professionals also use this phrase to explain what motivates them in their work; therefore by using *making a difference* to signify what they find intrinsically rewarding about their work, health visitors are similar to other healthcare professionals such as nurses (Maben 2008) and doctors (Christmas and Millward 2011). The health visitors in this study who felt they were *making a difference* for children and families believed their work was worthwhile. Students identified *making a difference* as a key motivation for embarking on a health visiting career.

The AI exercises indicated that for our participants *making a difference* was connected with improving life chances; enhancing child and family health; preventing ill health and other problems; protecting children; and assisting vulnerable people. To *make a*

*difference* in these ways, participants recognised that health visitors needed to gain access to people's homes, to form relationships with them and learn about their private lives, which enabled health visitors to offer appropriate help and support:

*During my time in placement whilst working with my practice teacher I was able to see how early intervention and prevention can make a difference in situations with mothers with postnatal depression. (S-A14)*

*I felt happiest a few years into my health visiting career, this was a time when I felt confident in practice and had a really good knowledge of my caseload. I would receive a telephone call from another professional and be able to talk about and know a family. I recognised people at clinic as I had visited them on several occasions. I felt I was always learning. I felt I was making a difference and could follow through with behavioural interventions and see results. I had a mixed caseload not all children in need, child protection. Was valued by team, had good team. (HV-A11)*

To be allowed to enter people's homes and lives, and to achieve this level of intimacy with clients, was acknowledged as a privilege and some participants described it as a *humbling* experience.

*Enjoyed meeting vulnerable mum who had been displaced to this area after seeking asylum. Made me see the difference of lifestyles and circumstances and surprised me. It highlighted people's strength in the face of adversity. I came away feeling very humbled that someone who had circumstance previously of such trauma, could be so trusting and open. It inspired me that this was an area of work where I could feel valued and welcomed. (S-A12)*

*Throughout the 26 years of my health visiting career I have valued the unique and privileged opportunity to work with families with young children over a period of time. No two families are the same and each and every birth notification and "movements in" presents exciting challenge. The first time you knock on the door you are starting a new and exciting journey. (HV-A16)*

This suggests that *making a difference* offers both personal and professional rewards. The personal rewards are at an emotional level, and achievement of *making a difference* is linked to experiences of satisfaction, accomplishment and self-worth. Professionally, being able to provide evidence of *making a difference* not only meets managerial and organisational requirements, it also reaffirms for the practitioner that their practice is fulfilling professional values and vocation.

In our analysis of data from the AI exercises we found that the same key themes emerged for students and health visitors. These represent the aspects of health visiting practice that both groups identified as critical to achieving the core aspiration of *making a*



*difference* to children and families. As well as contributing to the overarching goal of *making a difference*, these aspects of practice also offered practitioners intrinsic rewards. We first present the students', then the health visitors' beliefs and values about *making a difference* and how the four themes were interwoven in discourses of health visiting.

### Attracting new recruits: students starting out

In the AI exercises, students talked about what had first motivated them to think about becoming a health visitor. Some traced their interest in health visiting back to experiences during pre-registration nurse training, on placement with health visitors:

*My very first placement was with a health visitor in the community and she was really, really inspiring and I always thought, 'I'll end up one day being a health visitor hopefully.' [...] because she [...] really fought for [the community in] a very deprived area, and she would take me out to quite bad cases. And she wasn't frightened to show me how bad it can be and it was very inspiring, her attitude. (7-S-grpB)*

Emotive experiences like this were powerful enough for students to identify them as reasons for embarking on health visitor training and wanting to *make a difference*. There were also examples of students and qualified health visitors acknowledging that they had been inspired by their own health visitor when they became mothers. In these instances the individual had pursued nursing with the intention of becoming a health visitor.

*But it was my health visitor who came to see me with my third son who said she was a mature student as a student nurse and went into health visiting. It just sounded really appealing. [...] Because it's a positive experience. There's someone there supporting you when you're feeling at your absolute most sore, you're feeling quite vulnerable, very tired, not being judged. But I was able to offload on to my health visitor... I didn't have lots of issues, he was just a premature baby. (3-HV-grpA)*

### Connecting with families and communities

In the students' AI stories, accounts of engaging with individuals and families were particularly prominent, and these experiences were identified as reinforcing the motivation to become a health visitor. Making a connection with families enabled students to appreciate the resilience of others which they found rewarding in itself. One student describing it as a *privilege to see the children thriving* after their living conditions had improved, which she said, *energised me as a health visitor*. The nature of the relationship with families was also important to students, who envisaged being a *source of support* to assist with *improving outcomes* in terms of child development, education, social skills, emotional wellbeing, attachment and bonding. To achieve this they identified developing relationships with parents as essential, *the bedrock of the role* and

*the starting point to offering any sort of help.* Through building trusting relationships with families students aspired to be understood as someone who was:

*on their side, and you're not on the outside looking in but you're on their side a little bit. I'd want that role'. [...] That's how I would want to portray myself as a health visitor rather than somebody coming in looking to see if there's problems. (13-S-grpA).*

Developing a relationship with a client also offered the opportunity for health visitors to intervene early and help prevent difficulties in future, as discussed by two students in the focus group interview:

Student 1 *Particularly with postnatal depression and things like that, I think if you can establish a relationship early on and stop the mother going down that route, which is so detrimental for the children, it's a lot about preventative...*

Student 2 *That work in the early days as well, and it might even be that you might not have necessarily prevented the problems, they know that they can ring you because you've put that work in in the early days, and you will get that phone call to say, 'I'm struggling,' or...*

Student 1 *Stop it escalating.*

Student 2 *Yeah. It can make that difference. (6-S-grpA)*

The discussion above also highlights continuity as an important aspect of relationships in which the client knows there is someone to turn to and will actively seek help from a trusted health visitor. Continuing relationships with individuals and families were seen by students as increasing the opportunity to *make a difference: I think the longer you're involved with the family, the more impact you can make.* Continuity also enables health visitors to assess the impact of the support they have provided. Students valued confirmation that they were *making a difference* and particularly welcomed getting feedback directly from clients, for example:

*I followed this visit up with a phone call and she thanked me very much for the support I had given and said she had begun to make changes to her day to day life that were having a hugely positive effect on her and her family. The reward for me was realising that because we had got a good therapeutic rapport I was in a position to help and she was then able to help herself. (S-A17)*

When students saw evidence of the impact of health visiting support or received verbal feedback from clients that their action had *made a difference*, this validated their decision to pursue a career in health visiting. In addition, feedback that specifically conveyed a level of appreciation for their individual contribution was important for students' sense of self-worth, and helped to maintain their commitment during training,

when the demands of the programme were occasionally such that some students worried they would *[lose] sight of why I wanted to do this in the first place.* (6-S-grpA)

These examples illustrate that students perceived the nature of their relationships with families as an attractive aspect of health visiting and a sustaining experience in practice. They also recognised the connection between managing trusting relationships with clients and other aspects of practice, notably being able to use their knowledge and skills to help families and to bring in other professionals and services to provide necessary support.

### Working in collaboration with others

Working as part of a wider health visiting team and cooperating with other professionals and services was not so extensively discussed by students as forming relationships with families, possibly because they had limited experience of working with families with complex needs that required this type of collaboration. However, students showed they understood that offering help and support to a family included drawing on the skills and strengths of the wider health visiting team and putting families in touch with other local services and resources:

*So that light-bulb moment for me was the fact that we're out there in the community, you're in a family, you see something that could be improved within that family, and you've got the opportunity to do it and say something to suggest them trying something different or suggest a children's centre activity or whatever it might be for that family. You're in a really important position to actually see it and do something about it.* (7-S-grpB)

A student who had previously worked in a community post reflected on her AI story about a family whose circumstances were complex and required working with a wider team and other services to *make a difference*:

*So the story that I wrote about was a child protection family that I was working with, it was quite a long on-going, you know, there'd been domestic violence and the children weren't thriving in school [...]. They went on the child protection register because [...] there was definite neglect. So obviously with all the different agencies – that's what's really good about child protection [safeguarding] as well, is you've got all the different agencies working and putting in time, because they have to do that you see. [...] Yeah, so working with the other agencies, the family went from being in chaos and fear to where the children started thriving in school and thriving at home as well, and the parents started putting their children's needs first, and just watching over them, because it was probably about a year [...] I worked with them ...* (6-S-grpB)

## Using knowledge, skills and experience

Students saw the move to health visiting as a *step up* or career progression: it gave them a chance to enhance their skills and knowledge, particularly in prevention, by further study and training. They suggested that working with families to prevent illness, rather than responding to illness by providing treatment, was a progressive thing to do, personally and professionally: *you have to develop to become a health visitor.* (7-S-grpB) Students' accounts indicated that they valued opportunities to apply knowledge and to practise new skills, and experienced a sense of achievement when they felt they had helped a client or family, as in this AI story:

*One year developmental review in which the mum disclosed she had been feeling low in mood. She had experienced PND following the birth of her 3 year old daughter. I have no previous experience professionally with postnatal depression and am aware of the limitations of resources within the local area. Despite receiving training in Solihull and motivational interviewing, I was not sure how best I could support and welcomed a potential opportunity here to 'make a difference'! I listened to her and congratulated her on how brave she was to acknowledge her feelings which she described as being the same as previously. She agreed to speak to her GP and made an appointment, in addition to welcoming my offer of further support. I have welcomed this opportunity to further support this Mum and others on my future caseload.* (S-AI2.8)

Other students were keen to use skills that enabled them to work in a way that was aligned with families' own definitions of their needs and circumstances, by 'agenda matching' e.g. tailoring a contact to address pressing issues identified by the client rather than adhering to a list of pre-determined topics:

*....motivated that have made a difference by giving advice that is realistic for that family; recognising and being able to tailor/agenda match care/advice that is most relevant and pertinent to that family/child.* (S-AI2.5)

Although some students framed 'agenda matching' as application of knowledge and skills, others also appreciated that it required health visitors to exercise professional discretion. Picking up cues from clients, making assessments, and knowing when and how to intervene were perceived by students as sophisticated accomplishments that required them to draw on their accumulated experience, emotional maturity and confidence, as well as their health visitor training. Students believed that the experience they brought with them to health visiting and autonomy to use it, contributed to their effectiveness as health visitors.

### Professional autonomy to respond appropriately and flexibly to needs

Students perceived health visiting practice as offering them more autonomy and independence than many other nursing roles. They aspired to practice autonomously, for example by listening for concerns raised by clients and ‘agenda matching’, but this could be difficult to achieve if they were also required by practice teachers or mentors to use scripts with pre-determined questions or topics to guide their interaction with clients. The tension between using discretion in responding to a client’s needs and meeting the expectations of a supervisor was illustrated by a student’s AI story of drawing on midwifery knowledge and experience to offer a mother tailored breastfeeding advice. The student had acted decisively, but realised she faced disapproval from her mentor who was uneasy about the advice, noting that the *mentor was less happy and would have preferred the mother to give formula milk*. However, the mother’s positive response to the advice and baby’s improved weight gain reaffirmed for the student that she had acted in the best interests of the family, such that she aspired to *try to continue to practice autonomously after qualification*. (S-AI1.5)

Other students anticipated that once they had qualified and gained experience, it would be more feasible to practice autonomously:

*I’d like to think when I’m qualified as a practitioner I’d be able to do anything confidently, justifying having the evidence to do that. But I don’t know whether the students have got that much capacity. Not capacity, that much autonomy to be able to do that, because you are answerable to your practice teaching team. It’s a bit difficult to do that while you’re in [...] student role, yeah.* (13-S-grp)

In summary, the four inter-related and mutually reinforcing aspects of health visiting practice – connecting with families; working in collaboration with others; using knowledge, experience and skills; and professional autonomy – were seen by students as important in themselves for providing worthwhile and rewarding work experiences and as essential for achieving the goal of *making a difference* to families. However, it was not always easy for students in training to fulfil their aspirations of health visiting practice, although this did not seem to affect their motivation to become health visitors. Their experiences – positive and negative – tended to reinforce their expectations about health visiting and their commitment to *making a difference*. We turn next to explore how the ideology of health visiting practice featured in qualified health visitors’ accounts of their work.

### Health visitors in practice: staying with it

The stories of positive experiences that the qualified health visitors brought to the AI exercises were similar to the students’ accounts in that they identified circumstances in which the practitioners felt they had *made a difference* to families and in particular to the

lives of young children. However, in the AI exercise, the health visitors typically wrote about more complex scenarios that featured long-term involvement with families, often over many years. They emphasised that although these cases were the most demanding, they derived the greatest sense of achievement from them: *the most satisfying work [is] with families who are experiencing complex difficulties, for whom there are no easy answers and no quick fixes* (HV-AI1.6). The examples given by the health visitors included family members seeking asylum; experiencing post-natal depression; and domestic violence or other forms of abuse.

Another aspect of the health visitor AI exercises was that some participants described good practice experiences from the past, which gave a sense of harking back to a mythical golden age of health visiting when *making a difference* had been easier to achieve. While these recollections served to pinpoint essential and enduring features of practice that participants valued and reinforce continuities between past and present, they were also a way of illuminating changes over time and perceived problems in current practice that participants felt threatened to diminish their motivation and job satisfaction. However, one health visitor made a point of illustrating how her current job compared favourably to a previous health visiting post in another area where the resources available, contact with other agencies, balance in nature of work, e.g. the conditions surrounding practice, were different.

The positive features that came out of all these reflections were that health visitors wanted to *embrace the whole role*, which included offering families continuity of care from the antenatal period onwards and engagement with community public health activities such as independent living groups, health walks, and community groups. They valued knowing their caseload of families, developing an understanding of a particular community, and working closely with general practitioners, all of which they linked with care quality and being *able to deliver a higher standard of care which was tailored to the meet the needs of that community*. *Making a difference* across such a wide spectrum required collaborative efforts, including *partnership working between the health visiting service and the local children's centre; close working relationships with GPs, practice nurses, midwives, social workers and nurseries; support from other local agencies and voluntary groups*; and working with specialist healthcare providers such as consultant psychiatrists. The AI stories also featured working as part of a supportive team; good leadership and managerial support; and being offered opportunities for learning and development.

We go on to explore further how the four themes of connecting with families and communities; working in collaboration with others; using knowledge, skills and experience; and professional autonomy were expressed by the health visitors in the AI exercises.

## Connecting with families and communities

For qualified health visitors, like the students, being able to establish trusting relationships with clients and families was an essential aspect of health visiting practice, which was rewarding in itself as well as being a means to *making a difference*.

Practitioners emphasised the mutuality of the relationship, *I'm the named health visitor for all these families, so they know me and I know them*, and that it was their responsibility to do everything they could, even if it meant working outside of organisational preferences, to give a relationship the best chance of flourishing:

*So when a family have a baby or transfer into the area I make sure I get in there and I see them at home, even though we're encouraged, if they're over one, to just send them a pack or invite them to clinic, I like to actually visit people because it only takes me about twenty minutes, half an hour, and I'm building up some kind of relationship. (15-HV-int)*

*I've been health visiting over 26 years, and it's working with those families on a long journey that I really enjoyed. (4-HV-grpB)*

Some stories emphasised the value of maintaining continuity with vulnerable families over the long term; and the skills required to achieve this and prevent such families being excluded. One health visitor described a review meeting following the death of a child from a large family, at which she was nominated to visit the family after the GP was reported to have said: *Well, the only person who can get through the door is their health visitor*. The health visitor continued:

*I actually went to the child's funeral as well, and the family thanked me for doing that. Very few other professionals turned up. But because I've seen this family for the last 12 years, every year with the baby, I've got in where others can't. They won't let other people in because of that fear of, 'What are they going to do?' And that makes a big difference. (4-HV-grpB)*

As this quote illustrates, health visitors often mentioned that they had received positive feedback from clients or families, and it is apparent that knowing they were appreciated was rewarding in itself. As one health visitor wrote: *great feedback from clients is wonderful for motivation. (2-HV-A14)*

In contrast to the students, the health visitors were much more likely to talk about the importance of connecting with communities as well as individual clients and families; they discussed the value of home visits, but also emphasised the different ways and varied settings in which health visitors could interact with parents and children. The following quote illustrates this well, although it is not clear whether this health visitor was

referring to current or past practice; nevertheless she conveyed what *being known* in the community meant to her:

*I think my story was about almost feeling I had ownership of my caseload and responsibility, and you would know all your families, they would come to you, the GPs knew you, the social workers knew you, the nurses knew you, the families would phone you and text you. They knew who you were, you were there at the clinic, they saw you. So you kind of were quite pivotal in their lives. [...] I think it's just about being able to identify in your community that there is a need, and being allowed to run a postnatal group, do your baby massage, what your community needs. It might be doing a swap shop of clothes. Whatever you think they need. (4-HV-grpB)*

Others made the point that *being known* and being visible in community settings such as clinics and community groups, was also important for encouraging parental agency and community responsibility. Health visitors who were known and easily accessible were likely to be approached for help, thus providing a resource and a safety net for families.

*I can recall when I was working in one area where we talked about a community clinic [child health or well-baby clinic] and many is the time it was the mothers who came from the maisonettes to tell us about a child that had moved in and how worried they were about that particular mother, 'Please don't mention that it was us.' They would come in a little group of three. (9-HV-grpA)*

These health visitors also drew attention to the value of being on familiar terms with professional colleagues working in the locality and with the same families, thus increasing the possibilities for collaboration, which we consider next.

### Working in collaboration with others

The health visitors gave richer accounts than the students of multidisciplinary and multiagency working with families in complex circumstances and referred to the strength they derived from working with others to pool knowledge and service resources. The purpose of collaboration was primarily to ensure families could access the help they needed, but health visitors also recognised that they benefitted from co-operating with others, which *increased [their] own knowledge of resources and services in supporting children and families with complex health needs* (3-HV-AI2.3). In short they noted: *what makes the job easier is accessing services for families* (9-HV-grpA). Thus the process of collaboration enhanced health visitors' ability to be helpful to families, which reinforced their motivation:

*The more we work with our local services, you know who to go to for an instant answer rather than going round in circles. So I find that really empowering. (3-HV-grpA).*



Health visitors also placed high value on being part of a team of colleagues who could be relied on to provide peer support in the workplace, from informal 'off-loading' at the end of the day to more focused assistance with difficult cases. Reciprocity was expected as part of health visiting teamwork:

*I think how it is now we will all go through phases of perhaps more stressful times, for whatever reason, whether it be child protection [safeguarding] or volume of work or perhaps a particularly stressful family situation, either at home or in work, but people in the office I think realise that and then when it's their turn, you return the favour. (27-HV3-int)*

In contrast, lack of reciprocity in teams, for example unwillingness to share work when one member of the team was overloaded, was associated with diminished sense of accomplishment; as one health visitor said, it did *not help me feel good about the service I was able to offer*. For others however, when the immediate team lacked resource, support could be gained from the wider primary health care team if services were arranged in such a way that brought professionals together on a regular basis. In one example the health visitor explained that during a health visitor team shortage a specific attempt was made to co-ordinate clinic services involving health visitors, midwives and GPs. This helped maintain care continuity for women and kept professionals in regular contact with each other. For the health visitor this meant that:

*....despite working with vacant HV post I felt supported by PCHT [Primary Health Care Team] team at the surgery and rewarded by mothers (HV-A12.9)*

More recently-qualified health visitors valued the opportunities teams offered to *bounce ideas off each other*, and noted that *even experienced health visitors, they throw into the pot, don't they, Oh, this family, I don't know how to go about this*, (3-HV-grpA). This quote illustrates the importance placed on informal learning in teams, which is considered further below.

### Using knowledge, skills and experience

Being able to use their knowledge and skills fully and having the chance to develop were identified by the health visitors as important aspects of worthwhile jobs. A health visitor who had worked with families seeking asylum said this role had given her job satisfaction, partly because she felt appreciated, but also because she:

*... had a manageable caseload and sufficient time to listen to clients and to get to know them. The team was well managed and there was good morale. I felt I was able to fully use my skills to impart health promotion to a population that might otherwise have felt totally neglected. (HV-A12.1)*

This health visitor felt she was *making a difference* because she was in control of her workload, had time to form good relationships with families and could use her knowledge and skills appropriately. Keeping knowledge and skills up to date and finding opportunities for development were seen as important by all participants; and some health visitors were particularly concerned about maintaining their breadth of knowledge, which needed continual investment if they were to be competent to deliver a universal service:

*I haven't been doing two and a half year checks so I would be struggling there as to what I'd look for. Just keeping up to date with weaning and sleeping and all of those behavioural snippets. (5-HV-grpC)*

Concerns about maintaining competence to provide guidance and information on topics such as weaning were raised with respect to the changing nature of the workforce and the possible reduction in nursery nurses, who have for some years been employed as part of the health visitor skill mix team.

For some participants, becoming practice teachers had helped to compensate for losing the broader public health role they had previously enjoyed. Teaching students required them to exercise professional autonomy; and investing in the development of the workforce made them feel their job continued to be worthwhile, and offered them a form of career of progression which *helped morale*. (4-HV-grpB)

*As you become a student you grow into the role and you grow in the workforce as well. And [as a practice teacher] you'll be able to impart all that experience and information, you're giving that over to somebody else and you can see them grow into that role. And you're growing the workforce as well, the profession is continuing. (9-HV-grpA)*

Health visitors perceived their knowledge and expertise as specific and different from that held by others, particularly colleagues in the child and family workforce. They positioned themselves having a more holistic view of child and family needs, as in the quote below, which also claims that health visitors have more experience and skill:

*But I think we need to lead a lot in the health, because I think the children's centres workers aren't as experienced and have as much training as us. So then we work with the families, we're taking the full holistic picture, and we observe lots of mother/baby interaction, all the cues. Whereas the children's centres, a lot of them are nursery nurses and child focused. Not all of them. I think our skills are greater. (4-HV-grpB)*

Interestingly, this assessment of the health visitor's role vis-a-vis other professionals does not mention the health visitor's autonomy or use of professional discretion, the aspect of practice we consider next.

### Professional autonomy to respond appropriately and flexibly to needs

Autonomy was an aspect of health visiting practice that the qualified health visitors valued and regarded as important for enabling them to offer accessible and timely assistance to families. In health visitors' AI stories, working autonomously was often woven together with other aspects of practice, many of which featured the health visitor taking the initiative and using discretion to respond appropriately to family and community need. This is apparent in the following discussion between three health visitors who were trying to summarise what being a health visitor meant to them:

*HV5 Building a relationship with the family. Working with the whole family.*

*HV4 Being able to address as many of their needs as they need addressing, without constraints being put on them ... like bureaucracy.*

*HV6 For me, I could be doing a developmental check, and from that check I could see vulnerability, some targeted work that needs doing, carrying it forward, and it might go to the fourth level of universal services<sup>5</sup> depending on my assessment and the needs... (4-HV-grpB)*

Use of professional knowledge and skills in assessment, followed by freedom to decide how to act to take the work forward encapsulated the autonomy cherished by health visitors:

*Basically I just felt happy, at the end of the day I thought I'd done a good job. They appreciated my work. And I was able to work autonomously, but with a good team framework. (3-HV-grpA)*

Students linked autonomy with being able to match their advice and support to a family's needs. Health visitors also saw a connection between autonomy and 'agenda matching', a distinctive technique that requires the health visitor to exercise discretion. In addition, they identified autonomy in managing their work as an essential feature of maximising the effectiveness of practice. The example below emphasises knowing the client and continuity of the relationship, while underplaying the decision to visit at home, which was crucial to having a conversation that enabled the health visitor to respond to cues and help the client:

*... because I know her and I know the history of domestic violence and the impact, I feel that I picked things up that might not have been picked up on because I did the check at home rather than in a clinic and the mum sort of opened up to me about a few things.*

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<sup>5</sup> The Universal Partnership Plus level of service for families with complex needs requiring additional help from a range of agencies. We have referred to cases at this level as 'intensive cases' within this study.

*So if you haven't got that closeness and that continuity, things like that can slip through the net. (21-HV-int)*

The health visitors' accounts illuminate the interplay of the four aspects of practice that were connected with being able to achieve the goal of *making a difference* to children and families. Accomplishing each aspect of practice supports accomplishing the others; each provides its own intrinsic rewards, giving health visitors a sense that they are doing the job well and their work is worthwhile. The findings also give glimpses of how health visitors' narratives about their work reinforce their professional identity and contribute to the broader discourse of professionalism in health visiting. The health visitors' accounts also indicate their experience of an organisational context that creates tensions and places constraints on them working in ways that are congruent with their ideology of practice, which can diminish their motivation and job satisfaction.

The following section considers the context in which health visiting is carried out and explores the conditions for practice identified by participants as enabling them to fulfil their aspirations and expectations within their job. In doing so, more evidence for understanding those factors that help retain health visitors and those that attract new recruits to the profession are identified.

### **6.3 Organisational context: supporting job satisfaction**

The extent to which health visitors believed they were able to provide a service that *made a difference* depended on the practice conditions created by the surrounding culture and resources. What health visitors and students were concerned about for now and the future was an ability to practice what they understood to be health visiting. As part of this a plea that *I just want work to value what I value* (13-S-grpA) was made to those with a hand in managing the future of the service. There was a concern that those delivering the service and those managing needed to be *on the same page*, share the same priorities, and understand how health visiting needed to operate to achieve its goals in improving health for families.

Staff expressed satisfaction with their job when they perceived the conditions for practice were *allowing me to do my job* (9-HV-grpA) and they were supported in their role. That is when their knowledge and contribution was respected as valuable and the nature of the work they were involved in seemed congruent with their professional priorities for delivering quality care to families and their own personal development. Here we present key features of the conditions for practice which represent organisational characteristics and approaches that promote job satisfaction. These features are captured as part of the remaining section concerning the organisational context.

At the end of this section we bring together the themes pertinent to understanding health visitor recruitment and retention which are summarised in a visual model Figure 7. At the centre of the model is the driver for professional practice and motivation to start and stay in health visiting; the satisfaction of **making a difference to children and families**. This is made feasible by a health visiting training and job that supports core health visitor practices (home visiting, relationship building and needs assessment) and thus enables health visitors to **connect with families and communities, work in collaboration with others, and use of knowledge, skills and experience as well as professional autonomy, to respond appropriately and flexibly to needs**.

**Figure 7. Health visitor recruitment and retention factors**



The following excerpt from a group interview with health visitors brings together the study themes illustrated in the model. It is an example of health visitors explaining a helpful organisational context where they spoke of working closely with other agencies and the opportunities for colleagues to share, learn and problem solve together, facilitated by the availability of reflective practice sessions. A manager with a good understanding of health visiting indicated value and respect for the health visitor role by inviting their participation in decisions about changes to the service and by ensuring mechanisms (the health visitor action group and reflective practice sessions) for staff involvement. As a consequence, health visitors felt that they had been able to retain a

sense of professional control over practice specific decisions and thus the nature of work, with which they were involved. They explained that they continued to have good contact with families, and maintained a position where they applied their professional knowledge whilst still working with others within a skill mix team.

*HV1: [...] there was involvement with lots of local agencies, voluntary agencies, children's centres and we all knew each other. We all got together, we did appropriate referrals, they contacted us, we contacted them and that was great. We have a really, really good team ethos, everybody works really hard. We do reflective practice every other month...*

*HV2: so we have six reflective practices every year, where the agenda is chosen by us, by all of us [...] We've had great leadership, really, really good management/leadership.*

*INT: And was that because of the respect?*

*HV2: Absolutely, Who as a health visitor by background [the manager], understands health visiting and we therefore have been involved in change. We've had a health visitor action group where we could look at our work and how we needed to work and then when the healthy child programme came in, collectively we decided how it was to be delivered and the skill mix thing... that was really good because I know my families really well because I have been able to [do home visits], I decide to whom I might or might not delegate work, so it's my decision, it's not a protocol, it's not written elsewhere, it's my decision based on my knowledge of the family and I think that is just essential.*

*HV1 Yeah, absolutely.*

*HV3 Absolutely.*

*HV2 You're agreeing with us?*

*HV4 Yeah, I feel that. [...] that's it in a nut shell really. (9-HV-grpA)*

Organisations that promote health visitor job satisfaction, support development of an organisational context that nurtures the belief that professional practice is valued and respected and that there is a commitment by the organisation to shape the nature of work to assist health visitors to do their job.

In the remainder of this section the features of the organisational context pertinent to recruitment and retention are considered. These are the:

- nature of work
- organisation of recruitment and training

- being valued and respected

## Nature of work

Issues important to the way in which work was experienced included team organisation and workload, which are considered in turn below.

### Team organisation

As noted in section 6.2, an important concern of practitioners was the extent to which they were able to know families and communities, make best use of their knowledge and skills, make autonomous decisions or make use of the resource that others could offer. Health visitors felt this had been achieved when teams had been encouraged to organise themselves to develop their own models for managing and distributing the work across the wider skill mix team. That is where they had worked collegially to develop models (e.g. team leadership, corporate caseloads or management of the skill mix team) and establish agreements that ensured that they retained the means to keep in touch with families and practice a range of skills. Their ability to do this helped maintain a desire to stay in the job and was attributed to the support of a democratic manager as previously explained.

*I think I'm very lucky because I think we still work very much with the model that [colleague] works with and if you feel that there's somebody at two [child's age] you want to follow up, you do. It may only be for covering holidays but we can dip into the weaning... I might say to somebody, 'Oh if you're on holiday, can I do the weaning for you that month?' it keeps my skills up, it keeps me meeting mums and if I get a bit of health promotion, so for all the perhaps less enjoyable parts of the job of child protection, you've got to have a good bit, you have to have a bit of satisfaction to keep reminding you, 'Actually, you know...'. (9-HV-grpA)*

Other health visitors described teams that were managed by adhering closely to *organisational rules*, which limited their professional autonomy, and made them feel like *a cog in a wheel*. They experienced this process-driven environment as *quite sterile and quite de-motivating*. (15-HV-int)

*And she [the team leader] is working with the skill mix and deciding what is happening with the weaning, what's happening with this, what's happening with that, and I'm thinking, 'Hang on, we're the caseload holders we should have some say in this.'* (10-HV-grpB)

Team arrangements that were perceived to offer limited opportunity to know clients, use professional knowledge and make professional decisions were highlighted as unhelpful and contributing to tensions and poor morale, especially among experienced

practitioners. A tension they recognised was the need to be *motivational* if leading other staff delivering the healthy child programme, however: *it's very difficult to be motivational if lots of other things are happening in your role at that same time really.* (9-HV-grpA)

Specific concern was provoked when corporate working was managed *like a big melting pot* (21-HV-int) and when after the first client visit by a health visitor, anyone in the team would provide contact. In this context health visitors were frustrated at not providing continuity of care, a valued care quality feature, and the inability to use the full range of their knowledge and skills, to fulfil the breadth of their public health role. A team model that was perceived as unhelpful, an escalating workload and managers unable to recognise the difficulties and assist in seeking solutions was a potent mixture that left practitioners feeling stuck and disillusioned.

*Well, I think at the moment I'm looking out and seeing there are some teams in such a mess and so down and stressed, and lack of foresight from management, and they can't really think it through themselves because you need to be able to stand back to look at what could improve. There are little things that could help. But it's just implementing them.* (3-HV-grpA)

*A lot of my colleagues who had to work a system where they come in in the morning, they're at a new birth, you won't see them again probably because you won't be running the clinic next week or the week after anyway, they'll see a myriad of different people, the relationships aren't being built up. So I think for clients, it's been a massive backward step before the health visitor implementation plan. Because a lot of them, unless you were vulnerable, [...] no one was really coming near you very often because they were so busy. I think then the [lack of] job satisfaction of that and the fact that you're trained as a health visitor and you're not able to use your skills or professional judgment, or being able to see families on a regular basis, so you don't feel you're giving what you've been trained to give. If you've been trained some years ago, then a lot of people have become very disillusioned.* (3-HV-grpA)

Certain systems of team organisation, such as being based in a centralised office, were understood to impact on how much time health visitors spent with colleagues. Plans for centralisation tended to provoke negative reactions from health visitors, on the grounds that this would reduce client access and interaction with colleagues. Managers also recognised that this would limit opportunities for health visitors to provide each other with informal support and suggested introducing fixed *team time*.

Other features of team organisation raised were technology aided mobile working, particularly when this was used by managers to 'monitor' individual practitioners and directly allocate work to electronic diaries. Implementation of mobile working, a practice favoured by managers, assisted communication but also provided scope for health



visitors to feel that they had even less control over their activities and ability to work autonomously.

*You can message your colleagues, you can have a look at their diaries to see where they are. Team leaders can go and look at these diaries and slot work in. So this is quite a new innovation for us and people either love it or hate it. (8-M-int)*

*But also I do know that they do look... because we're mobile working they look on our [diaries], they look at exactly how many contacts everybody is having, how long they're there. They can go in and out to see... [...] we are being monitored. (5-HVgrpC)*

Mobile working using new technology and centralised offices had been implemented as part of service modernisation and were still bedding down. However, without careful and sensitive management there was a risk that these changes increased pressures on staff. Some health visitors noted that *more often than not, staff are working more hours* (21-HV-int) and pointed out that mobile technologies made working from home more feasible and increased the likelihood of disruptions to work-life balance. Writing electronic records was often cited as an example of work that was done at home in health visitors' own time. Reasons given included lack of time in the working day, but in some cases health visitors were ignoring instructions to complete records in the home during a visit because of technical difficulties and perceived incompatibility of using a computer and engaging with the family.

*I've probably used my laptop at home about three or four times this week, in the evenings. So if I've not had time to put work on, I can just do it as soon as I get back. (21-HV-int)*

### Work and workload

Health visitors perceived that their role was one that required them to be flexible, proactive, an advocate and a negotiator to deliver a service that was aligned to clients' needs. This provided a degree of exciting challenge, but also required a degree of persistence.

*It's a case of you can't sort it out, if you can't go through it you go over it or go round it, you keep trying and don't give up at the first hurdle. (3-HV-grpA)*

Many health visitors' accounts indicated that their work had intensified in recent years with less time spent on universal and community level practice. They suggested the latter was more enjoyable, or at least more obviously concerned with prevention which was a motivating factor for entering health visiting:

*But then on the other hand [colleague] and I were saying that our work is very constrained in the sense that we're doing mainly child protection, domestic violence, new birth visits. You know, we are not doing the more enjoyable type of work. (5-HV-grpC)*

Work intensification affected job satisfaction because it changed the nature of health visiting, limiting the breadth of the role, and increased demands on the individual health visitor, such that work could feel *never ending*. Sometimes the workload could feel so demanding that the health visitor reached a point of saturation. The health visitors shared examples of their ability to be persistent waning and sometimes being unable to hear about additional client needs that they would normally recognise as requiring action or attention:

*But I get to the point where I actually go into a visit and I think, 'Please don't tell me anything that I don't... because actually, I haven't got the capacity to deal with it.' So I think, 'Please let this be a straightforward new birth,' because actually I haven't got the capacity to act on it, and I will have to act on some of it. There are issues. (4-HV-grpB)*

An imbalance in workload, which pulled health visitors away from community involvement also reduced their sense of knowing the community and the community knowing them, a mechanism they relied on for maintaining competent and safe practice. They felt concern that:

*I'm going to miss something, and: this isn't what health visiting should be about. (15-HV-int)*

Those who had been able to get through 'work difficulties' attributed their resilience to the support they accessed from colleagues.

*I think there are times it does... you do think, 'I'm sure this isn't why I came to do this job,' [...] It depends, actually, like we were talking about how supportive your team is, whether you're managing it in isolation, whether you have that [opportunity] to come back and talk to people about. It is unpleasant; [...] and it can be quite emotionally difficult as well as professionally, but it's part of the job. (27-HV-int)*

However, the high number of intensive cases within the health visitor caseloads was seen as *driv[ing] a lot of people out of the profession with stress and long-term sickness (15-HV4-p4)*. Sickness absence reduces the availability of colleague support and one health visitor reported this was a continuing problem in her team that was beginning to take its toll: *I'm just feeling myself starting to buckle, really. (4-HV-grpB)*. One participant in commenting on the experience of a colleague explained:

*she gave up health visiting because all she was allowed to do was safeguarding and new birth visits [...] she went into school nursing, because she wanted to do health promotion. If you're working really hard, slogging your guts out doing all the*

*safeguarding [colleague's name] is doing, all your visits and doing everything the management are asking, some people need to be able to follow your dreams of doing whatever your interests are, so some health promotion groups or whatever that may be (4-HV-grpB).*

Practice teachers also noted that intensification of health visiting meant they had to work especially hard to ensure student health visitors were sufficiently prepared for *the real essence of health visiting* (15-HV-int), by which they meant public health practice and working across all the levels of the service vision. They were concerned that students' learning experiences were dominated by *much more reactive health visiting* giving them a *jaundiced* view of health visiting (15-HV-int), which they had to take action to counter. Where students and health visitors were able to deliver the universal level service, other difficulties could arise when new organisational policies required them to engage with clients in specific ways, e.g. sending out a pack as opposed to doing a home visit; completing a visit in a set amount of time; or introducing specified topics and explaining leaflets during a new birth visit. Some were concerned that the visit *tends to be led by the amount of information that we have to give and leaflets* (13-S-grpA), which interfered with 'agenda matching' and developing a relationship with the family. As noted previously, some managers made helpful contributions by supporting teams to interpret policies and implement changes in ways that did not constrain professional autonomy in making decisions about who to visit when, and what to cover during a visit.

For more experienced health visitors difficulties arose when their work became restricted in variety and the job was no longer interesting or challenging. Health visitors looked for challenge in their work and linked this with *making a difference*. However, for some the sense of excitement arising from 'challenge' was not sustained when the work was *more of the same*. This became problematic for experienced health visitors when they no longer felt they were learning anything new, failed to see *any impact* from their efforts and could not see their career progressing.

*I got to a point where I thought, 'I'm not being stretched, I don't feel I'm progressing.' And I think in health visiting, apart from going down the CPT route, there aren't a lot of other options.[...] Maybe it was more of the same, but I didn't feel I was learning. (4-HV-grpB)*

*I got to a stage years ago where I actually thought that health visiting, I wasn't having any impact, and I thought, 'Oh, God, why am I doing this? I'm not making any changes, not having any impact.' Then as I changed to a different area and I took over a caseload that had been empty for a year, and you knew there was just all this... so much child protection, vulnerability, and you worked at it for a year, and at the end, [...] you could actually see the work. [...] it was just so obvious that we do have an impact, and that kind of centred me again. (4-HV-grpB)*

Another way of finding renewed purpose was for health visitors to become practice teachers. Moving to different posts was seen by some health visitors as a way of keeping work interesting and ensuring they continued to develop, while others saw this as a way of managing the stress of continual *soul destroying* work with intensive cases.

*...in terms of me working and wanting to stay in health visiting, having that ability to move into different departments and develop my role and different areas I think will keep me fresh and interested, rather than being just staying in the same place. (3-HV-grpA)*

*I think what most of us find very difficult is the fact that the lower band families, where you can see all these things going wrong, but you have not enough evidence to take it to court. [...] I think that's just soul destroying because you see these children and actually you're trying very hard to improve their life chances, but it's intractable. [...] So I think that gets to people if they don't move around, and I think that's what's important also, that there's internal rotation. (15-HV-int)*

Health visitors recognised the risks to themselves of an unbalanced role: *that's how people get, you know, poor morale, burnout, poor work/life balance, that sort of thing (21-HV-int)*. As noted in section 6.2 a limited range of practice also meant loss of knowledge and skills and therefore reduced ability to function confidently at a universal level. One student added: *I think working at the top level [Universal Partnership Plus] could be quite wearing... (6-S-grpB)*. Health visitors who had more balanced workloads considered themselves fortunate:

*I'm quite lucky in that respect but it's not all middle-class clients, you know, where it's a bit kind of routine and, you know, quite straight forward. You have got more challenging clients as well that keeps all your skills up to date. (21-HV-int)*

*I'm able to do a lot of preventative work. [The mixed caseload] It's a big positive, because I've never worked with such a variety of clients, from every walk of life, which is great. (3-HV-grpA)*

It appeared that the type of work health visitors and students carried out could support or stifle their ability to learn and develop. Putting skills and knowledge to good use was something that was influenced by workload, but also by the model of team working. Not being able to do the job they were trained to do and underutilisation of health visitors' skills signalled a failure in managements' understanding of health visiting, which was likely to elicit a response such as *what is the point...? (5-HV-grpC)*

*Because it takes away that autonomy; it also takes away from some newly-qualified the ability to make decision and to manage, because somebody else is there doing it. (9-HV-grpA)*

## Organisation of recruitment and training

The recruitment of new health visitors to the workforce involved a number of activities and a process that started before applications were made and continued through to newly-qualified health visitors being appointed. In this next section we consider the need for recruits to be sufficiently informed about the health visitor role, the importance of practice learning experiences, and the expectations students have about their future health visiting jobs.

### Being informed

We have already noted how becoming a health visitor involved a change in type of work. Developing a realistic understanding of the role and the departure from general nursing in particular, meant that it was important that there was opportunity for potential applicants to be properly informed about the role. The following health visitor makes the point about the role being misunderstood not just by future applicants, but the general nursing workforce.

*I just do feel that there's still a mismatch of what health visiting is about, even amongst the students, let alone the public. [...] . Sometimes I think if nurses don't actually really understand what health visiting is about, they go into it because they think it's a 9 to 5 job, they hear about weighing babies and lots of cups of tea, and I'm not quite sure that the reality sometimes... reality hits, especially in very busy areas. (15-HV-int)*

When asked about action that could be taken to improve potential candidates' knowledge about the profession, all participants made reference to the importance of information events. Some raised the issue of HEI and NHS organisations working more closely in partnership to support these and all other aspects of the recruitment process. Where specific events had been noted as successful, they had involved existing students sharing their perspectives and qualified staff ready to explain different aspects of the job and any specialist areas of practice. These were important for properly informing potential recruits about the role and not just the course, although lecturers also felt there was a need to think more creatively about how potential recruits could gain more experience prior to applying.

*I don't think there is much information really about the health visiting role out there. The NHS Careers stuff, and there's been more stuff more recently, but it's not really about the detailed aspects of the role. So it probably [the recruitment event] could look at the information that's available for applicants, yeah. As I said before, if there is some way of making it easier for them to gain some experience, just to observe even for a day a health visitor in practice, yeah. (2-L-int)*

Being proactive through capitalising on organised information systems or planned sessions targeted at eligible workforces was recognised as a means of helping prospective recruits make informed choices about health visiting as a career. Such exercises were also thought to have potential for helping candidates come to decisions about 'de-selecting' themselves early enough in recruitment exercises to avoid taking a career opportunity that was not right for them. In one example a manager explained about a particular conversation with a nurse who had attended a recruitment event, who although motivated to *make a difference* and work with families, realised that an immediate career move would deny her the opportunity to put into practice the other training she had recently completed and move rapidly to a specialist role.

*I said, 'Well what made you think,' do you know, 'with health visiting? She said, 'I thought, I want to make a difference...' And all that sort of right things, and she said, 'To work with families, and to be able to do that.' And so I said, 'Right okay.' But I think what she was realising was that she almost wanted to hit the floor running to some degree, and consolidate all the acute training she'd done. And I think it was sort of... the recognition was coming in that maybe she wouldn't be able to do those things, and it's very much more to sit back, to engage, to let people come to those decisions.*

*[...] She said, 'I know I want to escalate to that specialist bit. And,' she said, 'It's just not for me at the minute.' And I said, 'Fantastic'. (11-M-int)*

Here the opportunity to meet with current student health visitors, generic and specialist health visitors, provided clarity about the role and what to expect, which enabled the candidate to make an informed decision about becoming a health visitor. However, once they began training students revisited the question about whether a health visiting career was what they wanted, as the reality of practice, work conditions and how others might perceive the role became clearer. This implies that recruitment experiences were not limited only to successful application to commence the health visiting course, as events throughout training can impact on recruitment to the profession.

### [Practice learning and teaching](#)

Students who maintained a positive intention to work as a health visitor often cited the *pivotal* relationship they developed with practice teachers, and other health visitor colleagues. Practice teachers were in a prime position to *really encourage* students and *acknowledge the experiences that [they] could bring to the role* (26-S7-int). One student highlighted how the practice teacher could fuel enthusiasm by providing positive verbal feedback indicating the student's strengths and making comments such as: *it's wonderful to see that you're thinking outside the box* (28-S8-int). Others referred to how practice teachers modelled interactions with clients providing formative learning experiences that *helped to further define the way I wish to go*. (13-S-grpA)

For others poor practice learning experiences provoked a high degree of anxiety and a desire to change their practice teacher; some students even considered leaving the course:

*I had a really negative experience with my practice teacher at the beginning of the course, to the point where I have been with replacements, [...] What turned out to be quite an upsetting experience at the beginning ...it was really difficult. I felt very vulnerable because I gave up my job to do this. ....I couldn't leave, and even though I wanted to on certain days, I couldn't leave. I had to see it through. But now I've come through and I've seen that there is a different way [to practice]. (13-S-grpA)*

Variation in the quality of practice teaching was a concern to students, especially those who had not had good experiences. Some felt that the opportunity to be taught by several practice teachers and mentors had benefits in terms of exposing them to a range of styles of practice and suggested this could help to ensure that students gained experience of all aspects of health visiting in different settings. This was a view shared by others involved in deciding the models for practice learning, who raised the point that *the pitfall is that the practice based learning experience is only as good as the quality of the CPT [community practice teacher], and it's only as good as the breadth of practice experience the CPT can access. (24-SHA-int)*

Some students had experienced an alternative approach to traditional one-to-one allocated practice teaching, in which they had a number of mentors. In these instances students and SHA stakeholders described benefits from being able to devise a learning programme that capitalised on various expertise whilst still having access to an experienced practice teacher. This is generally referred to as a 'long-arm' or 'hub and spoke' system of support and assessment. However this model seemed to require the practice teacher to be very adept at moving between caseloads as they worked alongside different mentors. This could have implications for issues of continuity of care and the workload practice teachers were managing which in turn could negatively impact on the capacity to provide quality teaching experiences. Furthermore, in the 'long-arm' model there was an expectation that the practice teacher would have considerably reduced caseload responsibilities as explained by an SHA stakeholder.

*What we know is that so long as the practice teacher is freed up from caseload, significant caseload responsibilities... so long as the mentor is well prepared, the evidence seems to be emerging is so long as the CPT, the practice teacher, doesn't have a student themselves then they can take much more than a one in two, one in three ratio. And actually it provides a much more satisfactory method of learning for the student and also engagement of the mentor. (24-SHA-int)*

However at a local level there was a perception that it was rare for practice teachers to be sufficiently relieved of caseload responsibilities and the burden of increasing workload could make the role unattractive:

*And they don't have a reduction in caseload so there's a disincentive to be a practice teacher for some people. (20-L-int)*

The short supply of existing qualified practice teachers and the common concern that *we're never going to achieve the numbers if we don't have the support in the system (22-SHA-int)* was used to justify arrangements such as the 'long-arm' approach mentioned above. This created an organisational context in which large numbers of students were being taught by practitioners who were relatively inexperienced or recently qualified in their teaching roles, or currently undertaking training.

*We were running out of people again last year. The problem we had, and have still, is that you can only have so many really when you are doing the course for yourself, [practice teacher training], then obviously there is a limit to what else you can take on in the 'hub and spoke' (mentor) method really, and you're not signed off until you've had your own for a year after. (16-M-int)*

Students were sensitive to teacher inexperience and this led some to question the quality of their placement learning. In the following account it seemed that there was a poor match between teacher and student, which could have been averted by prior assessment of student learning needs and teacher capability.

*I think for me my experience was a bit rocky at first because my practice based teacher was totally new to the area and to her job. [...] And a lot of the time she would say, 'Oh, well, I don't know either, let's go and find out together.' Which is fine, but I felt quite nervous and I wanted ... I was new to children and I wanted the health visitor that had done it for a long time. My colleague got the one that has done it for years, and she's already worked with children. And I wanted to swap, but obviously, couldn't. (7-S-grpB)*

Some students seemed content with a student role that required them to be fairly passive: observing, following guidelines and reproducing behaviour modelled by their practice teachers. Others found the student role they were expected to adopt more difficult and constraining, especially when their knowledge and experience would have enabled them to make a fuller contribution. This created a tension for some students that may have been exacerbated by expectations created by those involved in their education and development. For example, during recruitment lecturers encouraged students to demonstrate *evidence of their transferrable skills [including] intensive high level communication skills and whether they're confident (17-L-int)*. In contrast, several students referred to occasions early on in practice placements when they were expected to just observe rather than taking the initiative, which made them feel *completely*



*disempowered.* A student talked about her frustration when accompanying the practice teacher on a new birth visit, an interaction she was very familiar with as a midwife:

*Because you're so used to being in control and being the lead professional, going into houses and dealing with and sorting the problems, and then I had to sit there like a mute beside a health visitor who I had the same knowledge as, and I could have done, you know. The discharge visit for a midwife on the first visit of a health visitor is so much more relaxed. I could probably have done it on the first day. So to have to sit there and not do anything was just awful, awful, absolutely awful. (6-S-grpA)*

Initial challenges with recruitment and training were also noted by a return to practice (RtP) student who faced difficulties first in locating an RtP training course, then identifying an NHS practice placement able to accommodate learning needs. Once the RtP student had found a placement, she discovered she was competing with other students for learning opportunities. However, these challenges were compensated for by a supportive team and a mentor who was considered to be excellent:

*And where I am, they are four students including me. They are bit saturated. It's saturated in terms of finding mentors, practice education facilitators and all the various people they need to get them through the courses. [...] I've got an excellent, very experienced supportive mentor and all of the other staff are supportive. The only problem is, it's not their fault but there probably aren't as many opportunities available to me as there would normally be because there are so many students wanting to grab opportunities. We're all wanting to grab opportunities and spend time with the different team members as well. (23-HV-int)*

The process for selecting students was very similar at each study site involving screening of application forms and any additional information; written assessments for numeracy and literacy; and an interview with a panel which included a lecturer, manager and often a practice teacher. Lecturers or managers telephoned or e-mailed candidates about whether they had been successful. Further information about recruitment and criteria used for selection are included in Appendix 8.

Lecturers and SHA stakeholders felt that recruitment should be treated as a *joint activity* (2-L-int) and *collaboration* between the HEI and the NHS was seen as of central importance to achieving satisfactory process.

*The interviews are held in the Trust premises out in the county. A member of university staff is present, so you have a panel interview with at least two Trust members and one university member interviewing [...] The interview process is quite rigorous. There are set questions that are asked of every candidate and there are expected responses that would be ticked off or graded, and then everyone on the panel confers whether they all*

*agree or not and have a discussion afterwards as to whether they, all of them, agree that that candidate is suitable or not. (1-L-int)*

Some students experienced recruitment as confusing and *chaotic* and poor communication appeared at the centre of difficulties. Poor procedure included delays in receiving written confirmation of a sponsorship place; provision of incorrect course application forms and accompanying information; a delay in agreeing an employment contract; and unhelpful group feedback on job interview performance. In the most extreme cases this undermined students' confidence in their employing organisation and prompted them to reassess their decision to become a health visitor.

*Student4 They didn't give us written confirmation that we were on the course. All I got was a phone call, and that made me feel uneasy. They were asking me to give my notice in for my full time job.*

*Int Based on a phone call?*

*Student6 That was the same as me.*

*Student7 I didn't have an email, I didn't have anything. It was just a phone call from somebody I've never met [...]*

*Student5 It's been a bit fragmented really. When we started we were told it was twelve month fixed-term contract, and then we actually did start we were given a learning and a substantive contract, so we all assumed we had jobs. They were taken away when... [...]*

*Student4 You had the sense that they really didn't know themselves what was going on and they were making it up as they went along.*

*Student6 Yeah, very much.*

*Student4 We all felt very vulnerable because of that, and we did give up stable jobs. (13-S-grpA)*

In these circumstances, where the boundaries were uncertain, students became insecure and unconfident. Indeed the failure to provide concrete information about what was formally expected breached what they understood was reasonable and fair.

### [Expectations of new recruits](#)

Another issue that arose for some students at both sites concerned their expectations about pay on qualification. They realised that a position as a newly-qualified health visitor would not necessarily bring a pay rise, which added another reason to question themselves and their decision.

*We were talking about it at lunchtime. [...] Suddenly my old job seems great. ...suddenly I'm thinking, 'Why am I putting myself through this', it's the same grade, no more money, in fact I'll earn less, I'll have to work more days for the same money. (6-S-grpA)*

*I think I was disheartened that I wouldn't get a top band six pay anymore. (13-S-grpA)*

Despite voicing these doubts as they approached the end of the educational programme, the students who were interviewed said that they intended to continue a career in health visiting. The process to become a health visitor had included some unhelpful experiences, but the expectations they had held about the role had been sufficiently matched by practice experiences for them to conclude that it had been the right career move at this time.

*It was absolutely the right choice for me and I made a choice for all the right reasons and what I felt I could bring to the role, and I have no regrets in making that choice. It's been a full on year; it's been a very intense year with the training and there's a lot of hoops as well - some hoops I would have questioned whether they were necessary to be there [laughs]. But yeah, but absolutely no regrets with where I'm at, at this moment in time. (26-S7-int)*

Looking ahead to their year as newly-qualified health visitors, the students were expecting a high level of support, including preceptorship, and further training. Many students had a general expectation that their new colleagues would be supportive, but a few also had very particular expectations, some of which might be considered unrealistic, given the evidence concerning the demanding caseloads health visitors had reported they were managing.

*[...] I'm hoping to be working in a team that does support me and allows me to develop and have that opportunity to get to know families, not to be tied by the constraints of such a busy caseload that I don't feel that I can really learn about it. That's really important to me. (13-S-grpA)*

*an opportunity to be able to sit down and talk to them. ...And also, if I felt I needed it, somebody to accompany me on a visit. (30-S-int)*

Anxiety was a feature of being a newly-qualified health visitor that existing qualified staff recognised and therefore gave support to plans for adequate preceptorship.

*And certainly [what is important for] retention in the early days, is an acknowledged period of preceptorship... (9-HV-grpA)*

However, the details of the available preceptorship support were not always clear to students, which did not ease their anxiety about coping with workload demands.

*... it will be quite good to see what sort of preceptorship package we're going to get because I think we'll need a lot of support. [...] Yeah, especially the safeguarding, I'm a bit worried about it, but I think we'll have monthly supervision and our preceptor will guide us through our cases. (29-S-int)*

Where managers had provided clarity about the preceptorship arrangements, students seemed more realistic in their expectations of support which helped ease their anxiety about starting a new role.

*... the service manager has assured me that they are going to organise a preceptorship for me so .... We're going to have a kind of a mentor who we can have regular meetings with. It is a kind of hot desk, booking desk type of situation. So as long as I've got someone I can ring and ask questions and I'm not frightened to ask, you know, if I'm unsure. I'm just going to see how it goes really and hope. I'm going to trust them that they are going to support us as they say they're going to. (28-S8-int)*

## Being valued and respected

For both students and practising health visitors knowing their work was worthwhile and valued, and the health visiting role was generally respected, were important reasons for becoming a health visitor and, once in practice, factors that maintained motivation and job satisfaction. Participants drew on information from various sources to assess value and respect, including feedback received directly from clients; views expressed by friends, family and colleagues; and their interaction with managers, which perhaps most importantly gave practitioners a sense of the extent to which health visiting was valued by the organisation that employed them. We briefly consider the feedback from clients and friends' and colleagues' perceptions of health visiting, before discussing the role of communication with managers in conveying whether health visiting was valued, respected and supported organisationally.

### Feedback from clients and perceptions of others

In section 6.2 we saw that student health visitors and experienced practitioners found it motivating when they had first-hand evidence that their input had benefited clients and families: it confirmed they were *making a difference* and was uniquely powerful in supporting commitment to continue in practice when other aspects of the job were experienced as challenging. However, in practice clients may feel constrained about expressing their views on the service directly to health visitors. One health visitor, asked about assessing impact, replied:

*I don't think you ever actually really know, unless the mum says, 'Thanks very much for that. I really appreciated it.' And actually, sometimes the mums you go the extra mile for would never, ever say that - maybe perhaps a particularly vulnerable mum, or a mum*

*who has been depressed, or a teenage mum. You hope you've made a difference or you think you have, but you never know for sure. And actually, it's the mums who perhaps have been at the most vulnerable that you hope you've made a difference, but you would never necessarily get the feedback about.* (27-HV-int)

Scarcity of feedback about their practice, positive or negative, occasionally led health visitors to question whether what they were doing was worthwhile: *When you're in doing it, you sometimes think, 'What am I doing? Am I making any impact?'* (4-HV-grpB)

The unsolicited nature of health visiting contacts also means that health visitors are not always well-received by clients and developing relationships can be emotionally challenging. Students noted that health visitors had a *definite different relationship* with clients than they had been used to as nurses or midwives. For some students, in particular those who were midwives, it was difficult to make the transition from being in a role that was generally viewed favourably and guaranteed a warm welcome to one that evoked more ambiguous reactions: when making home visits they found it *hard to then get a grumpy face at the door* (6-S-grpA). This took them some time to come to terms with, as did the views and attitudes towards health visiting they encountered among friends, family and colleagues.

A recurrent theme in students' discussions was coming up against a lack of understanding about health visiting and repeatedly having to explain their new role and to justify it as a career move. For example one student was surprised to find that even other professionals needed an explanation:

*Student 1 My neighbour's a retired Macmillan Nurse and her daughter is a policewoman and they both said, 'So what will you be doing then?' So I had to explain.*

*Student 2 Gosh.*

*Student 1 And I thought they would know. They were like, 'So what will you actually do?'* (6-S-grpA)

Students particularly resented health visiting being misrepresented as being *only about babies*; disparaged as being a *cushy* job; or associated with *inspecting* and making judgements about people's homes. On hearing about her decision to take up a training place, one student's former colleagues referred to health visiting as *the midwife's graveyard* (6-S-grpA). Such negative experiences and the discomfiting thought that *actually a lot of people dislike health visitors* (13-S-grpA) challenged students' resolve and prompted admissions such as *I really was questioning why I was doing it [the health visitor course]* (7-S-grpB). In contrast, meeting someone who affirmed and valued health visiting gave a boost to self-esteem, such as the student who said she *felt so proud* when a relative who worked for the police responded to hearing she was training to be a

health visitor with *Oh my God, that is fantastic. I've been to child protection conferences and they're so fantastic, they do such a good role.* (6-S-grpA)

The limited feedback available from clients and the mixed messages students and health visitors received from others about the status and value of their work, increased the importance of knowing that their work was valued and supported in the organisational context.

### Communication with managers

Interactions with managers<sup>6</sup> provided health visitors and students with powerful signals about the culture of the organisation; the value placed on health visiting; and what was expected of them as employees. Health visitors were very sensitive to managers' roles in creating an organisational context for health visiting that allowed them to practice in ways that were congruent with their professional ideology. Managers' behaviour towards them as individuals also conveyed a sense of whether practitioners were valued and respected. Health visitors and students valued being consulted and listened to by managers which helped them feel they had a voice in the organisation and some control over how they practiced.

Where changes to service organisation and delivery were being proposed or introduced (examples discussed included the introduction of team leaders, 'mobile working' and centralised offices) the ease with which practitioners felt able to respond was recognised by health visitors to be *dependent on your manager and how they approach it* (21-HV-int). The approach of some managers' was characterised as imposing decisions with staff being told about changes resulting from new organisational policies, without the opportunity for negotiation. In these circumstances health visitors felt their practice-specific knowledge, skills and experience were being ignored and their autonomy curtailed, which threatened their belief in their ability to do their job effectively. It also eroded their loyalty and commitment to their employing organisation.

*Whereas my feeling is from this end [the managers' approach is] 'We say, you do it. It doesn't matter whether it works, whether it doesn't work, if it all goes bottom up next week then we'll think again.' And that's doesn't make staff feel valued; it doesn't make your staff feel respected or listened to.* (9-HV-grpA)

*if you don't feel valued, then you'll question your loyalty. You think, 'Well, if nobody really is bothered with my predicament, then...'. (27-HV-int)*

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<sup>6</sup>It should be noted that health visitors tended to make a distinction between managers who were close to the front line (team leaders and 'middle' managers, who usually had a health visitor background) and 'senior' managers, who were portrayed as remote and lacking an understanding of health visiting.

In another area, a Trust wide policy change supported by senior managers following a serious case review was perceived by health visitors as incompatible with their approach to working with families. A local manager listened to a health visitor team's concerns and challenged them to work out a solution.

*...basically our nurse manager and our nurse consultant said, 'If you don't like it, what are you going to do about it? We have these recommendations, this is an issue from a serious case review, how do you feel you could deal with it?' So a group of people came together. (10-HV-grpB)*

*We were allowed to make it work, we were allowed to go and have the evidence to say, 'We don't think that will work but parents want this, is that okay?' (9-HV-grpA)*

The manager concerned was interviewed for the study and also spoke about how this issue was tackled, indicating the dilemma for a line manager who had to implement organisational policies and act as an advocate for professional concerns:

*We did have one situation where there was going to be an imposed plan [...] and that actually became quite a tense moment because I think as a manager as well you almost had to step out and take risks and be willing to challenge the establishment for the benefit of the service and that's a very hard thing to do because it costs you. (12-M-int)*

Another manager had introduced mobile working and was aware that it could prevent practitioners meeting regularly and thus inhibit informal support and learning. Solutions were therefore needed that would re-establish *team time*:

*I've tried to book some particular time, and each team has done it slightly differently, whereas they might have a time in the office where they have a team time.[...] And also we encourage people to link with everybody else and to know what other people are doing, but there are certain times that we will allocate them to come into the office to see other people. [...] We're also really trying to enforce the different supervision models, so that there is protected time for people to be able to talk rightly about their practice and be reflective. (16-Man-int)*

The manager recognised that face-to-face interaction was vital, but reference to a plan to *allocate* specific times for meetings and *enforce* supervision models, seems to have missed the point that informality is key and that team members may need to find their own ways of making time to meet and talk. This choice of words also seems to betray the sentiment of support over direction.

The health visitor managers who discussed supporting staff to find solutions to problems felt they were enabled by the culture of the wider organisation to engage with their staff in this way; indeed their approach reflected that modelled by the Head of Service:

*Man1 I think it's, as I said, we were quite privileged to have a Head of Service who was very accessible and listened and respected...*

*Man2 And valued... valued quality and what we were doing and trusted us to deliver*

*[...]Man1 Like we just said very sort of open, accessible, willing to listen and respect our opinions. We were a sort of a vehicle I suppose, a medium to feed the views of the staff. You know, if [Head of Service] couldn't necessarily see those people she would listen to our views and not always be able to make changes to affect what staff are asking for but I think there was a culture of respecting the discipline. (12-M-int)*

Managers' influences on students feeling valued were also discussed in one of the group interviews. These students had already become disaffected by a combination of confusion over their pay and conditions (in their current posts and as newly-qualified health visitors) and frustration with poor administrative processes. However, the situation was inflamed by an uncompromising manager's ill-judged comments at a meeting, which conveyed to the students a disregard for the experience they brought to the health visiting workforce and lack of respect for them as individuals. In this context, the pay and conditions offered on qualification came to symbolise their worth to the Trust as *it was about value*:

*Student 2 If you don't meet what we're asking of you, or what we're offering, then go. That's what [was] said. If you don't feel happy...*

*Student 1 Go.*

*Student 3 ... apply elsewhere. Leave, yeah.*

*Student 2 Quite brutal really.*

*Student 1 [...] Everyone knows health visiting is a post graduate course. We're all professionals. We've all come from other areas and there's no acknowledgement or respect for that fact, I don't think. And I think it should because lots of us have worked for the NHS for a number of years and got vast experience to transfer to them, and to help us in. [They] basically said that will count as nothing, your transferable skills [...]*

*Student 3 It's like going back to the 1950s.*

*Student 2 Yeah, that was the feel, it was just so dated.*

*Student 1 It wasn't even a lot about the recognition in pay or things like that, it was about value, and almost going back to don't value women.*

*Student 4 I wouldn't want to work for them. (13-S-grpA)*



These students had been *horrified* to learn that managers held such attitudes and this experience had clearly contributed to diminishing their confidence that their employer valued them and would treat them fairly. For some, commitment to their sponsoring trust had been badly damaged and although they wanted to work as health visitors, they were less sure about staying with the same NHS Trust on qualification.

Where communication had not been as good as it might have been, as above, students found themselves revisiting questions about why they had elected to change career.

*Sometimes I think, 'Why have I done this?' And still now, we've only got what, twelve weeks left. (13-S-grpA)*

This illustrates that although they had been recruited to the educational programme, their recruitment to the profession was a continuing process, not always without setbacks, throughout their period of learning.

Health visitors wanted feedback from managers but were sensitive to the way in which feedback was given. Reference was made to local managers and team leaders being *key in my job* and some were described as *brilliant*. The *brilliant* manager had been able to convey that they valued the health visitor *as a person* by making specific comments and offering development opportunities as a reward for effort. This approach was contrasted favourably with that of other managers and team leaders, who were criticised for sending *patronising* emails saying *I'm so proud of you*, which was likened to *getting a star*, a reward more appropriate for *children than grown women*. (4-HV-grpB)

The need for a person-centred approach was echoed by a lecturer who had a joint appointment as a practitioner and had been involved in delivering intensive home visiting support to vulnerable families. She raised the issue of care quality, pointing out the need for practitioners to feel *nurtured* and respected, so the service they provided to families was delivered with a similar sentiment: *getting it right is important rather than just getting it done*.

*[...] getting it right for parents and their babies by ensuring we have the highly skilled and confident practitioners [...] I think it's something about health visitors being supported. I don't use it in a patronising way, but nurtured, looked after, respected, in order that they can deliver that care for that client in a way that really embodies that. Because if they don't feel that investment in themselves then that may have an impact on how they're able to deliver the service. [...] if people feel supported, and the organisation is supported, and people around them are supported, then you're able to deliver a service really well. (19-L-int)*

Moreover, health visiting was seen as different to nursing where *you fix it, you make it better, you do your task and you come out* and as a result it was felt to be often

misunderstood. This was cited as a reason why it was especially important to have a good *manager who has an understanding of health visiting and what you're trying to do*. That is, have an understanding that, as opposed to *fixing it*, the health visitor was *in for the long haul, the continuity, the support, the proactive* [action] where the aim is *to get in there to head things off at the pass so that things don't get to a situation where it's all falling apart*. (9-HV-grpA). Health visitors and students considered the health visitor role and nature of the work involved as demanding and challenging, but worth it when clients, colleagues or senior staff valued and respected their contribution. Experiencing value and respect in practice supported job satisfaction and was a motivating force for staying with it to *make a difference*.

## 6.4 Section Summary

The findings of the empirical study are presented in two main parts according to the following themes:

- motivations and aspirations
- organisational context: supporting job satisfaction

### *Aspirations to make a difference to children and families*

The first part of the findings draws on data from the AI exercises, in which participants (students and qualified health visitors) discussed work experiences they found motivating, and focuses on their frequently expressed aspirations to *make a difference* to children and families. Participants used the phrase *making a difference* to signify their understanding of the purpose of health visiting and associated it with a set of values and work practices that were seen as essential for effective health visiting practice. Together these beliefs, values and work practices form part of a distinctive professional ideology of health visiting held by both qualified health visitors and students that influences how they define worthwhile and rewarding work.

Four key aspects of health visiting practice were consistently perceived to contribute to *making a difference*, these were:

- connecting with families and communities
- working in collaboration with others
- using knowledge skills and experience
- professional autonomy to respond appropriately and flexibly to needs

These four key aspects of health visiting practice were seen by students as being interconnected and important in themselves for providing worthwhile and rewarding work experiences and as essential for achieving the goal of *making a difference* to families. However, it was not always easy for students in training to fulfil their aspirations of health visiting practice, although this did not seem to affect their motivation to become health visitors. Their experiences – positive and negative – tended to reinforce their expectations about health visiting and their commitment to *making a difference*.

Experienced health visitors typically talked about complex scenarios that featured long-term involvement with families, often over many years, giving examples including family members seeking asylum; post-natal depression; and domestic violence or other forms of abuse. They emphasised that although these cases were the most demanding, they derived the greatest sense of achievement from them.

Health visitors' narratives about their work tend to reinforce their professional identity and contribute to the broader discourse of professionalism in health visiting. The health visitors' accounts also give some indications of the tensions and constraints they experience in their work which may inhibit them from working in ways that are congruent with their ideology of practice.

### Organisational context: supporting job satisfaction

The second part of the findings, drawn from the full range of stakeholders contributing to the study, examines features of the organisational context pertinent to recruitment and retention. These are the:

- nature of work
- organisation of recruitment and training
- being valued and respected

*Nature of work:* the organisation of the health visitor team and the workload they managed impacted on whether health visitors felt they could continue to deliver the service in a way that was consistent with their professional ideology. Some new working arrangements and large workloads were identified as unhelpful for achieving the aspiration to *make a difference*. When the work felt as if it was just *more of the same* health visitors could lose sight of their original aspirations. In these circumstances the absence of career progression opportunities posed a real threat to retention. Health visitors who had been given the opportunity to become practice teachers or change posts reported feeling reinvigorated and more positive about their work.

*Organisation of recruitment and training:* Trusts and HEIs needed to work together to enable future recruits gain sufficient information about the health visiting role. Potential applicants were enabled to make informed decisions about a health visiting career when they had had direct contact with existing students and practising health visitors. Practice teachers had a pivotal role in helping maintain students' enthusiasm for a career in health visiting. Contact with managers was important for informing students' expectations of employing organisations. In terms of future employment students had high expectations of support available and where managers were able to provide greater detail about preceptorship arrangements, students felt reassured.

*Being valued and respected:* health visitors and students were sensitive to feedback from others. Positive feedback reaffirmed their commitment to their professional ideology and desire to *make a difference*. Negative feedback could provoke them to question whether their contribution was sufficiently valued. Fortunately many described positive experiences balancing out the negative and they were able to hold on to their aspirations. The approaches adopted by managers were, however, very influential.

Helpful approaches included acknowledging staff as individuals, recognising staff knowledge and inviting contribution when decisions were required. Unhelpful management approaches included failing to involve staff in decisions, not listening and delivering instructions without negotiation, which negatively impacted on morale and reduced job satisfaction.

Further, the findings indicate recruitment is not a one off experience but an on-going process that feeds into retention. That is, it extends beyond initial application and entry to a programme of study, into the period of 'training' when the organisational context continues to shape the recruits' thinking about starting a their career in health visiting.

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## 7. Discussion

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In the previous section we presented findings from the AI exercises, group interviews and semi-structured interviews mainly with health visitors and students, but also managers, lecturers and SHA representatives. The discussion is separated into three sections. The first addresses the cross-cutting theme of *making a difference* that underpinned students' and practitioners' aspirations and sense of purpose. This is followed by explorations of issues directly relating to recruitment and retention which address specific research questions.

### 7.1 Addressing our research objectives

Section 3 identifies four objectives for the study, which are important to meeting two aims concerned with identifying factors important to successful recruitment of health visitors and developing an understanding of retention issues in the health visitor workforce. The specific objectives were:

1. Examine what people want from their job as a health visitor and how it links with their aspirations.
2. Identify what attracts new recruits and returners to the health visitor profession.
3. Identify what factors help retain health visitors.
4. Seek insights into the organisational characteristics and approaches that promote job satisfaction.

The data collection methods were informed by Appreciative Inquiry and participants were asked to provide written examples of 'good' and 'inspiring' experiences. These AI exercises were used to identify why they had come into health visiting and why they stayed. Group and individual interviews enabled exploration of specific aspects of the 'good' experiences and contrasting bad experiences, which allowed identification of factors associated with motivation and job satisfaction at different points in health visiting careers. For each section the relevant research objective is detailed as an aide memoire, however there is a degree of overlap in the issues pertinent to each objective.

#### *Making a difference*

##### [Research objective 1: Examine what people want from their job as a health visitor and how it links with their aspirations](#)

The AI exercise encouraged health visitors to reflect on their job and share a range of personal positive stories. On occasions they made a point of contrasting their good

experiences with negative experiences as a way of elaborating what they did and did not want from their job. The common thread emerging from health visitor and student stories was that **they aspired to make a difference to the lives of children and families** and the health visitor role was identified as the vehicle to achieve this aspiration.

The aspects of health visitor practice identified as important for *making a difference* included using knowledge to promote the health of families and communities, by applying skills in relationship building and working collaboratively with others providing important resources. Key to this was professional autonomy, which enabled the health visitor to practice in a flexible and proactive way, to provide a relevant service aimed at working *with* families and communities to make best use of resources available.

This form of practice was identified from a detailed analysis of the health visiting literature, in the *Why health visiting?* report (Cowley et al. 2013) and explained as an orientation to practice that finds expression through a triad of core practices; fostering a health visitor-client relationship, home visiting and needs assessment. **What our informants wanted from their job was to be involved in the breadth of health visiting work – to have contact with individuals in families and community groups, to proactively promote health, remain sensitive to context and deliver a service that valued individual needs.** Thus their beliefs, values and preferred work practices form a distinctive **professional ideology consistent with an orientation to practice** explained by existing health visitor research (Cowley et al. 2013). In seeking to uphold their professional ideology they were ready to accept and indeed were excited by the challenge of working closely with families in complex circumstances and valued evidence of small changes as important steps towards *making a difference*, which in turn gave a sense of job satisfaction. **In accepting this challenge they assumed they would be able to exercise professional autonomy and make decisions about when, to whom and how often they provided health visiting. They also wanted to develop a relationship with clients by visiting at home and offering continuity of care.** As indicated by previous health visiting research (Cowley 1995b; Appleton and Cowley 2008b) health visitors working on this basis believed they could use their health knowledge and skills to align their offer of a service to family circumstances and work proactively to assess needs and strengths in order to promote family health.

**Important to achieving results was collaboration with other professionals and the ability to draw on other community resources to support families.** In addition, working with others put health visitors in touch with informal systems of support for themselves, which boosted their resilience in managing the intensive cases that created emotional as well as professional demands. Like the district nurses in Adams et al.'s (2012) ethnographic study, the health visitors identified opportunities for informal

learning and support arising from regular contact with team members as an invaluable resource that helped them 'get the job done', and more importantly 'get it right'. **Regular and meaningful exchanges with others and reciprocal acts of listening when there was a need to 'off-load' became an important means of managing stress.** It provided an opportunity to share ideas, which enabled aspirations to be maintained even when the job got difficult. **This informal support was therefore an important mechanism for being persistent and *not giving up* on a family which was identified here and elsewhere (Bidmead 2013) as a central feature of health visiting practice.**

Health visitors' persistence and being there for the *long haul* meant being available; knowing families well enough to align practice to their needs; and working at their pace (Appleton and Cowley 2008b) which helped clients feel cared for (Plews et al. 2005). The provision of continuity and time also enables families and communities to know and use health visiting services and provide feedback, directly or indirectly, that communicates the difference the health visitor's contribution is making. **Indeed, the strength of the commitment to honour their professional ideology is seen in the determination of health visitors to use professional discretion to offer a service aligned to client need, even if this involved occasionally deciding to ignore local guidance.**

Other aspirations held by students and health visitors included the **opportunity to develop and progress their career.** When health visitors felt their work was just *more of the same* and no longer offered sufficient challenge, they began to doubt that they were *making a difference*. These circumstances prompted some health visitors to set about changing their job and rediscovering their sense of purpose by finding a new post or extending their role. Sometimes this involved moving to a job in another trust or **simply a change of caseload** in their current trust. They sought to **alter the nature of their work to create fresh challenges and develop skills by delivering health visiting to a different population.** Other health visitors found their enthusiasm reignited and general morale improved by **training to be a practice teacher.** Taking on this role allowed them to revisit what they valued in health visiting practice and gave them the opportunity to share their knowledge and experience with a new recruit, who in turn would go on to *make a difference*. By making changes to the nature of their work these health visitors achieved a closer match between aspirations informed by professional ideology and their actual work experiences. They once again found work fulfilling, which strengthened their commitment to their job. However, for those who were not attracted to practice teaching and who thought a change of caseload was insufficient to keep them feeling *stretched*, there were limited options for professional development and the **lack of career progression opportunities were a threat to job satisfaction.**

Student health visitors had been motivated to apply to the education programme not only because they believed that as health visitors they could *make a difference* to children



and families, but also because they saw becoming a health visitor as a career move. Previous studies also found that health visitor students saw a move to health visiting as a form of career progression (Thurtle 2005; Poulton et al. 2009; Ridley 2012). However as discussed above, qualified health visitors in this study confirmed concerns raised by Lindley et al. (2010) that opportunities for career progression after qualification were limited and were a potential source of role dissatisfaction. In the next section we consider in more detail what attracted recruits to the profession.

## Recruitment

### Research objective 2: Identify what attracts new recruits and returners to the health visitor profession

In their AI stories and group interviews students expressed a desire to develop a career as a health visitor because it would enable them to do more to **prevent ill health rather than focusing on treatment of illness** as many had done previously as nurses. They were also attracted to health visiting because they saw this as **a career move**. They were prepared to take a reduced salary during training because it was temporary and understood to lead to their development as a knowledgeable practitioner who would be able to work autonomously and more closely with clients to tailor care according to need. They welcomed the opportunity to work with other professionals and **have a role in improving family health**. In short, they were attracted by the wellness model, which is one of the reasons nurses give for moving to community roles (Poulton et al. 2009). However, along with this they anticipated that work as a health visitor would provide more **scope to work autonomously** and, as Thurtle (2005) suggests, an opportunity to use their own initiative when working directly with families.

Issues of salary on qualification have been raised by Lindley et al. (2010) and noted by others (Cowley and Bidmead 2009; Baldwin 2012) who have been concerned that for experienced nurses interested in health visiting the salary on qualification (Band 6 on the NHS Agenda for Change) was a disincentive to opt for a career change. This point was not borne out by the students in our study, although **salary on qualification was not an inconsequential point, as those who realised during training that their eventual banding was unlikely to equate to a pay rise were prompted to question their decision to pursue the qualification**. However, any doubts were not powerful enough to prompt them to leave the programme or deter them from seeking employment as a health visitor.

The human resource literature and research based on the psychological contract assumes that employees are primarily motivated by financial remuneration, which supports Baldwin's contention that current pay levels are a barrier to health visitor recruitment. However, the traditional psychological contract model assumes a bipolar

continuum with economic/transactional exchange at one end and socio-emotional/relational exchange at the other, which O'Donohue and Nelson (2007) argue does not capture the breadth of ideological factors important to those signed up to a profession as well as employment. Although we did not ask directly about the significance to students of salary on qualification, it seemed that the **desire to fulfil aspirations of making a difference offered a stronger positive influence** than any negative perceptions about salary. Previous research with preregistration nursing students (Muldoon and Reilly 2003; Ridley 2012) did not address this question either; and because our sample did not include those at the pre-application stage, we are not able to say whether future salary prospects deterred some from applying. Further research is required to gain a fuller picture of factors that deter nurses from choosing health visiting as a career and whether a case could be made for offering special employment packages to experienced practitioners.

The stories shared by students and experienced health visitors indicated that **personal and professional experiences had often played an important part in attracting them to health visiting**. For some becoming a health visitor was a longstanding goal, prompted by the care and service they had received from their own health visitor. Other significant experiences included positive pre-registration nursing placements with a health visitor or working alongside health visitors once qualified as a nurse. Currently little is known about the impact of pre-registration nursing placements on future career choice, although the limited research in this field suggests that specialist placements are important for informing career decisions (McKenna et al. 2010) and may put nurses off a particular career route (Marsland and Hickey 2003). Anecdotal evidence suggests that where placements are difficult to obtain, focused workshops or study workbooks are used to encourage student nurses to explore specialist areas of practice. However, some evidence suggests that whilst workshops for student nurses can raise interest, these interests are hard to sustain through to actual career choices (Lucassen et al. 2007). It could be that knowledge and information about an area of practice needs reinforcing by practical experience. In examining student nurses experiences of health visiting placements, Ridley (2012) notes that students are often alerted to the attractiveness of the community as a work setting. Brown (2012) proposes that there could be benefit in universities arranging final sign off placements for child branch students with health visitors, as learning from similar arrangements in district nursing suggests that this can increase students' confidence in applying for community positions on qualification. Certainly it seems that **student nurse placements with health visitors provide a window of opportunity for capturing the interest of prospective recruits to health visiting**. Moreover, in view of our finding that recruits were influenced by previous interaction with practicing health visitors (delivering the service or mentoring students), it is important that the existing workforce does not underestimate the impact their daily practice has on recruitment.

In the study sites, **workshops on health visiting were used to support recruitment** but differed from those mentioned above as they were directed at qualified nurses. These events provided an opportunity for potential recruits to speak to qualified health visitors and existing students and were believed to help create realistic expectations of the role and the training. However study participants also suggested that there should be more opportunities for pre-recruitment work experience with health visitor teams. Emphasis was placed on experience of practice to ensure a greater understanding of the role and realistic expectations. Arguably this is especially important given that students in this study emphasised the contrast between health visiting and general nursing; characterising the former as working *with* families, being in it for the *long haul* and being proactive in preventing disease compared with nursing's focus on treating illness and its more reactive and episodic nature. Increased opportunities for pre-application work experience could be created if NHS Trusts explored options for rotational or work based models already reported (Stinson et al. 2004; Abbott et al. 2005). Having such models in place could help communicate to prospective recruits that the organisation values health visitors and thereby wishes to ensure those recruited to posts are properly matched in terms of expectations and aptitude for the role.

During the 12 month educational programme, students typically encountered situations that caused them to revisit their intention to become a health visitor, reaffirming it or causing them to question it. Although they had been successfully recruited to the course, they were not yet fully committed to the profession or their employing organisation. Students in this study maintained their commitment to the profession largely due to practice teacher and colleague support; however difficult encounters with managers were found to undermine loyalty to the employing trust, with the result that some students elected to apply for health visitor posts elsewhere. Thus **recruitment to the profession should be understood as a process during which a student's decision to become a health visitor is continuously reassessed in the light of experience.** It is not a 'one off event' and for a good recruitment experience the process from start to end needs to assist growth of ideas and identity, reaffirming the decision to become a health visitor.

The contribution made by those with experience and skills in supporting practice learning should not be underestimated. Different models of support for student practice learning were in operation at the study sites. These included traditional allocation of one student to one practice teacher as well as 'long arm' practice teaching support, in which students are allocated to named health visitor mentors, who in turn are supported by a practice teacher responsible for final student assessments. Concerns about threats to maintaining quality practice learning for health visitors have been voiced previously (UKPHA 2009; Lindley et al. 2010) with reference to the increasing demands on practice teachers as their numbers have dwindled. **It was clear that students in our study were**

**sensitive to the variation in practice learning situations and experiences, with poor experiences generating a great deal of anxiety.** It was not the purpose of this study to investigate practice placements, but several of the issues raised warrant further research. These include the distinctive roles and contributions of the practice teacher and the mentor; the impact of introducing 'long-arm' models on student learning; and practice teacher workloads.

The present study was unable to address the views and experiences of returners, e.g. those on return to practice (RtP) courses for health visiting, because of small numbers. The limited number of students enrolling on RtP courses has been acknowledged previously (Amin et al. 2010; Chalmers et al. 2011). Indeed, the new health visitors' minimum data set showed only 44 health visitors completing return to practice courses in England between April and September 2012, with a further 22 entering the courses in September 2012 (The NHS Information Centre 2012). The limited opportunity to learn from RtP students' experiences has however suggested that those taking this route are often motivated by changed personal circumstances (Amin et al. 2010). In this study a participant completing a RtP course did not find it easy to return to health visiting: she had difficulties in locating a course and finding a placement, and then creating appropriate learning opportunities. This suggests that RtP students may face difficulties that test their resolve to rejoin the workforce. Others have suggested those supporting RtP courses need to give attention to ensuring a smooth transition back into health visiting, as students commonly experience 'culture shock' when faced with the differences in contemporary practice arrangements (Abbott et al. 2012).

## Retention

### [Research objective 3: Identify what factors help retain health visitors](#)

and

### [Research objective 4: Seek insights into the organisational characteristics and approaches \(including working practices and professional culture\) that promote job satisfaction.](#)

The findings presented in section 6 indicate the complexity and breadth of factors that were implicated in retaining health visitors. Our findings are therefore similar to nursing workforce studies which highlight the importance of job satisfaction, managerial approaches, organisational commitment, professional development and a collegial environment (Maben 2008; Tourangeau et al. 2010; Cowden and Cummings 2012). As discussed above, health visitors were likely to remain in their job if they were able to practice in a way that matched their professional ideology, expressed as *making a*

*difference*. This finding resonates with evidence from nursing workforce research (O'Donohue et al. 2007; Maben 2008) and medicine (Christmas and Millward 2011). Informants in this study **placed great importance on factors intrinsic to the health visitor role as sources of job satisfaction, including relationships with clients, working autonomously, enabling clients to access appropriate support and applying their knowledge and skill**. They also believed that the tensions they experienced in practice were largely due to conditions that the employing organisation was in a position to shape. In this next section we discuss factors impacting on job satisfaction and the key role played by managers as perceived representatives of the organisation. We also consider the health visitors' expectations, particularly those who were newly-qualified, and how threats to retention might arise if these go unfulfilled.

Experienced **health visitors in the study sites saw health visiting as a job that offered challenge and excitement**. A balanced caseload **offered them an element of discovery by meeting new people and *travelling on a journey with families*** and this kept the work interesting and satisfying. Health visitors also welcomed opportunities to be involved in developments to improve service delivery and, like the nurses in the US 'Magnet Hospitals', felt enthusiastic about being a part of such changes (McClure et al. 1983). **Health visitors felt valued when managers sought their views and involved them in organisational developments**. In addition, **mangers who signalled that they were interested in and 'cared' about individual members of staff, lifted health visitors' morale and strengthened their resilience** when responding to challenges arising from organisational change. **When health visitors felt proposed changes would be detrimental to service delivery and they had not been involved in decisions or listened to during consultation exercises, morale and motivation was negatively affected**. In these circumstances health visitors gained the impression that their role was poorly understood or undervalued by the organisation. Additionally, they felt that their professional autonomy was being eroded, which has been found to be a cause of job dissatisfaction when combined with large workloads and a sense that there was little time to manage demands or assist colleagues (Honey and Walton 2008; Sadler 2010).

Earlier research has shown that health visitors have low levels of job satisfaction in comparison to other nurses in the community (Traynor and Wade 1993; Wade 1993). Qualitative data accompanying a survey reported by Wade (1993) indicated that health visitors were concerned about three issues: their prospects, feeling undervalued and that organisational priorities were not sufficiently client care-focused. Students and health visitors in our study also raised these issues, with **feeling valued being the most prominent**. Wade proposed that there was a risk that health visitors would begin to doubt the value of their work, especially as much of it was invisible to others and for longer term gain. Indeed, in our study some health visitors questioned whether their

contribution was worthwhile, doubts that were exacerbated when managers failed to acknowledge and appeared not to understand their contribution. In contrast **supportive managers were identified as key to maintaining morale in challenging work environments confirming earlier work that identified the critical role line managers have in employee engagement** (Robinson and Hayday 2009). Good managers have strategic vision, interest in their staff as individuals, foster a positive team culture yet are challenging, approachable, and have good skills in communicating and listening. Robinson and Hayday (2009) found that engaging behaviours can be learnt, which is good news for aspiring managers. Students in our study saw managers as representing the organisation and their interactions with managers informed their assessment of how much the organisation valued health visitors and therefore whether the students wanted to work for the sponsoring trust on qualification..

Managers can be instrumental in actively nurturing a positive workforce culture through providing time, space and resource for reflection and collegiate activities such as group clinical supervision or action learning sets (McGill and Beaty 1995). Describing a model of supervision used with health visitors in the West Midlands, Wallbank and Woods (2012) suggest that the 'restorative' nature of their model equips health visitors to deal with the stressful aspects of their work. This is achieved by focusing on developing constructive relationships with others (peers, managers or clients) which supports a healthier working environment. Our findings suggest that managers should not underestimate the value of communicating their understanding of the health visitor role, professional goals and challenges, and showing their appreciation of health visitors' contribution. In this study, **managers had an important role to play in helping health visitors to strive to *make a difference* to children and families whilst also working with an organisation undergoing modernisation and changing conditions for practice**. In short, managers' approaches moderate how health visitors understand and engage with organisations, which can positively impact on job satisfaction and health visitors' intention to remain in their jobs. Organisations need to support effective communication between managers and staff to enable clearer expression of the psychological contract (Guest and Conway 2002) which could reduce mismatches in expectations.

The way the health visiting team was organised influenced the relationships health visitors formed with clients and colleagues. Health visitors who were unable to offer continuity of care to families perceived that they were not fulfilling their role, which was a source of dissatisfaction and stress, as they recognised the risk that cases of concern could be missed by 'slipping through the net', which echoes the findings of previous surveys of the health visitor workforce (Craig and Adams 2007; Adams and Craig 2008). Health visitors who felt the scope of their role had narrowed, due to heavy workloads or allocation of cases in a skill mix team, were worried about maintaining and developing

their knowledge and skills in key areas of practice. **Lack of involvement in community public health activities and specific areas of family advice-giving meant that some health visitors felt they needed access to in-service development opportunities to be able to contribute to the full service offer championed by the *Call to Action*** (Department of Health 2011a). This finding supports previous reports that the health visitor workforce, although willing to become engaged in wider public health activities, is concerned that years of individual child-focused work may have diminished public health skills (Brocklehurst 2004).

Health visitors in our study discussed organisational changes that were being introduced which required changes in the way teams and individual practitioners worked. **The combined introduction of mobile working (using electronic diaries and records) and centralised office bases was changing patterns of contact with colleagues and how work was shared or allocated.** Some health visitors welcomed the flexibility accompanying new systems, whilst others felt they reduced opportunities for 'off-loading', sharing information and gaining informal support from colleagues. When unhelpful circumstances for practice were understood to be partly due to managerial decisions or actions (about workload allocation and team organisation) the employing organisation was held responsible for curtailing professional practice. The psychological contract for the health visitor includes an expectation that the employer will provide suitable conditions for work and in return the health visitor will provide a professional service that makes a difference for children and families. When health visitors perceived an infringement of their ability to practice as expected and develop their expertise in important aspects of practice, their psychological contract with the organisation was breached.

Managing dissatisfaction and perceived breaches of the psychological contract appeared to be achieved by accepting 'trade-offs'. This involved **acceptance of difficult work or unfavourable conditions for practice when they were compensated for by good team relationships, a supportive manager, and feedback that provided a sense that they were *making a difference*.** In this study a few health visitors spoke of being at the limit of what they could tolerate in terms of working conditions, which resonates with Meadows' (2000) description of the *last straw* leading to resignation and Maben's (2008) illustration of the cumulative effects of *difficult work*. However, **participants in our study had managed to regain the strength to continue by changing their circumstances (becoming a practice teacher or moving to a new caseload).** They were enabled to do so by supportive managers. They also maintained their commitment to a professional ideology. Our finding that health visitors sought to preserve the service they offered to clients even when challenged by competing organisational priorities can be explained by ideas of ideology-infused psychological contracts and is consistent with other research into professional practice (Thompson and Bunderson 2003; Hyde et al. 2009).

Human resources research suggests that those with higher qualifications tend to have higher expectations of the employing organisation (Sturges et al. 2000; Sturges and Guest 2001). All newly-qualified health visitors are graduates and with many HEIs catering for graduate entrants, increasingly hold post-graduate qualifications, although exact proportions are not known. Sturges and Guest (2001) point out a risk of losing graduate workforces if there is a mismatch in expectations between the employee and organisation with regard to career prospects and progression. This has also been a concern in general nursing (Robinson et al. 2006) and the sports industry, where the warning 'use them or lose them' has been sounded with regard to retaining highly qualified employees (Minten 2010).

Health visitor students in this study were about to take up health visiting posts and their expectations of their employing trust in the first year included: 1) being offered preceptorship; 2) being placed with a supportive team; 3) workload commensurate with their experience (e.g. reduced or selective caseload). These expectations were based on what students had been told by managers, but **the extent of support they would be given once in post had not always been confirmed**. Lack of clarity on such issues may result in employees forming unrealistic expectations, which may pose a threat to the psychological contract and thereby retention (Sturges and Guest 2001). Helping potential recruits form accurate expectations is one way that organisations can manage the organisational commitment of recruits and improve retention. A study of graduate employees by Sturges and Guest (2001) found that this required providing honest and accurate information about the role they would fulfil; being clear about training and career development opportunities; explaining systems of support for staff; and encouraging new applicants to be proactive in informing themselves about the organisation. The authors conclude that there will always be a proportion of employees who move jobs to support their own careers, but those whose starting expectations closely match their employment experiences are more likely to develop strong organisational commitment because they perceive their psychological contract is being honoured.

The lack of detail about preceptorship that was to be offered to students in this study could be partly due to the fact that the Department of Health guidance document (Department of Health 2012a) regarding career support had only recently been published at the time of the interviews. Previously little had been published about preceptorship for health visitors and where packages of support had been devised they were informed by guidance for newly registered nurses and consequently were not considered very useful (Philips et al. 2013). Since then Philips et al (2013) report a preceptorship pilot study which suggests it is possible to provide a useful preceptorship programme for health visitors, although the impact on retention is not yet known.



## 7.2 Strengths and Limitations

Our study was driven by policy questions that are topical at a time of fast-paced development of services. Our research questions were developed and refined in light of policy concerns and service improvement requirements and might not therefore capture what is most important to service users. We did consult with practitioners, educators and policy leads when developing the research. However, in future we would consider carrying out further research on health visiting practice in which service stakeholders had greater opportunity to contribute to shaping the design and focus of empirical work. This would include service users as well as practitioners, as they too are likely to have a perspective on the health visitor workforce, how it is prepared, what it engages in and how investments made for preparing a workforce can be optimised in terms of service provision and personnel retention. Indeed, in this study a service user perspective could have commented on the relevance of the health visitor participants' interpretation of what is needed for health visitors to make a difference to the lives of children and families.

A particular strength of the approach taken in the study is derived from the inclusion of AI exercises which provided opportunities to focus on positive and best practice. Group interviews immediately after the AI exercises enabled participants to discuss the more challenging aspects of practice in a balanced manner and to offer detailed appraisals of factors they believed were implicated in recruitment and retention. However, the study included only those currently engaged with the profession and does not represent the views of those who are likely to be most dissatisfied (that is, dissatisfied enough to leave). Nor does it include those who have chosen not to become health visitors. Consequently, this study was unable to explore why health visitors leave the profession and what deters people from entering health visiting.

Similarly, we were unable to explore issues particularly relevant to those returning to service. The sample included one RtP student, but we are cautious about generalising from a single account. At best we are able to offer insights that in the context of other published work indicate that further research examining RtP issues would be worthwhile.

To set the scene for our empirical research we chose a narrative approach to examine the very little literature on health visitor recruitment and retention experiences in the UK, however this background knowledge was broadened by considering the wider human resources literature. We also had the advantage of drawing on our extensive review of the health visiting literature (Cowley et al. 2013), which we believe adds real strength in this work.

Our data analysis did not aim to provide generalisable findings, but to offer useful insights into the experiences of health visitors, students, teachers and managers. The

findings prompt reflections and suggestions for policy, research, and practice that are likely to prove relevant to different health visiting contexts. The resonance of our findings with existing literature and with the broader human resources literature suggests we have captured a range of important issues that can inform future policy, research and practice.

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## 8. Implications for policy, research and practice

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On the basis of our data analysis and discussion of our findings, we outline some potential recommendations for further policy and practice development and directions for future research in the field.

The purpose of employing health visitors is to provide opportunities for health promotion and preventive action early in family life. Health visitors aspire to improve the life chances of others; a motivation to practice as a health visitor is to *make a difference* to the lives of children and families. This means that recruitment and retention of health visitors is central to improving services and outcomes. The boost to health visitor numbers initiated by the Government's Implementation plan needs to be supported and maintained and not allowed to drop back after 2015.

- 1) *Policy recommendation: Commissioners and providers of children's services should be required to identify, work with and regularly review strategies for maintaining health visitor numbers and sustaining the on-going recruitment and retention of health visitors as part of plans for improving child and family health.*

Health visitors derived a great deal of job satisfaction from being able to fulfil professional aspirations of working autonomously, developing relationships with families, using their knowledge, skills and experiences and working with multi-disciplinary teams. When working in this way they were able to honour their professional ideology which is consistent with an 'orientation to practice' identified by previous research (Cowley et al. 2013).

- 2) *Policy recommendation: Strategies for retaining health visitors should address how health visiting services are organised to ensure health visitors are able to work autonomously to use their knowledge and skills to develop relationships with families and link with multi-professional teams.*

The new service vision for health visiting, the *Call to Action* (Department of Health 2011a), sets out practice across a continuum that requires health visitors to fulfil the breadth of their public health role. Health visitors were committed to this vision, but were concerned that some organisational contexts limited aspects of their practice (in public health and family advice giving). This was a source of frustration for health visitors and posed a threat to meeting students' expectations of their role when qualified. Restricting the breadth of the health visitor public health role has implications for the ability of health visitors to contribute fully to the complete service offer and to the retention of health visitors.

- 3) *Policy recommendation: Employing trusts should regularly review, and develop as necessary, arrangements for health visitor service delivery in line with the Call to Action.*
- 4) *Practice recommendation: Managers should regularly appraise health visitor knowledge and expertise in public health practice and make available development and education opportunities to equip health visitors to fulfil the breadth of their public health role.*

Students anticipated that becoming a health visitor offered a positive career move. However qualified health visitors noted that there were few opportunities for career progression that included continuing with client contact. Without progression opportunities, the job for some felt like *more of the same* and was not satisfying. A change of caseload or the opportunity to qualify as a practice teacher had helped some health visitors reconnect with their professional aspirations.

- 5) *Policy recommendation: Employers reviewing service needs should consider whether health visitors in specialist or advanced practice roles could be a valuable addition to the workforce, whilst also introducing career progression opportunities that ensure health visitors skills are retained for direct service delivery.*

Recruitment to health visiting was supported by early exposure to positive health visiting practice, clear information from existing practitioners, and later experiences that reaffirmed the decision to join the profession. Students were motivated by professional aspirations and although salary was not insignificant, it was not a primary motivator. Students were sensitive to the variation of practice learning situations, with unhelpful situations provoking a great deal of anxiety during role transition. Recruitment to the profession should be understood as a process during which students' decisions are continuously challenged and reaffirmed.

- 6) *Practice and education recommendation: NHS Trusts and HEIs should work together to map out the process of recruitment to the profession and ensure systems include opportunities for applicant contact with practising health visitors offering experiences that support informed decision making.*

Students experienced various arrangements for practice learning, with some attached to practice teachers directly and others indirectly through a health visitor mentor. Students' experiences varied, but commonly the qualified health visitor primarily responsible for providing learning opportunities was of central importance to their experience. The purpose of this study did not include assessment of learning placements and given the

departure from the traditional model of one-to-one support with a practice teacher, more needs to be understood about the impact on future practice of newer teaching arrangements, for example so called 'long-arm' models. Similarly there was little opportunity to examine the experience of those returning to practice as a health visitor, due to few students taking this opportunity.

- 7) *Research recommendation: Research is needed to examine the quality of practice learning for students undertaking an educational programme in health visiting, including in particular the contribution of the practice teacher role (in comparison with that of the mentor), and the impact of 'long-arm' models on student learning.*
- 8) *Research recommendation: Focused research is needed to assess the ease with which former health visitors who consider returning to practice are able to do so.*

The organisational context created the circumstances for practice and health visitors' perceived ability to practice according to their professional ideology. Managerial approaches were instrumental in moderating how the health visitor and student interpreted the requirements for practice set by the employing organisation. Consistent with previous research we identified that an engaging manager also supported the health visitor by indicating an understanding of professional intentions and the challenges of the role. They communicated value and respect for role and individual, which enhanced job satisfaction and increased health visitors' resilience when doing 'difficult' work. This helped maintain the psychological contract and supported health visitor retention.

- 9) *Practice recommendation: Senior leaders and managers should follow the lead of the Department of Health in demonstrating the high value placed on the health visiting contribution. They should visibly convey that health visitors' work is valued by their employing organisations by routinely involving them in organisational decisions that may affect them or their work.*
- 10) *Practice recommendation: Those appointed to directly line manage health visitor teams should be able to demonstrate a clear understanding of health visiting professional practice and adopt styles of working and management strategies that support both teams and individuals to deliver a high quality health visiting service.*

A prominent feature of the current working environment was the introduction of changes that impacted on the ways in which health visitors communicated with clients and each other. These included the introduction of mobile working (using electronic diaries and records) and centralised offices. Health visitors expressed concern about how these changes would affect their ability to develop and maintain relationships with clients and

access informal support and learning from colleagues. The former was an essential feature of delivering health visiting and the latter an important mechanism relied upon to counterbalance stress resulting from 'difficult' work.

*11) Practice recommendation: Senior leaders and managers should review how new service developments are implemented to ensure health visitors have sufficient support to manage change whilst still being able to deliver a quality health visiting service that provides continuity of care and values client relationship building, autonomous practice, application of knowledge and involvement of multi-disciplinary expertise.*

The human resources literature and findings from this study indicate the threats to recruitment and retention from insufficient or unclear information about a job and mismatches between employers' and employees' expectations. Good communication can avoid difficulties. Health visitors expected their employer to support working conditions that enable them to orientate their practice towards *making a difference* to children and families. Students had high expectations about the support they would receive on qualifying, although not all were clear what the Trust would provide, particularly the details of planned preceptorship.

*12) Practice recommendation: during student recruitment to educational programmes and health visitor recruitment to employment managers should establish each applicant's expectations of the post / programme and provide up to date and accurate information about: salaries, terms and conditions, role requirements and the availability of support with career and professional development.*

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## 9. Conclusions

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The health visiting workforce has been particularly stretched in the last decade with low numbers being recruited into health visitor education programmes and retention of existing staff being challenged as the workload and capacity ratios alter. Morale, as a consequence, has been poor and whilst considerable investment is now being made through workforce expansion and mobilisation, the pressures for frontline staff have remained during the first half of the delivery of the Health Visitor Implementation Plan, as additional students in practice settings introduces further demand. Pressure arising from increased workload and changes to supportive conditions at work are known to threaten organisational commitment and hence workforce retention. Theory concerning the psychological contract has been used, here and elsewhere, to explain the level of commitment employees have for their employing organisation and for those with professional roles, the employee's ideological perspective adds a further dimension to how they define worthwhile employment.

With this in mind the empirical qualitative research presented in this report, set out to examine health visitor workforce recruitment and retention, by asking what works well for recruiting and retaining staff. The use of Appreciative Inquiry workshops to support data collection, meant that issues of recruitment and retention for health visiting were considered by participants starting from an asset based perspective. Thus health visitors normally stressed by workload demands and students dealing with an intensive education programme were able to give good consideration to what they valued about health visiting and detailed elements of their professional ideology. What is more, they were able to weigh up the challenges faced, that had the potential to threaten recruitment and retention, and propose solutions. These included: creating opportunities for prospective applicants to have contact with practicing health visitors; involving existing students in applicant information events; ensuring opportunities for 'team time' to enable continuing peer support when moving to centralised bases; offering role variation to combat despondency that arises from unchanging workload challenges; and developing mechanisms for frontline practitioner involvement in decision making about changes to service provision.

In this report we are able to explain what existing and prospective health visitors valued about the health visitor role. This, they summarised in the statement *making a difference* and fulfilment of this was consistent with working to an acceptable professional ideology. Features of the practice environment, referred to in this report as the *organisational context*, that health visitors believed impacted on their ability to fulfil their role are of note

since they had a bearing on job satisfaction and desire to stay as a health visitor. The approaches and actions of those (including managers and practice teachers) in a position to communicate value and respect, support opportunities for learning and facilitate involvement in service development and decision making that impacts on nature of the work, are significant to shaping experiences of organisational context.

The research reported here also specifically adds to our understanding of the student experience when choosing a career in health visiting. It points to recruitment operating as a process, as opposed to a 'one off event', and as a journey that extends beyond the initial application into a period of 'training' when features of the organisational context, such as management approaches, continue to inform student decisions about career and employment options. Supporting student role transition during this process requires collaborative pro-action between educationalists and service providers to ensure informed decision making about starting a health visiting career and provision of appropriate on-going learning opportunities once qualified. The report evidences a desire in the workforce for *getting it right - rather than just getting it done*. This requires attention by policy makers and service providers to features of the organisational context. That is, the organisation and operation of health visitor teams, styles and methods of communication between managers and practitioners and availability of appropriate practice teaching and learning opportunities, , so that the potential within practitioners to make the right career choice and deliver practice to meet client need and professional goals, can be realised. These factors are important in recruiting the right people and retaining a workforce with a desire to work with children and families to *make a difference*.



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## Glossary of Terms

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Corporate caseload	A caseload shared across a team of health visitors
Child protection and safeguarding	Participants in the study used the terms child protection and safeguarding interchangeably when referring to the more intensive nature of the workload.
EIS	Early implementer site
HEI	Higher Education Institution
Intensive cases	Client cases that have been identified as having complex needs that require additional help and support form a range of professional and informal support services
Skill mix team	A team including a number of different personnel with different professional qualifications and skills. In health visiting skill mix teams often include health visitors, nursery nurses, child qualified staff nurses and administrative staff.
Mobile working	Working in different settings with the aid of electronic devices such as laptop or tablet computers, mobile telephones and electronic diaries.
Mentor	A qualified nurse or health visitor who has completed an approved graduate level course of preparation to teach and assess pre-registration students.
Practice teacher	A qualified health visitor who has completed a post-graduate approved course to teach and assess specialist practice students. It is a requirement of the NMC that students qualifying as health visitors are assessed by a qualified and registered practice teacher who is also a registered health visitor.
The organisation	The body employing health visitors.



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# Appendices

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## Appendix 1

### Advisory Group Members

Cheryll Adams, Founding Director, Institute of Health Visiting

Helen Bedford, Senior Lecturer in Child Health, Institute of Child Health, UCL

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Ann Rowe, Implementation Lead, Family Nurse Partnership Programme, Department of Health

Sally Russell, 'NetMums' Director, parent, and user of health visiting services

Stephen Scott, Professor of Child Health and Behaviour, Department of Child & Adolescent Psychiatry, Institute of Psychiatry, King's College London

Alison While, Professor of Community Nursing, King's College London

## Appendix 2

### Examples of information sheets

#### **Start and stay: examining recruitment and retention of health visitors**

##### **Information sheet for HEI students**

###### **Hello!**

We would like to invite you to participate in this original research study. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information.

###### **The research**

In 2011 the Department of Health introduced the Health Visitor Implementation Plan which set out to strengthen and expand the health visitor workforce in the UK by 2015. As a key part of the plan is to recruit an extra 4,200 health visitors, we need to understand what motivates people to join the health visiting profession and why they stay. Our research aims to provide evidence on what factors impact upon decisions to join or stay in the health visiting profession, which we will do through interviews and workshops.

###### **Why have I been chosen?**

In this project we are focusing on students who are currently enrolled in the SCPHN (health visiting) course. You are being invited to take part in this study because you are on this course and therefore ideally placed to tell us about your motivations and aspirations for a health visiting career. You should only participate if you want to; choosing not to take part will not disadvantage you in any way. Your lecturers will not be informed about your decision to participate or not.

###### **What will happen if I take part?**

We will invite you to a workshop facilitated by two independent researchers from King's College London. In this workshop we would like you to reflect on and share what inspires and motivates you about health visiting, and what your aspirations are for the future. You will be invited to discuss these with a partner before sharing with the group, for an audio recorded discussion. Feel free to ask questions throughout the workshop and also please don't feel that you have to talk about a topic if you don't want to. During the workshop each participant will have the opportunity to share, hear and reflect on 'positive practice stories' which we hope may help you in your own practice. The workshop will take place at your university during term time and we envisage that the workshop will last 90 minutes-2 hours.

We would like to follow-up with workshop participants with a face-to-face or telephone interview, which will be audio recorded and then transcribed into text. It will take place at your convenience, in person or over the phone, and will last approximately 30-45 minutes.

If you would prefer to take part only in the workshop this is fine.

### **What information will be held about me?**

Please be reassured that we will follow ethical and legal practice and all information about you will be handled in confidence. If you choose to take part in the interview, details of your particular experience will not be identifiable and we will ensure that your name and any identifiers (e.g. place of study) will be removed from any text or report. Please note that what is discussed in the workshop and interview will not be shared with any of your lecturers, personal tutors or with fellow students.

The researchers leading the study, Dr Astrida Grigulis and Dr Karen Whittaker will be responsible for security and access to the data. The data collected for the study will be analysed to learn more about successful recruitment factors. At the end of the study the research data will be secured for five years in keeping with standard research practice. If you decide to take part you are free to withdraw from the study any time up until July 2012 without giving a reason. After this time, participant data cannot be withdrawn as it is anonymous.

### **What will happen to the results of the study?**

Throughout this study we hope to learn more about what factors contribute to the successful recruitment of health visitors. Anonymised results may be published in a professional journal or presented at a conference. They will also be shared with policymakers at a national level to help improve recruitment arrangements in England. If you would like a copy of the findings we will be happy to send you these, please let us know.

### **Who is organising and funding the research?**

Start and stay: examining recruitment and retention of health is one of three pieces of work in our research programme which aims to support the Health Visitor Implementation Plan through empirical work and literature reviews. This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health (the views expressed are not necessarily those of the Department). It is being organised by a team of researchers from the National Nursing Research Unit at King's College London led by Professor Jill Maben.

### **Who has reviewed the study?**

This research project has been approved by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee (REC Reference Number PNM/11/12-55) they aim to protect your safety, rights, well being and dignity.

### **What if there is a problem?**

Given the nature of this research it is highly unlikely that you will suffer harm by taking part. However, King's College London has arrangements in place to provide for harm arising from participation in the study for which the University is the Research sponsor. If this study has harmed you in any way you can contact King's College London using the details below for further advice and information: Professor Jill Maben (Tel: 0207 8483060, Email: [jill.maben@kcl.ac.uk](mailto:jill.maben@kcl.ac.uk)). Please note that there will be a disclosure protocol in place regarding disclosures made during the study which require action (for example, evidence of professional misconduct). This protocol would begin with a discussion with the principle investigator to decide the most appropriate course of action.

**Thank you for reading this information sheet and we hope that you will take part**

### **If you have any questions about the project**

Please contact Dr Astrida Grigulis or Dr Karen Whittaker (Tel: 0207 848 3064, Email: [astrida.grigulis@kcl.ac.uk](mailto:astrida.grigulis@kcl.ac.uk) or [karen.1.whittaker@kcl.ac.uk](mailto:karen.1.whittaker@kcl.ac.uk)). We are based at: Florence

Nightingale School of Nursing and Midwifery, King's College, London, James Clerk Maxwell Building, Waterloo Road, London SE1 8WA

## **Start and stay: examining recruitment and retention of health visitors**

### **Information sheet for Health Visitor Managers**

We would like to invite you to participate in this original research study. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information.

#### **The research**

In 2011 the Department of Health introduced the Health Visitor Implementation Plan which set out to strengthen and expand the health visitor workforce in the UK by 2015. As a key part of the plan is to recruit an extra 4,200 health visitors, we need to understand what motivates people to join the health visiting profession and why they stay. Our research aims to provide evidence on what factors impact upon decisions to join or stay in the health visiting profession, which we will do through interviews and workshops.

#### **Why have I been chosen?**

In this project we are focusing on what supports the retention of health visitors in England. You are being invited to take part in this study because you are ideally placed to tell us about the retention arrangements for health visitors within your NHS Trust. You should only participate if you want to; choosing not to take part will not disadvantage you in any way.

#### **What will happen if I take part?**

We will invite you to a key informant interview based on questions regarding measures in place to support health visitors in your organisation, for example, continuing education opportunities, flexible working etc. It will take place at your convenience, in person or over the phone, and will last approximately 30 minutes.

#### **What information will be held about me?**

Please be reassured that we will follow ethical and legal practice and all information about you will be handled in confidence. If you choose to take part in the interview, details of your particular experience will not be identifiable and we will ensure that your name and any identifiers (e.g. place of work) will be removed from any text or report. Please note that what is discussed in the interview will not be shared with any of your colleagues.

The researchers leading the study, Dr Astrida Grigulis and Dr Karen Whittaker will be responsible for security and access to the data. The data collected for the study will be analysed to learn more about successful recruitment and retention factors. At the end of the study the research data will be secured for five years in keeping with standard research practice. If you decide to take part you are free to withdraw from the study any time up until July 2012 without giving a reason. After this time, participant data cannot be withdrawn as it is anonymous.

#### **What will happen to the results of the study?**

Throughout this study we hope to learn more about what factors contribute to the successful recruitment and retention of health visitors. Anonymised results may be published in a professional journal or presented at a conference. They will also be shared with policymakers at a national level to help improve recruitment and retention

arrangements in England. If you would like a copy of the findings we will be happy to send you these, please let us know.

### **Who is organising and funding the research?**

Start and stay: examining recruitment and retention of health is one of three pieces of work in our research programme which aims to support the Health Visitor Implementation Plan through empirical work and literature reviews. This is an independent report commissioned and funded by the Policy Research Programme in the Department of Health (the views expressed are not necessarily those of the Department). It is being organised by a team of researchers from the National Nursing Research Unit at King's College London led by Professor Jill Maben.

### **Who has reviewed the study?**

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### **What if there is a problem?**

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**Thank you for reading this information sheet and we hope that you will take part**

### **If you have any questions about the project**

Please contact Dr Astrida Grigulis or Dr Karen Whittaker (Tel: 0207 848 3064, Email: [astrida.grigulis@kcl.ac.uk](mailto:astrida.grigulis@kcl.ac.uk) or [karen.1.whittaker@kcl.ac.uk](mailto:karen.1.whittaker@kcl.ac.uk)). We are based at: Florence Nightingale School of Nursing and Midwifery, King's College, London, James Clerk Maxwell Building, Waterloo Road, London SE1 8WA.

## Appendix 3

### Consent form



#### CONSENT FORM FOR ALL RESEARCH STUDY PARTICIPANTS

**Please complete this form after you have read the Information Sheet and listened to an explanation about the research.**

Title of Study: **Start and stay: examining recruitment and retention of health visitors**

Study ref: PNM/11/12-55 approved by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee.

Thank you for considering taking part in this research. We will explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask us before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

**Please tick or initial**

- **I consent to the processing of my personal information for the purposes explained to me. I understand that such information will be handled in accordance with the terms of the Data Protection Act 1998.**
- **I consent to my interview being audio recorded.**
- **The information you have submitted will be published as a report. Please note that confidentiality and anonymity will be maintained and it will not be possible to identify you from any publications.**
- **I understand that if I decide at any time during the research that I no longer wish to participate in this project, I can notify the researchers involved and withdraw from it immediately without giving any reason. Furthermore, I understand that I will be able to withdraw my data up to the point of publication in July 2012.**

**Participant's Statement:**

I \_\_\_\_\_

**agree that the research project named above has been explained to me to my satisfaction and I agree to take part in the study. I have read both the notes written above and the Information Sheet about the project, and understand what the research study involves.**

**Signed**

**Date**

## Appendix 4

### AI workshop exercise students



#### **Start and stay: examining recruitment and retention of health visitors**

Study ref: PNM/11/12-55 approved by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee

**Thank-you for registering to be part of our study into recruitment and retention in health visiting. We are very pleased that you will be joining us for the Appreciative Inquiry (AI) informed workshop. Below you will find some information on what you can expect from the workshop and details on a preparatory exercise.**

#### **What is an Appreciative Inquiry (AI) informed workshop?**

In our study we want to understand what motivates students to pursue health visiting. To do this we are running a workshop from a positive (appreciative), solutions-focused angle. You will be invited to reflect on the reasons why you pursued health visiting and share these with others in the group. By sharing your experiences this will help to build a picture of what motivates people about health visiting more broadly. This workshop will also give you an opportunity to strengthen your reflective practice and collaboration skills.

#### **What will happen in the workshop?**

- The timing and location of the workshop will be sent to you by email and/or by text message.
- Before the start of the workshop we will explain what will happen during the workshop, ethics and consent issues, and details on what will happen with workshop discussions.
- You will then be divided into small groups to share your health visiting stories (see the preparatory exercise overleaf). You will then have the opportunity to share with the wider group what you have discussed in your smaller groups.
- The workshop will be facilitated by a member of the research team and another member will take notes as part of the data collection exercise. With the permission of all workshop participants, the wider group discussion will be audio recorded and later transcribed by a member of the research team.
- After each workshop, individuals willing to be followed-up will be invited for a non-obligatory audio recorded interview. These will take place approximately 2 weeks after the workshop and will be conducted over the telephone or face-to-face depending on your availability and preference.
- It is important to note that transcripts and notes resulting from workshops and interviews will not reveal the names of participants. The names of individuals or organisations will not be included in any study reports or papers resulting from this study.

#### **In preparation for the workshop**

To make the best use of available time we are asking that you prepare a short positively-framed story in preparation for the workshop. You **will not** have to send these to us before hand, but we would ask you to bring it along to share with us at the workshop. This story should be about an experience when you felt particularly energised about becoming as a health visitor. We have provided a form overleaf on which to write your story. We would be grateful if you could also include some details, for example, your gender and age group. Please note that whatever you write will be confidential and will not be shared with anyone outside the research team.

**Thank you!**

**If you have any questions about the project** Please contact Dr Astrida Grigulis or Dr Karen Whittaker. National Nursing Research Unit Tel: 0207 848 3064, Email: [astrida.grigulis@kcl.ac.uk](mailto:astrida.grigulis@kcl.ac.uk) or [karen.1.whittaker@kcl.ac.uk](mailto:karen.1.whittaker@kcl.ac.uk)

**Please provide the following information:**

**-What course are you currently enrolled on**

**-Full time or part time** (delete as appropriate)

**-Your gender**

**-Your age group (circle as appropriate)** 18-24, 25-29, 30-34, 35-44, 45-64, 65+

**-What were you doing before enrolling onto your Health Visiting course?**

**Please tell us about a practice experience you have felt excited and motivated by and briefly describe the factors that contributed to this:**



## Appendix 5

### AI workshop exercise health visitors



#### **Start and stay: examining recruitment and retention of health visitors**

Study ref: PNM/11/12-55 approved by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee

**Thank-you for registering to be part of our study into recruitment and retention in health visiting. We are very pleased that you will be joining us for the Appreciative Inquiry (AI) informed workshop. Below you will find some information on what you can expect from the workshop and details on a preparatory exercise.**

#### **What is an Appreciative Inquiry (AI) informed workshop?**

In our study we want to understand what factors impact upon decisions to stay in the health visiting profession. To do this we are running a workshop from a positive (appreciative), solutions-focused angle. You will be invited to reflect on what inspires and motivates you about health visiting and share this with others in the group. By sharing your experiences this will help to build a picture of what motivates people about health visiting more broadly. This workshop will also give you an opportunity to strengthen your reflective practice and collaboration skills.

#### **What will happen in the workshop?**

- The timing and location of the workshop will be sent to you by email and/or by text message.
- Before the start of the workshop we will explain what will happen during the workshop, ethics and consent issues, and details on what will happen with workshop discussions.
- You will then be divided into small groups to share your health visiting stories (see the preparatory exercise overleaf). You will then have the opportunity to share with the wider group what you have discussed in your smaller groups. With the permission of all workshop participants, the wider group discussion will be audio recorded and later transcribed by a member of the research team.
- After each workshop, individuals willing to be followed-up will be invited for a non-obligatory interview. These will take place approximately 2 weeks after the workshop and will be conducted over the telephone or face-to-face depending on your availability and preference.
- It is important to note that transcripts and notes resulting from workshops and interviews will not reveal the names of participants. The names of individuals or organisations will not be included in any study reports or papers resulting from this study.

#### **In preparation for the workshop**

To make the best use of available time we are asking that you prepare a short positively-framed story in preparation for the workshop. You **will not** have to send these to us beforehand, but we would ask you to bring it along to share with us at the workshop. This story should be about an experience when you felt particularly energised about practising as a health visitor. We have provided a form overleaf on which to write your story. We would be grateful if you could also include some details, for example, your gender and age group. Please note that whatever you write will be confidential and will not be shared with anyone outside the research team.

#### **Thank you!**

**If you have any questions about the project** please contact Dr Astrida Grigulis or Dr Karen Whittaker.

National Nursing Research Unit Tel: 0207 848 3064, Email: [astrida.grigulis@kcl.ac.uk](mailto:astrida.grigulis@kcl.ac.uk) or [karen.1.whittaker@kcl.ac.uk](mailto:karen.1.whittaker@kcl.ac.uk)

**Please provide the following information:**

**-Your gender**

**-Your age group (circle as appropriate) 18-24, 25-29, 30-34, 35-44, 45-64, 65+**

**-What were you doing before you became a health visitor?**

**Please tell us about a time when you felt happiest working as a health visitor and briefly describe the factors that contributed to this:**

## Appendix 6

### Topic guide



### Start and stay: examining recruitment and retention of health visitors

#### TOPIC GUIDE for each respondent group

##### All workshop discussions and interviews will begin with the researchers:

- Giving an introduction and reminder of the purpose of the research
- **Going through the information sheet, highlighting** their rights as interviewee regarding withdrawal from the interview, confidentiality, use of data, data storage
- **Going through consent form** and gaining consent for an audio recorded interview

#### HEI Health visiting students

##### Workshop topics to cover

Focus on examining how the following factors affect students' decisions to pursue health visiting:

- health visitor placements they may have experienced previously
- social factors
- financial factors e.g. available bursaries
- the image of health visiting
- academic/professional development
- career & professional aspirations
- working with social/wellness model of health and illness
- being pro-active
- advocacy for children and families

##### Individual interview topics to cover

- What was your experience of the recruitment process?
- What are your expectations of the role?
- What are your plans for the future? (career development, position, job role etc.)

#### Practising health visitors

##### Workshop topics to cover

Focus on examining how the following factors affect health visitors' satisfaction with their job/role/workplace (and retention generally)

- social factors
- financial factors e.g. salaries
- academic/professional development factors (e.g. autonomy, CPD access, topic & type)
- organisational characteristics (e.g. support and supervision provision, preceptorship, impact on morale)

- career and professional aspirations (in particular do their prior expectations of the role match with their current experiences? How far does this motivate them to stay or seek alternatives?)

#### **Individual interview topics to cover**

- What measures are in place to support you in your own organisation?
- How could these be changed, improved? And is there anything else you would like to see in your organisation to support your retention?
- What are your plans for the future? (career development, position, job role etc.)
- How could your plans be best supported?

### **Mapping exercise**

#### **SHAs: health visitor plan leads n=10**

All Strategic Health Authorities (SHAs), n=10, will be asked the following question over email:

Have centralised or local recruitment systems been used for the 2011 September Specialist Community Public Health Nursing (health visiting) programme?

### **Key informant interviews**

#### **SHAs: health visitor implementation plan leads n=4**

#### **Topics to cover**

- Does a centralised or a localised system for recruitment operate within your SHA?
- What are the existing arrangements for recruitment – do HEIs or NHS Trusts pair up at all?
- How satisfied has the SHA been with the recruitment levels achieved in their own area?
- What support is there for workforce professional development?
- How has recruitment this year (for Sept 2011) compared to that in previous years?
- Are there plans to change the process for next intake (Sept 2012)?
- Are literacy and numeracy tests included in the selection process – and if so at what stage?
- Comments on the use of such tests and their value

## **Lecturers/course leads**

### **Topics to cover**

- What, in your opinion, makes a good recruit to HV training?
- What are the desirable and essential criteria, including attributes, skills and knowledge?
- What are the stages to the recruitment process?
- What criteria are applied at each stage in order to refine the selection of applicants? How are criteria applied?

## **Health visitor managers**

### **Topics to cover**

- What measures do you think support health visitor retention?
- What measures are in place to support health visitors in your own organisation? e.g. continuing education opportunities, flexible working.
- Have you experienced or are you currently experiencing any issues with retention? If so how have you/are you dealing with them?

## Appendix 7

### AI workshop schedule all participants



#### **Start and stay: examining recruitment and retention of health visitors**

Study ref: PNM/11/12-55 approved by the Psychiatry, Nursing and Midwifery Research Ethics Subcommittee.

#### **Data collecting workshop schedule: 2 hours HEI Students/Health Visitors (n=10/10)**

##### **FACILITATED WORKSHOP**

###### **15 minutes**

At the start of the workshop the facilitators will address the following:

###### **CHECKLIST:**

- ✓ Overview and details of the workshop for example, timings, housekeeping issues (including fire exits and procedure in the event of an alarm)
- ✓ Ethical issues including respondents' rights regarding withdrawal from the interview, confidentiality, use of data, data storage, audio recording
- ✓ Gain written consent from each participant for audio recording the wider group discussion

###### **20 minutes**

- Participants are divided into small groups (2-3 people)
- They are asked to share their health visiting stories (from the preparatory exercise) in their groups and to write down key themes from their discussions on the flip charts provided. One member from each team to be nominated to present these to the wider group

###### **25 minutes**

- Each group will feedback to the main group their key discussion themes
- The facilitators will then facilitate discussions around these main themes and take notes

BREAK for refreshments

##### **GROUP INTERVIEW**

###### **45-60 minutes**

- The participants will then be invited to stay and take part in a group interview based on key themes which have emerged from the exercises and questions as outlined in the topic guide (workshop topic, topics to cover for both HEI students and health visitors)
- These will be run by the facilitators and audio recorded

##### **END OF THE WORKSHOP**

###### **5 minutes**

Respondents will be thanked for their involvement and reminded about ethical/consent issues.

Facilitators will then explain about the follow-up interviews. Respondents will be invited to participate in a follow-up interview which will take place 2 weeks after the workshop. People will be asked to volunteer to take part in the follow-up interviews.

#### CHECKLIST of equipment

- ✓ Flip charts and pens
- ✓ Informed consent forms
- ✓ Refreshments

## Appendix 8

### Additional Recruitment Information

#### Recruitment of students

In addition to the research aims and objectives agreed policy colleagues asked the research team to gather information about recruitment of health visitor students where possible and particularly to address the question:

*What criteria are used by Higher Education Institutions (HEIs) and National Health Service (NHS) partners to select and deselect candidates for recruitment to health visitor education programmes?*

In the interviews carried out for the study HEI lecturers and managers in NHS Trusts were asked about recruitment and selection processes. Lecturers had more to say than managers on this topic, so the information included here draws mainly on their responses, which highlighted the following issues:

#### Resources for the expanded training programme

Interviews were carried out when the first larger intake of students had been recruited as part of the Implementation Plan and the resulting increased demands on Trust and HEI resources were uppermost in the minds of managers and lecturers. Lecturers felt that their workload had grown substantially, but since the rise in student numbers would be short-term and universities received no additional funding on top of tuition fees, they reported that there had been a reluctance to invest in infrastructure to support them with recruitment and management of training programmes.

*Well, I don't think any university or Trust could entertain that intensity of recruitment process, particularly with the numbers now at the moment. It's just taking up so much time, everybody's time. You almost need a dedicated person that could deal with recruitment issues. (2-L-p)*

#### Coordination between HEIs and the NHS

HEIs and NHS trusts working together closely in the recruitment process was seen as essential by all stakeholders. The lecturers felt was particularly important to ensure that applicants received full and consistent information about health visiting, the training programme, the process of applying and what Trusts and HEI were looking for in recruits, because this would give applicants confidence that training was well-organised. The SHAs tended to *put the emphasis on local ownership and local recruitment and retention strategies being the order of the day (22-SHA-p1)*, in contrast to centralised regional recruitment processes. Lecturers often had to deal with several trusts, each with



different systems and processes, which meant that it could be difficult to ensure applicants received consistent messages:

*So we continue to do joint recruitment. However, some of the trusts... and bear in mind, some of these are new trusts who have formed out of old ones with new leadership, have kind of taken it on themselves to say, 'Right, we've got this target to meet and it's very high stakes so we're going to do our own recruitment process,' which has upset the applicant a bit really. [...] we've got one trust doing their own thing, which sort of, as I say, unsettles the process a bit. (20-L-p5)*

The same lecturer also raised the issue of coordination of national or regional recruitment initiatives and local processes:

*'... the central university, and their timelines and everything for recruitment is different to ours and so we try to have closing date but the Department of Health will send out loads of leaflets of babies in nappies and more people would apply. Or the SHA would put something out but we've closed. But then some were a few short but we've got 100 more applicants so we have to shortlist them all so then interview them just for four places so how are we going to do this? So it's a bit of a challenge. (20-L-p16)*

### Recruitment and selection processes

The initiative to attract more applicants for health visitor training had implications for the process of recruitment, not least there were challenges in dealing with the sheer number of people who showed an interest in applying and wanted to know more about health visiting. Several lecturers welcomed the improved information about the health visitor role that was being provided for applicants, but felt that more detailed information was required. They thought potential applicants should be encouraged to gain experience of health visiting, for example by observing a health visitor in practice. Another lecturer thought road shows helped and *one of the things we say in our open days is to try and get some experience of shadowing health visitors in practice*. However, this was not always popular with Trusts who *curse us every time we say that because then they get lots of phone calls. Other trusts have said, 'Well, we can't do that, we can't physically do that but we'll run a day where we'll get lots of health visitors in to talk about their role,' and that's been quite successful. So I think I would perhaps say that more proactive applicants have got a better idea what health visiting is about. (20-L-p17)*

Lecturers had a clear idea of the attributes they were looking for in health visitor students and emphasised the value of interviews for assessing listening and communication skills. They also mentioned open-mindedness, tolerance, flexibility, being approachable and non-judgmental and having transferrable skills. They felt the Department of Health guidance on *health visiting attributes* (Department of Health 2012e) was a helpful document for potential applicants.

One lecturer commented that 'there is a lot more emphasis now on the recruitment process' and the initiative to recruit more students had caused some Trusts and HEIs to review their recruitment procedures. Some SHAs were trying to introduce a standardised procedure across all Trusts, but not all Trusts were willing to comply. Some had created bespoke requirements, for example introducing written tests for applicants or asking them to submit written material. One Trust had created a new form that students had to complete and submit with their application, which was scored by assessors (as part of shortlisting procedures). There were four questions relating to essential competencies of Specialist Community Practitioners: communicating, networking and influencing; working in teams; managing planning and organising; and focusing on patients and customers. Each question required the applicant to give a fairly brief (200 words) example of using the competency. The fifth question asked about reasons for applying and the personal qualities and experiences the applicant brought to the role.

### Quality of recruits

With more students entering training programmes, the lecturers felt that it was more important than ever to select students who had a good chance of succeeding on the academic course, since they were now less likely to know students personally and to be able to identify and offer help to those who were having difficulties. There were also limits to the individual support they could provide. This was a concern to some lecturers who noted that in the current year more students had left the course than in previous years (although this may simply reflect the higher number of students on the programme and we have no way of knowing whether the proportion leaving had increased). Another lecturer felt more confident that '*we've kept our standards the same but the pool has got bigger, so we've recruited more*'.

However, one lecturer pointed out that for the first time students had been 'discontinued from practice' because of their attitude to learning:

*... they knew everything and didn't need to learn anything, didn't need to turn up on time, all those sorts of attitudinal things. I don't think any of the interviews pick up those sorts of issues. I think probably when we had smaller student numbers we could have picked those kinds of difficult attitudes up fairly early on, but we can't now with such a big group. It's still difficult to know student names and that sort of thing. So I think that recruitment process is absolutely essential.*

This lecturer thought there was probably much to be learned from the selection processes used for other occupational and professions training courses. How issues of selection and quality of recruits might be addressed raises interesting questions that were beyond the scope of this study to address.

**We hope these insights, whilst in no way comprehensive, provide some useful information for policy. We do suggest however that much more work is required in this area in order to provide more comprehensive understanding and insights into this complex issue.**