

**A Classic Grounded Theory Study Exploring the
Social Processes of the Health Visitor Antenatal
Home Visit**

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Abstract

Background

The Health Visitor (HV) antenatal contact, conducted between 32 and 34 weeks of pregnancy, is typically the first meeting between expectant parents and HVs. Government directives and targeted home visiting programmes highlight its importance in early intervention, reducing health inequalities, and fostering family-centred relationships.

Although expectant mothers valued face to face contact for learning about the HV role, discussing baby related topics and relationship building, limited evidence exists on expectant parent and HV experiences of the antenatal visit. Researching this area is vital to understand how HVs can better support expectant parents, enhance relationship building, and optimise the effectiveness of antenatal visits.

Research Question

What are the perceptions and experiences of expectant parents and HVs about the HV antenatal home visit?

Methods

Following a Classic Grounded Theory (CGT) approach, data was collected from three observations of the HV antenatal home visit and unstructured interviews with thirteen HVs and six expectant parents. Participants were recruited from one Scottish health board, and a constant comparative method of analysis was employed.

Findings

Therapeutic and supportive relationship building helped develop parental trust in the HV so parents would use the HV service for advice and support. It was the gateway to assessing the wellbeing of the unborn baby, where parents shared their transition to parenthood, whilst HVs assessed parental need. The wellbeing needs of the unborn baby were the main concern of HVs and parents with a focus on safety. Managing the antenatal visit involved HVs providing appropriate support and advice according to parental need.

Conclusions

The study led to the discovery of the substantive theory: expectant parents and HVs adjusting to support the wellbeing of the unborn baby at the antenatal visit. It established the significance of therapeutic relationship building underpinning early identification of need and provision of individualised HV support to parents.

Declaration

I affirm that the content of this thesis is my original work, except where explicitly acknowledged or referenced otherwise.

Signature:

A handwritten signature in black ink, appearing to read 'T. Barrows', is placed over a light yellow rectangular background.

Tina Barrows

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Table of Contents

Chapter 1: Introduction and Background	19
1.1 Introduction.....	19
1.2 Organisation of the Thesis.....	20
1.3 Background	22
1.4 Clinical Context.....	24
1.5 Chapter 1 Summary	29
Chapter 2: Literature Review	30
2.1 Non-Committal Review of the Literature and Search Strategy	30
2.2 Findings of the Literature Review.	33
2.2.1 Relationship building	35
2.2.2 Timing and location of the HV antenatal contact.	40
2.2.3 Content of the HV antenatal contact.	43
2.3 Chapter 2 Summary of Literature Review.....	46
2.4 Conclusion.....	47
Chapter 3: Research Methodology	49
3.1 Introduction.....	49
3.2 Research Question.....	49
3.3 Justification for Utilising a Qualitative Methodological Approach	51
3.4 Choosing a Qualitative Approach	57
3.4.1 Case study	58
3.4.2 Ethnography.....	58
3.4.3 Phenomenology	59
3.4.4 Grounded Theory.....	61
3.5 Justification of a Grounded Theory Approach.....	63
3.6 Justification of a Classic Grounded Theory Approach	67
3.7 Chapter 3 Summary of Research Methodology	72
Chapter 4: Research Methods	73
4.1 Ethical Considerations	73
4.1.1 Participant anonymity, confidentiality, and data management	74
4.1.2 Potential for disclosures about previous experiences evoking anxiety..	75
4.1.3 Lone working.....	75

4.1.4 Potential for observing poor HV practice.....	76
4.1.5 Conflict of interest	76
4.1.6 Ethical approval	77
4.2 Participant Sample	78
4.3 Sampling Strategy	79
4.3.1 Initial sampling	79
4.3.2 Theoretical sampling	80
4.3.3 Participant inclusion and exclusion criteria.....	85
4.3.4 Patient and public involvement in the research study	87
4.4 Recruitment	89
4.4.1 Recruitment challenges.....	91
4.4.1.1 Negotiating organisational structures and processes.	92
4.4.1.2 COVID-19 Pandemic.....	93
4.4.2 Consent.....	94
4.5 Data Collection	95
4.5.1 Observations	96
4.5.2 Interviews.....	100
4.5.3 Researcher reactivity within observations and interviews	106
4.5.4 Field notes.	107
4.5.5 Theoretical saturation.....	107
4.6 Data Analysis.....	109
4.6.1 Constant comparative analysis	110
4.6.2 Computer software packages	112
4.6.3 Theoretical sensitivity.....	114
4.6.4 Theoretical memos.....	115
4.7 Coding	118
4.7.1 Substantive coding.....	118
4.7.2 Open coding.....	120
4.7.3 Selective coding	124
4.8 Main Concern	126
4.9 Core Category	127
4.10 Theoretical Coding	127
4.11 Substantive Theory.....	130

4.12 Research Quality	131
4.12.1 Fit, work, relevance, workability and modifiability	132
4.12.2 Reflexivity	133
4.13 The Use of Literature	136
4.14 Chapter 4 Summary of Research Methods	137
Chapter 5: Findings	139
5.1 Overview of Findings	139
5.2 Sample Characteristics	141
5.3 Main concern-The Wellbeing of the Unborn Baby.	145
5.4 Core Category: Parents and HVs Adjusting to Support Wellbeing Needs of the Unborn Baby at the HV Antenatal Visit	146
5.5 Main Category-Therapeutic and Supportive Relationship Building	148
5.6 Summary of Main Category-Therapeutic and Supportive Relationship Building	149
5.6.1 Building trust and approachability	150
5.6.2 Tailoring conversations to individual families	152
5.6.3 Information sharing in relationship building	154
5.6.3.1 Sharing self	155
5.6.3.2 Maintaining confidentiality	157
5.6.4 Balancing staying professional with sharing self	158
5.7 Main Category Assessing the Wellbeing of the Baby	159
5.8 Summary of Main Category- Assessing the Wellbeing of the Unborn Baby	159
5.8.1 Painting a picture of wellbeing needs of the unborn baby.	160
5.8.2 Identifying health needs	161
5.8.3 Assessing parental mental health	162
5.8.4 Focussing on safety of the unborn baby	163
5.8.4.1 Safe home and living conditions	163
5.8.4.2 Safe birth	165
5.8.4.3 Safe sleeping	165
5.8.4.4 Safe feeding	166
5.8.4.5 Safety of babies through parental lifestyles	167
5.8.5 Demonstrating preparation for baby's arrival	168

5.9 Main Category Managing in the Antenatal Visit	169
5.10 Summary of main category managing in the antenatal visit.....	169
5.11 Establishing an Antenatal Visit	170
5.12 Barriers to establishing the antenatal visit	171
5.12.1 Fitting with parental schedules and pregnancy progression.....	171
5.12.2 Engaging with partners of expectant mothers	172
5.12.3 Impact of work pressures	174
5.12.4 Parental past experiences.....	175
5.12.5 Impact of COVID-19 pandemic on antenatal visiting	178
5.13 Preparation for the antenatal visit	179
5.13.1 Information sharing with other professionals	179
5.13.2 Compiling reminder checklists	180
5.14 HV Past Experiences	182
5.15 Parental Support Relating to Parental Need.....	183
5.15.1 Supporting breastfeeding	184
5.15.2 Promoting baby development and parental emotional attachment. ..	185
5.15.3 Promoting safe parenting practices.....	186
5.16 Broaching Domestic Violence	187
5.17 Managing Mental Health.....	189
5.18 Chapter 5 Summary of Findings.	191
Chapter 6: Discussion	193
6.1 Introduction.....	193
6.2 Substantive Theory.....	193
6.3 The Theory and Current Literature	195
6.4 The Main Concern- Wellbeing of the Unborn Baby	197
6.5 Core Category- HVs and Parents Adjusting to Support the Wellbeing Needs of the Unborn Baby at the HV Antenatal Visit.....	199
6.6 Main categories	200
6.7 Therapeutic and Supportive Relationship Building	200
6.8 Assessment of the Wellbeing of the Unborn Baby.....	206
6.9 Managing in the Antenatal Visit	208
6.9.1 Preparing for and conducting the antenatal visit	209
6.9.2 Parental support relating to parental need	213

6.9.3 Broaching domestic violence	215
6.9.4 Managing parental mental health	216
6.10 Limitations of the Study	216
6.11 Strengths of the Study	218
6.12 Implications for Clinical Practice	220
6.13 Future Research	222
6.14 Summary	224
6.15 Conclusion	224
Chapter 7: References	227
Chapter 8: Appendices	263
8.1 Appendix 1 HV Participant Information Leaflet.....	263
8.2 Appendix 2 Participant Information Leaflet Expectant Mother	269
8.3 Appendix 3 Participant Information Leaflet Partner of Expectant Mother ..	275
8.4 Appendix 4 Privacy Notice	281
8.5 Appendix 5 University of Stirling Sponsorship Letter	284
8.6 Appendix 6 Ethical Approval North of Scotland Research Ethics Service .	285
8.7 Appendix 7 Local NHS Board RD&I Division Ethical Approval	289
8.8 Appendix 8 Standard Operating Procedure Midwife Recruitment of Expectant parents	291
8.9 Appendix 9 Standard Operating Procedure HV Recruitment of Expectant Parents	292
8.10 Appendix 10 Invitation Letter Health Visitor	293
8.11 Appendix 11 Invitation Letter Expectant Parent.....	294
8.12 Appendix 12 Substantive Amendment Ethical Approval	295
8.13 Appendix 13 Consent Form Expectant Mother	297
8.14 Appendix 14 Consent Form Partner of Expectant Mother	298
8.15 Appendix 15 Consent Form Health Visitor	299
8.16 Appendix 16 Observation Schedule	300
8.17 Appendix 17 Topic Guide for Interviews Version 1	302
8.18 Appendix 18 Updated Topic Guide for Interviews.....	304
8.19 Appendix 19 Draft Article for Publication	306

List of Tables

Table 2.1 Inclusion and exclusion criteria for literature review	33
Table 2.2 List of excluded articles	34
Table 4.1 Memos on codes and topics for interview	82
Table 4.2 Example of theoretical sampling	82
Table 4.3 Example of subsequent theoretical sampling	84
Table 4.4 Inclusion and exclusion criteria- HVs.....	85
Table 4.5 Inclusion and exclusion criteria- expectant parents	86
Table 4.6 Recruitment figures for HV antenatal study.....	91
Table 4.7 Example of completed page of observation schedule	99
Table 4.8 Development of concepts and coding relating to safety	104
Table 4.9 Example of field notes	108
Table 4.10 Memos regarding coding data	117
Table 4.11 Memos developing the substantive theory	119
Table 4.12 Further memo developing the substantive theory.....	120
Table 4.13 Open coding example	121
Table 4.14 Selective coding example.....	125
Table 4.15 Memos capturing the evolution of the main concern	128
Table 4.16 Memo demonstrating reflexivity.....	136
Table 5.1 Participant characteristics	144
Table 5.2 Field Notes Area A101	147
Table 5.3 Support memo.....	147
Table 5.4 Field notes from observation A701	154

List of Figures

Figure 4.1 Timeline of Recruitment and Data Collection	90
Figure 4.2 Interplay between theoretical sampling, data collection and comparative analysis	112
Figure 4.3 Visual map of codes and their characteristics	123

Figure 4.4 Reduction of codes on completion of open coding.....	124
Figure 4.5 Open codes from main category of assessing	126
Figure 4.6 Core category, main categories and sub categories	129
Figure 5.1 Core category, main and subcategories and their characteristics	141
Figure 6.1 Timeline of Literature Review.....	196

Glossary

<u>Term</u>	<u>Definition</u>
Anonymity.	The identity of those taking part is not known outside of the research team.
Antenatal.	The period of time from when a pregnancy occurs until the birth of the baby.
At risk.	Refers to children or parents who have risk factors that affect their health and social care or may be at risk of harm. Examples include poverty, poor housing and social circumstances, domestic violence or abuse.
Basic social process.	In grounded theory a basic social process is a central pattern of behaviour or interaction that evolves over time and helps explain how individuals manage or adapt to specific situations.
Bias.	An unintentional influence of effect that may distort the findings at any stage of the research process.
Category.	An idea or concept representing a group of codes. Sub category. An idea or concept representing a more specific group of codes within a main category, providing detailed insights and illustrating relationships within it.
Classic Grounded Theory (CGT).	A version of grounded theory from the original work of Barney Glaser and Anselm Strauss(1967) that was developed by Barney Glaser, also known as Glaserian grounded theory (see Grounded theory)
Client (Parent).	A user of the health visiting service. Usually referred to as parents but some researchers refer to them as clients.
Coding.	A form of shorthand that researchers use to identify repeated conceptual occurrences and similarities in participants' experiences. Open coding is the first stage of coding in classic grounded theory. The data is examined line by line and codes are attached to words or groups of words. Selective coding is the second stage of coding when open codes are grouped into higher level categories with a core category in mind.
Substantive coding.	The initial phase in grounded theory research where data is broken down into codes and categories to identify key patterns.
Theoretical coding.	The process of identifying and integrating relationships between categories to develop a cohesive theory in grounded theory research.
Concept.	An idea that summarises a descriptive explanation of an event or occurrence.
Constant comparison.	The act of comparing a piece of data attached to a concept with another piece of data that is also attached to a concept to see if they represent the same concept. Known as constant comparative analysis in grounded theory.
Constructivist grounded theory.	Emphasises the co-construction of meaning between researcher and participants, recognising the researcher's influence on the data and analysis in grounded theory.

Glossary

Core categories. A concept that captures a phenomenon from the categories and sub categories constructed about it and their relationships between them.

Core health visiting. A term used within health visiting in the UK that describes the health visitor delivering the universal programme of health visiting (see **Universal health visiting programme**).

Data. Raw material collected through sources such as interview, observations, literature, documents and artefacts used for research.

Data analysis. The processing, summarising and interpretation of raw data into meaningful information.

Data generation. The process by which a researcher engages directly with a data source to produce materials for analysis, for example in- depth interviewing.

Deductive. Start with a specific theory and test the implications of the theory with data to prove or disprove the theory. It is typically associated with scientific investigation.

Early intervention. Intervention means an activity by a professional or individual outside of family intended to deal with a health or development problem. Early intervention is acting as soon as possible so that the problem is dealt with before it becomes more difficult to deal with.

Early years team. An integrated team of health and social care workers who provide interventions to 0-5 year old children and their families. They include registered health visitors, staff nurses (training to qualify as health visitors, a practice lead who is a specialist community public health nurse registrant, community early years practitioners (working at a level of a community nursery nurse or social care worker) and administrative support staff.

Epistemological. Relates to the theory of knowledge, its nature, origin and scope, and the distinction between justified beliefs and opinions.

Ethnography. A research approach usually involving studying individuals or groups in their natural setting.

Evidence. An outcome of research that supports the existence of a concept, phenomenon or theory.

Family Nurse Partnership (FNP). Specially trained child and family nurses who provide an intensive structured home visiting programme to parents under the age of 20, until their child reaches two years of age. It aims to improved maternal health during pregnancy, improve children's development and improve parents' ability to be self-sufficient with their finances.

Family Partnership Model (FPM). American intensive structured home visiting programme provided by specially trained child and family nurses that the family nurse partnership model was based upon.

Geographical homogeneity. Close similarity between people that live within a specific geographical area.

Gestation. The time when a baby is developing inside its mother before it is born.

Glossary

GDPR (General Data Protection Regulation). A privacy and security law passed by the European Union (EU) May 25th 2018.

GIRFEC (Getting it Right for Every Child). Scottish Government commitment for children and young people to reach their full potential by providing them and their families with the support they need at a time right for them.

Glaserian grounded theory- see **Classic Grounded Theory (CGT).**

Grounded theory. A research methodology that generates theories about social behaviour that can be used within qualitative or quantitative research. There are several types that have evolved since it was first developed. See **Classic Grounded Theory (CGT)**, **Straussian grounded theory**, and **Social constructive grounded theory**.

Health plan indicator. Scottish Government guidance on levels of need. If a child or their family requires additional input to help meet their health or wellbeing needs from any health education or social care professional, that is over 3 months in duration their health plan indicator would be considered *Additional*. For children and families that are having their wellbeing needs met through provision of Universal Services their health plan indicator would be *Core* (see **Universal Services**).

Health promotion. Any planned or informed intervention which is designed to improve physical or mental health or prevent disease, disability and premature death.

Health Visitor (HV). Specialist public health nurses who promote healthy lifestyles and prevent illness. They work with children 0 to 5 years of age and their families commencing their involvement with families in the antenatal period.

Human ecology. Acknowledging an individual within their context through an ongoing process that considers both their personal and situational circumstances.

Human valuing. Showing respect and consideration for others by being mindful of them and adjusting focus to align with their needs

Inductive. In research it involves the search for patterns from observation and the development of broad generalisations that aim at developing a theory.

Iterative. The act of repeating something, as in **constant comparative analysis** in grounded theory.

In need. A child or family that, due to their health or social care circumstances needs help to improve their situation. Examples include poor housing, poor physical health, lack of social support, mental health issues, poor parenting.

Interpretive. Refers to understanding and explaining the meanings and social processes underlying the data from the participants' perspectives in grounded theory.

IRAS (The Integrated Research Application System). Is a single system for applying for the permissions and approvals for health and social care / community care research in the UK.

Glossary

LGBTQIA+ Lesbian Gay Bisexual Transgender Queer or Questioning Intersexual Asexual + Acronym for sexualities that are non-heterosexual and gender identities different to those assigned at birth. + is anyone not listed in the acronym but still identifies as part of the community such as two-spirit, non-binary, pansexual, demisexual, aromantic, genderfluid or agender.

Memo. See **Theoretical memoing and memos.**

MECSH (Miller Early Childhood Sustained Home visiting) trial (2008). The first Australian study of intensive child and family home visiting by professionals for at risk mothers living in a disadvantaged community The study commenced antenatally and continued until the children were two years of age.

My world triangle. A tool used to assess a child's wellbeing by considering their development, needs, and the impact of their wider world, including family, friends, and community. Part of **GIRFEC** framework developed by the Scottish Government.

Named health visitor. A health visitor allocated to families to provide consistency of care to families.

Named person. A clear point of contact for children, young people or their families when they need support for their wellbeing. The named person is a point of contact within universal services they can contact for information, advice or help. For children under 5 the named person is the HV, for school age children it is the headteacher. Part of GIRFEC principles (see **GIRFEC**).

Non-committal literature review. A literature review that gives no definitive opinion or intention.

Ontology/ontological. The philosophical study of existence and reality itself. It is about what exists and what does it mean to exist.

Open coding. See **Coding.**

Outcomes. The way something turns out, the consequences to the person.

Paradigm. A worldview, complete with assumptions associated with that view.

Paraprofessional. An individual who is assigned specific professional tasks but is not licensed to practice as a fully qualified professional. Examples include nursery nurses and community early years practitioners within health visiting or early years teams.

Participant observation. A research technique gathering observational data of a situation which the researcher is part of.

Preconception. The time before conception or the beginning of pregnancy.

Postnatal. The time after the birth of a baby, the postnatal period considered to be 6 to 8 weeks after the birth.

Primary prevention. The reduction of the number of new cases of a disease, disorder or condition in a population. It includes activities such as immunisation, prevention of accidents and child abuse, advice and support for parents.

Purposive (or initial) sample. A deliberate selection of participants or data sources in research based on their relevance to the research question.

Glossary

Qualitative research. Research that explores and interprets the meanings, experiences, and perspectives of participants through non-numerical data like interviews, observations, and texts.

Quantitative research. Research that involves collecting and analysing numerical data to identify patterns, test hypotheses, and make predictions.

Reciprocity. The dynamic interaction between two individuals when they are attuned to each other's emotions and needs and respond to these in a respectful manner.

Salutogenic. A proactive, health-promoting approach that is solution-oriented and enhances personal and situational strengths and resources.

SHANARRI. An acronym for a framework used in Scotland to measure and promote the wellbeing of children and young people across eight indicators: Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible, and Included.

Social constructivism. A research concept that recognises that reality is constructed by people who experience it and that research is a process of reconstructing that reality.

Straussian grounded theory. An adaptation of grounded theory first developed by Anselm Strauss and Barney Glaser (1967) that was developed by Anselm Strauss.

Sub category. See **Category**.

Sub code. A sub code is part of the substantive coding process. Sub codes are used to describe and categorise the data at a basic level being subcategories or sub-themes that fall under a broader main code or category. They help to further refine and specify the data, making it easier to analyse and understand the relationships between different concepts.

Substantive coding. Substantive coding involves breaking down data into smaller components to identify key concepts and categories.

Substantive theory. A theory that is produced in relation to the phenomena being studied and makes no generalisations beyond that phenomena.

Symbolic interactionism. Symbolic interactionism is a sociological framework that focusses on the ways people create and interpret meanings through their interactions with others. The importance of symbols such as language, gestures, and objects is at the core, as well as the meanings assigned to them.

Targeted Programmes. Delivery of a programme of health care that is for people with specific health needs or risk factors in order to improve their health and social outcomes: for example: smokers, young parents under 20 (See **Family Nurse Partnership**) parents with little social support, late receiving antenatal care, living in poor social conditions and in poverty, mental health problems such as depression, drug and alcohol issues, domestic violence, and risk of abuse.

Theoretical coding. See **Coding**

Theoretical memos and memoing. During coding the researcher breaks off to write down ideas about the codes they are working on. The writings are called **memos**.

Theoretical sampling. Deciding on analytical grounds where to sample from next.

Glossary

Theoretical saturation. The point in coding when no new codes are identified relating to a particular category.

Universal health visiting pathway (Scotland). A standardised framework for supporting families from pregnancy to preschool, emphasising early intervention and tailored care. It focuses on prevention, relationship-building, and aligning with policies like GIRFEC.

Universal services. Provision of a minimum level of care and support to all children within Scotland through health education or social care that promotes health, provides health education and guidance where needed and helps identify those at need so that additional services can be targeted to them.

Chapter 1: Introduction and Background

1.1 Introduction

Health visitors (HVs) support pre-school children and their families to maximise their life chances by delivering a universal service that promotes healthy child development, improves public health, and reduces health inequalities (Cowley et al. 2013; Scottish Government 2007; Scottish Government 2013; Scottish Government 2015a). In 2016, a national directive for a universal programme of HV delivery for families was implemented in Scotland. The HV antenatal visit between 32 and 34 weeks of pregnancy is the first contact on the programme when HVs and parents meet for the first time (Scottish Government 2015a).

The core health visiting principles of relationship building, home visiting and needs assessment are likely to occur at the HV antenatal home visit as they have been recognised as happening at HV contacts with families (Cowley et al. 2013). However, there is little information about how the principles present in practice in the antenatal period or for core families that are not high risk or have no additional needs (Elkan et al. 2000; Cowley et al. 2013).

The purpose of the research is to explore the social process of the HV antenatal home visit and address the following question:

What are the perceptions and experiences of expectant parents and HVs about the process of the HV antenatal home visit?

The findings are significant for HV clinical practice as theory is generated from the data collected which helps understand the perceptions and experiences of expectant parents and HVs. The theory helps inform the development of the HV role at the antenatal visit and aims to improve the health and wellbeing of families and the unborn baby.

The term mother and father has been referred to in the thesis as it was the terminology used within reviewed literature and by participants. Any reference to my original work may refer to *expectant mother or expectant parent* for the person who is biologically expecting the baby, and *partner* as being their partner. '*Expectant parent*' refers to either expectant mothers or their partners, unless stated otherwise.

Any references to *parents* apart from data collection and findings are used in the thesis to be gender and sexuality inclusive for lesbian, gay, bisexual, transgender, queer or questioning, intersex or asexual (LGBTQIA+) individuals who were not represented.

1.2 Organisation of the Thesis

This thesis researches the perceptions and experiences of expectant parents and HVs during the antenatal visit. Chapter 1 introduces the study, detailing its background and situating the research within its clinical context.

In Chapter 2 an analysis of the literature is presented, alongside a detailed explanation of the search methodology within the context of a CGT framework. By critically examining and synthesising the available research, the chapter identifies evidence gaps, emphasising the necessity for the proposed research approach. The limited availability of relevant studies serves as a basis for the study's justification. Finally, the chapter sets out the study's objectives and introduces the research question, shaped by the knowledge acquired through the review process.

Chapter 3 outlines the rationale behind the chosen methodological approach, supported by evidence from relevant literature. It outlines the use of a qualitative research design within a CGT framework, explaining how the research question shaped the choice of methodology and offering a robust rationale for a grounded theory informed qualitative approach. The seminal contributions of Glaser and Strauss (1967) and Glaser's subsequent work (Glaser 1978; Glaser 1992) on

grounded theory are examined in depth. The decision to apply a CGT methodology is explored, along with an analysis of its key strengths. The chapter closes by highlighting the advantages of utilising a CGT methodology, including its effectiveness in deeply exploring the HV antenatal visit, enabling the construction of conceptual models, and contributing to the formulation of a new theory.

Chapter 4 outlines the methods employed in the qualitative research design, utilising a CGT approach to address the study's research question. This chapter details the ethical approval process, which involved the University of Stirling research committee, the NHS North of Scotland Research Ethics Service, and the NHS Health Board (R,D&I) department. It also explores the strategies of initial and theoretical sampling alongside the data collection methods, including observations and unstructured interviews. The data analysis process involved constant comparative analysis through coding, identification of categories, and the development of a core category. These steps were essential in formulating a new substantive theory specific to the HV antenatal home visit.

Chapter 5 presents the findings of the research, which focused on examining the social processes involved in the HV antenatal home visit. The findings provide valuable insights into the experiences and perspectives of both parents and HVs regarding what happens during these visits. The chapter proceeds by detailing the main categories that developed from the core category and concludes by outlining the theoretical codes that contribute to the development of the new substantive theory.

Chapter 6, serving as the concluding chapter, examines the newly developed substantive theory originating from the research study. It presents the insights gained regarding the HV antenatal home visit. The chapter opens with an overview of the substantive theory and the theoretical codes that emerged. This is followed by a critical analysis of the theory in the context of existing literature. Finally, the chapter examines the study's strengths and limitations, its relevance to clinical practice, and potential avenues for future research.

1.3 Background

HVs are healthcare specialists who work with individuals, social groups, and communities, with a clear goal to promote health and prevent disease. They provide care and support to pre-school children and their parents, ensuring the protection and promotion of the health and wellbeing of both children and families (Horne and Owen 2022). HVs address the physical, emotional, and social wellbeing of individuals, with a focus on reducing health inequalities and addressing deprivation (Cowley and Frost 2006). The HV role is underpinned by four principles: 'searching for health needs'; 'the stimulation of an awareness of health needs'; 'the influence of policies affecting health'; and the 'facilitation of health enhancing activities' (CETHV 1977; Cowley and Frost 2006; Horne and Owen 2022). The principles are still relevant today and form the foundation for the current spheres of practice for specialist community public health nurses such as HVs, school nurses, occupational health nurses and public health nurses (NMC (Nursing and Midwifery Council) 2022).

Policy directives have changed the focus of HV practice across the UK to early intervention influenced by evidence about neurodevelopment in babies and parenting from Harvard University Center on the Developing Child and the Early Years Foundation (National Scientific Council on the Developing Child 2020; Early Intervention Foundation 2020). International and national directives and legislation focussing on the health and wellbeing of children and young people and their social, civil, and political rights have played a significant part in the changes in HV practice. They include: The United Nations Convention on the Rights of the Child (UNCRC), (UNICEF 1990, United Nations Children's Fund);

The Children and Young People Act (Scotland) 2014, *Health for all children* (Hall and Elliman 2006; Scottish Government 2005). Also a national assessment framework for assessing and promoting children's health and wellbeing known as GIRFEC (Getting it Right for Every Child) (Scottish Government 2022a). Social policy frameworks that address health inequalities such as the *Early Years Framework*, *Equally Well*, and *Achieving our Potential* also influenced HV practice

(Scottish Government 2008a; Scottish Government 2008b; Scottish Government 2009; Scottish Government 2011a).

In line with the focus on early intervention, the HV role in Scotland has undergone substantial changes through the introduction of improved ways of working, standardisation of HV practice and increased structured home visits. The changes were achieved through the provision of a universal HV service to all families with young children (Scottish Government 2015a). The visiting commences with the HV antenatal home visit which is the area of interest for the research study.

There is a paucity of information about the HV antenatal home visit in universal services. Some insight was obtained about antenatal visits in Australia by Kemp et al. (2006) from a family nurse home visiting programme targeted for high-risk families. Preventative care, preparation for parenthood, family wellbeing, maternal health and goal setting with families were highlighted as family nurse interventions. However, it is unknown how family nurse roles in Australia compare to the HV role in Scotland or how a programme of interventions compares to one single antenatal visit by a HV. Further research would be required to find out if the antenatal visits in the targeted interventions had any relevance to the HV antenatal visit in the UK.

Both international and national systematic reviews of literature have concentrated on critical aspects of health visiting practice, including home visits, needs assessments, and the development of relationships (Elkan et al. 2000; Cowley et al. 2013; Cowley et al. 2015). However, the studies cited within these reviews primarily focus on targeted interventions during the postnatal period, with no specific reference to antenatal visiting. It is therefore uncertain how the HV practice of home visiting, needs assessment and relationship building apply specifically to the universal HV antenatal home visit.

There is limited research exploring parental experiences or perceptions of the antenatal visit. A scoping review of academic literature examining service users' experiences and perspectives on HV practice in England revealed that the majority of parents had not encountered their HV during pregnancy. For those who did, the

interaction was appreciated for fostering relationships, providing information about the HV service, and setting expectations for their engagement with the HV (Donetto et al. 2013). The existing literature provides minimal insight into the dynamics of the HV parent relationship during the antenatal period. Additional investigation is necessary to examine how relationships between HVs and parents evolve across various settings of interaction (Cowley et al. 2013), including the antenatal visit. As the initial visit outlined within the universal HV programme of contacts with families (Scottish Government 2015a), the antenatal visit holds significance. However, it has not been consistently conducted by HVs for all expectant parents. Investigating the HV antenatal visit is essential for gaining insights into how HVs can strengthen relationship building, provide effective support to expectant parents, and maximise the impact of antenatal visits.

The following section provides an explanation of the clinical context that supports the decision to conduct a research study on the HV antenatal visit

1.4 Clinical Context

Comparable to public health nursing roles in other nations, including the USA, the HV role is designed to improve outcomes for children while addressing health inequalities affecting children and families (Doi et al. 2017; Kulbok et al. 2012; Scottish Government 2013; Scottish Government 2015a; Scottish Government 2022b). This study focusses on universal health visiting practice concentrating on the antenatal home visit. The next section provides further information on the Universal health visiting pathway and its development across the UK before concentrating on development within Scotland where the study takes place.

Universal health visiting refers to a public health service model aimed at improving family health and reducing health inequalities (Cowley et al. 2015). This model is linked to the strengthening of the health visitor workforce, professional development, and service delivery in England, known as 'A Call to Action.' (Department of Health 2011). It is part of a preventative health programme for children from conception to

five years of age which emphasises the importance of early intervention and support for all families with young children, regardless of their background or risk level. Health visitors play a crucial role in providing this service, which includes home visits, parental guidance, child development reviews, and support for nutrition and emotional well-being. The goal is to build trust and continuity between families and health visitors to improve health and wellbeing outcomes for children from birth to five years. This focus addresses health inequalities that arise from the social conditions people are born in to and live within (Cowley et al. 2015).

Children who grow up in socially and economically disadvantaged areas tend to experience poorer long-term health and developmental outcomes (World Health Organisation 2018). The gap between the health and well-being of children from wealthier backgrounds and those from poorer backgrounds is widening in the UK (Marmot et al. 2020). Within universal health visiting across the UK the approach to reduce the gap is known as proportionate universalism where a targeted approach is offered in response to identified need according to the social determinants in their areas (Marmot et al. 2010; Moseley and Phillips 2022).

The first three years of a child's life are crucial for their future development (Bellis et al. 2016; Center on the Developing Child 2019a; Center on the Developing Child 2019b; European Foundations for the Care of Newborn Infants 2020, Powell 2019). During the first 1001 days, from conception to a child's second year of birth, children form attachments with family members and caregivers, and their brains undergo significant development that forms the foundations for future health and wellbeing (Center on the Developing Child 2019a). This period is also when children begin to explore, learn, and communicate rapidly. Additionally, early childhood experiences can influence gene structure, a concept known as epigenetics (Center on the Developing Child 2019b). Policies and frameworks across all UK nations address the first 1001 days (1000 in Wales) by early intervention strategies to address health and wellbeing outcomes tailored to their regions (Black et al. 2019; H.M Government 2021a; NHS Wales 2023; Scottish Government 2025). They provide support to expectant parents and families during this time to promote nutrition, address children at safeguarding risk, foster positive child development, positive parent and

infant relationships, promote infant mental health, and address health and wellbeing outcomes. Early prevention and intervention strategies are a sound economic move for governments in investing in preventing ill health rather than finding a cure (Department of Health Northern Ireland 2010; HSC Public Health Agency Northern Ireland 2025; H.M Government 2021a; H.M Government 2021b; Scottish Government 2023; Welsh Government and NHS Wales 2022). The policies for each nation are linked to their universal early intervention public health approaches and frameworks for child health surveillance, immunisations, and health promotion (Department of Health 2009; Department of Health Northern Ireland 2010; Scottish Government 2015a; Welsh Government 2009).

Universal antenatal health visitor contacts across the UK are directed by the Home Office, with each country setting its own priorities. In England, the contact occurs at 28 to 36 weeks of pregnancy, either at home, a health or child centre, or via telephone. Northern Ireland also conducts a home visit around 28 weeks. In Wales, the visit is at 28 weeks for first-time parents, with additional targeted contact for those with identified needs. In Scotland a home visit occurs at around 32 to 34 weeks of pregnancy (Department of Health 2010; HSC Public Health Agency 2025; Scottish Government 2015a; Welsh Government 2009).

The implementation of universal HV practice was implemented in Scotland in 2015 via a Universal HV Implementation Plan (Scottish Government 2015a). Prior to its development there was a child health programme delivered by HVs and other health professionals for children from birth to 5 years and their families (Scottish Government 2011b). The program included activities such as monitoring child health, promoting health and wellbeing, offering parenting support, and in certain localities, administering childhood immunisations (Doi et al. 2017). Delivery was by HVs and skill mix within the HV teams from community staff nurses and nursery nurses or early years practitioners.

Attention to children's rights on an international scale (UNICEF 1990), alongside the enactment of the Children and Young People (Scotland) Act 2014 at the national level, led to a shift in emphasis toward early intervention and the promotion of

children's health and wellbeing through the delivery of universal services (Scottish Government 2015; Scottish Government 2022b).

The role of the HV was reviewed and refocused to meet the new national agenda, as well as to address a disparity of HV services across Scotland highlighted by a scoping exercise in 2013 (Scottish Government 2015a). With a change of title from Public Health Nurse to Health Visitor, the HV implementation plan ascertained the HV role as specifically targeted at birth to 5 years, including preconception. It set out national guidance on the core components of the HV role to help standardisation of practice through structured HV home visiting (Scottish Government 2015a). The shift in focus also introduced the Named Person role, a key responsibility of HVs, serving as a designated point of contact within universal services for children or families seeking information, guidance, or support to address their wellbeing needs (Scottish Government 2022a; Scottish Government 2022c).

The guidance also gave clarification to the level of need in families, known as a Health Plan Indicator (HPI). The level of HV service can then be assigned to provide the necessary support for the required level of need. An additional HPI indicates:

“That the child (and/or their carer) requires sustained (>3 months) additional input from professional services to help the child attain their health or development potential. Any services may be required such as additional HV support, parenting support, enhanced early learning and childcare, specialist medical input, etc” (Scottish Government 2015a, p.5).

A core HPI is a child or family having no identified additional needs that would be offered the Universal Health Visiting Pathway (Scottish Government 2015a) without any additional support. The HPI is reviewed regularly so that if additional needs arise at any time the HV offers or finds the most appropriate support to meet those needs (Scottish Government 2015a).

Prior to the HV implementation plan, HVs within the research study Health Board targeted antenatal visits only to those expectant parents who had an additional HPI identified by the midwife. The refocus of the antenatal visit emphasised provision of early engagement for all expectant parents regardless of HPI allocated by the

midwife. The provision of antenatal visits to families with a core HPI was a change in HV practice in the Health Board area. The refocussed guidance aimed to identify and address all expectant parents' health or wellbeing needs, any potential risks or concerns and offer the right support and resources to prepare expectant parents for their baby's arrival. The goal of the guidance is to ensure expectant parents feel supported and informed throughout their pregnancy journey (Scottish Government 2015a).

As part of the Government recruitment drive to provide enough HV posts to deliver the Universal Health Visiting Pathway several HV trainees were undertaking the HV training programme in the Health Board at the time of the research study (Scottish Government 2015a). As a HV practice assessor, previously known as a practice teacher, my role involved supporting and assessing the HV trainees in developing their HV roles in practice. Focus on the antenatal visit came from personal interest in it being the first visit in the Universal Health Visiting Pathway of visits. Although there was direction on the content of the visit (Scottish Government 2015a) my personal reflection was that I was familiar providing antenatal visits to antenatal families with additional needs but providing antenatal visiting to all expectant parents rather than just for families with additional needs was a change in practice. I reflected on how the delivery of antenatal visits to core expectant families, as opposed to solely those with additional needs, might differ in practice. Some trainee HVs and other HV colleagues had also raised similar thoughts. It gave the impetus to explore the evidence about core antenatal visits further to help inform clinical practice.

A realistic evaluation of the Universal Health Visiting Pathway in 2017 (Doi et al. 2017) provided insight from HV and parent perspectives about the pathway. However, the HV antenatal contact was not included in the evaluation so no new evidence was obtained. With a paucity of literature, exploring the HV antenatal visit appeared to be the best way to learn about it.

Utilising a classic grounded theory research approach the social processes of the HV antenatal visit are explored between expectant parents and HVs. Social

processes within grounded theory are defined as patterns of behaviour and interactions that develop over time within specific social contexts and reflect on how individuals adjust and transform in response to their circumstances and roles (Glaser and Holton 2023). Discovering more about the social processes that occur between HVs and expectant parents from their discussions, experiences and perceptions of the visit might provide insight of what it entails. Findings of the study will help inform the development of the HV role in the antenatal period and the care provided for expectant parents.

1.5 Chapter 1 Summary

The HV antenatal home visit is the first step in a programme of HV universal home visiting to families expecting a new baby (Scottish Government 2015a). Aspects of HV practice such as relationship building, home visiting and needs assessment are known to take place when HVs have contact with families (Cowley et al. 2013). However, little is known about the HV antenatal home visit. In particular what social processes occur during the visit, and what HVs and parents' experiences and perceptions are about the visit. This chapter introduced the thesis and presented the clinical context to the study. The next chapter critiques literature leading to the research strategy.

Chapter 2: Literature Review

The literature review chapter offers a non-committal analysis of existing research and describes the search strategy employed within a CGT framework. By examining and synthesising the research literature, it highlights gaps in the evidence, thereby justifying the need for the proposed research study.

2.1 Non-Committal Review of the Literature and Search Strategy

In CGT methodology, Glaser (1998) recommends postponing the review of existing literature related to the research area until the theory emerges naturally from the research process, rather than conducting this exploration at the start of the study.

Literature is typically examined at the beginning of the study to identify gaps in the current body of knowledge in other research methodologies, to refine the formulation of the research question, and establish an appropriate study design and data collection approach (Hallberg 2010). The rationale for the delay in CGT is that existing literature may not be relevant to the research study and might influence the process of developing theory, detracting from the originality and quality of the study (Dey 2007; Glaser 1978; Glaser 1998).

The literature review occurred at two different stages whilst being cognisant of the CGT approach to the literature and meeting requirements for gaining ethical approval for the study (Birks and Mills 2015). The first stage was the initial non-committal review to meet the requirements of doctoral study for a thorough review, which this chapter focusses on. In this thesis, the term 'non-committal' is employed as originally described by Urquhart (2013, p. 29). The concept highlights the role of the literature review not as a means to form or express an opinion, but as a tool to aid the researcher in understanding the nuances, concepts, context, and gaps within the research topic (Urquhart 2013).

The second stage of reviewing the literature occurred once the theory had been generated from the data and is referred to in Section 6.3

The initial non-committal literature review analyses four research papers. Due to the sparsity of literature available the review also draws on other relevant literature such as policy directives and seminal research about HV targeted programmes of intervention and postnatal studies on relationship building to provide more insight about the HV antenatal home visit. The literature review was regarded as a draft after completion due to the uncertainty about its relevance to the research study (Urquhart 2013). The literature played a role in informing the analysis rather than shaping its direction. Once the theory was derived from the data analysis in the research study (section 6.2), the significance of certain literature from the non-committal review became evident (Urquhart 2013). Additional literature was then utilised to further develop the theory (Glaser 1998).

Reviewing literature about the HV antenatal home visit provided insights into existing knowledge about the phenomenon. It helped orientate to the area of study without necessarily influencing towards existing theoretical ideas about it (Birks and Mills 2015). By maintaining theoretical sensitivity (section 4.6.3), using constant comparison (section 4.6.1) and memo writing (section 4.6.4) in addition to carefully adhering to CGT methodology, the principle of remaining receptive to concepts emerging from the data itself, rather than being influenced by the literature, was upheld (Glaser 1998; Andrew 2006).

The review highlighted a gap in the existing literature concerning the HV antenatal home visit. This finding guided the formulation of the research question, influenced the design of the research proposal, and supported the process of securing ethical and research approval (Cone and Artinian 2009; Hewitt-Taylor 2017), as acknowledged by Glaser (1998).

Systematic searches of published papers were undertaken from the following databases: CINAHL (Full text), MEDLINE, PsycINFO, SCOPUS, Trip and ProQuest (British Nursing Index and Nursing and Allied Health database), Cochrane Database

of Systematic Reviews. Other searches included University of Stirling STORRE online digital research repository of theses, DOAR (Directory of Open Access Repositories) hosted by University of Nottingham, and University of Warwick Publications Service, contemporary books with seminal text on health visiting, professional bodies including the Institute of Health Visiting, and manual searches of selected paper's reference lists. The original search was limited to 2000 to 2016 at the outset of the research study so that any papers incorporated policy changes relating to HV practice in the UK such as Every Child Matters 2004 (DH (Department of Health) 2004) and Getting it Right for Every Child, originally introduced in 2008, and updated in 2022 (Scottish Government 2022c).

The search for literature was carried out using a selection of the following terms: health visitor, public health nurse, health practitioner, FNP, family nurse, child and family nurse, family and child nurse, plunket, antenatal, antenatal care, antenatal education, pregnancy or gestation or trimester, family, parent, husband, wife, partner, spouse, maternal, paternal, carer, relative, peer, attitude, perception, experience, belief, effect. A decision was made to use search terms for other professionals who provide antenatal care in similar roles to a HV. Midwives, whose role is to provide antenatal care to expectant parents was not specifically included in the search terms in order to keep the focus on the phenomenon of the HV role. By utilising the terms *antenatal*, *antenatal care* and *antenatal education* in the search any relevant evidence from other health professionals involved in antenatal care would be sourced.

Clear criteria were set out to reflect the aim of the literature search in being broad and exploring existing knowledge about the phenomenon of the HV antenatal contact (Birks and Mills 2015). As interest in the study was from the perspective of HV universal service provision (Scottish Government 2015a), targeted interventions were excluded from the search criteria unless there was a specific focus on the antenatal contact. There needed to be evidence about home visiting as that is where the HV phenomenon of interest took place, during the antenatal period, and needed to be provided by a HV or equivalent health care professional. Table 2.1 summarises the inclusion and exclusion criteria for the literature review.

Table 2.1 Inclusion and exclusion criteria for literature review

Inclusion Criteria	Exclusion Criteria
Home visiting in the antenatal period	No antenatal contact
Completed by HV or equivalently qualified professional internationally	No home visits
Has information about content of antenatal visit	No client (parent) contact
Interventions related to universal HV service provision	Targeted HV interventions with specific outcomes such as domestic violence, smoking cessation, teenage parents unless the antenatal contact was focus of the study

2.2 Findings of the Literature Review.

Despite conducting an extensive search, the literature on the HV antenatal home visit remains limited. Only four articles were identified for inclusion in the review. The results of the literature search, along with the rationale for selecting these papers, are presented before analysing the findings from the selected publications.

The literature search, conducted using the specified search terms and data sources, resulted in the identification of a total of 86 articles (section 2.1) after excluding duplications. Screening of the articles eliminated 70 unrelated articles of which two were international Health Technology Assessments (HTA's). They were in other languages relating to health visiting in Austria (Winkler et al. 2012), and home visiting in public health in Malaysia (Malaysian Health Technology Assessment Unit 2000). Difficulty sourcing the documents and ability to access timeous translations within the limited timeframe and financial restraints of the study meant they were not included in the review.

The remaining 16 full text articles were assessed for eligibility relating to the inclusion and exclusion criteria. From the 12 excluded articles (Table 2.2) the majority of literature available related to targeted programmes of intervention, either midwifery led (two articles) or by HVs or other home visiting health professionals. One qualitative study involving HVs and parents was excluded due to being a postnatal study and not involving home visiting (Astbury et al. 2016).

Table 2.2 List of excluded articles

Excluded articles in date order	Description of article	Reason for exclusion
Oakley et al. (1990)	Midwifery antenatal intervention for mothers who previously delivered low birth weight babies.	Targeted programme. No HV involvement.
Black et al. (1994)	American randomised controlled trial visiting programme for women with drug issues.	Targeted programme. No HV involvement.
Elkan et al. (2000)	HTA systematic review of effectiveness of international and UK HV home visiting programmes, early years and elderly, 1962 to 1997.	Targeted programmes.
Tappin et al. (2005)	RCT. Glasgow midwifery led antenatal smoking cessation support using tel. contact and home visits.	Targeted programme. No HV involvement.
Sharps et al. (2008)	Literature review on American targeted programme related to domestic violence.	Targeted programme.
Turnbull, C and Osborn, D. A. (2012)	Cochrane Review antenatal and postnatal visits for alcohol or drug problems.	Targeted programmes. Mainly postnatal studies.
Penfold, J. (2015)	FNP Targeted programme for teenage parents in London area of deprivation.	Targeted programme.
McLackland, B. (2015)	AN programme delivered by nursery nurses promoting emotional attachment between parents and unborn baby.	Targeted programme. No HV involvement.
Jennison, L. (2015)	Development of HV antenatal pathway for teenage parents.	Targeted programme.
Harris et al. (2015)	Welsh Flying Start Programme for areas of deprivation.	Targeted programme.
Astbury, R. et al.(2016)	Shared decision making between HVs and clients on wellbeing of children.	No antenatal. No home visiting.
Fontein- Kuipers et al. (2016)	Dutch midwifery led antenatal programme aimed at reducing maternal stress	Targeted programme. No HV involvement.

The four remaining papers covered different aspects of the HV antenatal contact. Three of the papers involved pilot projects that utilised quantitative research methods involving surveys with parents and/or health professionals (Kemp et al.

2006; Monaghan and Owen 2012; Curtis and Davidson 2013) The final paper through a narrative review of the literature provides a UK picture of the HV antenatal contact and highlights evidence that supports the promotion of a universal HV antenatal home visit in Scotland (Christie 2016).

There was a variability in the presentation of the research methods within the three quantitative papers. Kemp et al. (2006) demonstrated robust research methods (Critical Appraisal Skills Programme (CASP) 2012). The development of the prepopulated checklist research tool was explained fully. Statistical factor analysis interventions and their possible association with any particular characteristics of the study were also thoroughly explained. However, Monaghan and Owen (2012) provided sparse information about the evaluation tool or about the outcome of the evaluation. Curtis and Davidson's (2013) survey questionnaire was observed to have errors after they were distributed which may have affected the reliability of the results (Bryman 2016). The published results of some of the answers showed little relevance to their questions. Caution therefore needs to be applied in relation to the credibility of Curtis and Davidson (2013) and Monaghan and Owen's (2012) findings, the weak presentation of their research methods and outcomes (Noble and Smith 2015).

The literature review identified three themes about the HV antenatal visit: relationship building; location and type of HV contact; and content of the antenatal contact, each are discussed in turn.

2.2.1 Relationship building

All included papers raised the issue of relationship building ranging from ways HVs attempted to engage with parents, feedback from parents and HVs about the HV contact, or exploration of aspects of the HV role in relationship building during antenatal home visits.

In their efforts to provide a needs led HV antenatal contact to expectant parents Curtis and Davidson (2013) surveyed 44 expectant mothers who were due to receive an antenatal HV contact, of which 82% requested individual face to face contact with their HV, and approximately half of those mothers valuing the importance of their partner also being present at the contact. There was no information on the reasons for the choices. Only expectant mothers receiving community midwifery care were included in the study, so any mother under the care of hospital maternity services did not get their voices heard, giving an incomplete picture of the expectant mothers in the study area. The HVs were at an early stage in relationship building, focussing on ways to engage with parents. Christie (2016) noted that parents first impressions with their HV establishes how they view the whole HV service and their eagerness to engage with the service, as recognised in core HV practices such as needs assessment and relationship within postnatal studies (Appleton and Cowley 2008; Cowley et al. 2015). The lack of evidence relating to initial contacts and first impressions of HVs by expectant parents within antenatal studies suggests further exploration was required.

Monaghan and Owen (2012) in their implementation of a universal HV antenatal home visit at 36 weeks of pregnancy aimed for HVs to build supportive relationship with expectant parents, and to promote relationship building between infants and their mothers in terms of emotional attachment. HVs stated they wanted to establish relationships that promoted familiarity between HVs and clients which they saw had developed from the study. However, their pilot involving 14 expectant women and 3 male partners, did not provide any further information about relationship building apart from stating all evaluations gave positive feedback. The sparsity of literature about relationship building between HVs and expectant parents in the antenatal period indicates further evidence is required.

Expectant mothers expressed a preference for face to face interactions with HVs (Curtis and Davidson 2013), as also observed in postnatal breastfeeding research, where mothers desired in person contact with HVs to foster relationships and create a comfortable environment for discussing personal matters (Brodrribb and Miller 2014; Lee 2013). However, the reasons underlying expectant mothers' preference

for face to face engagement remain unexplored, indicating the need for further investigation.

Working in partnership was identified by Kemp et al. (2006) in their study of the role of child and family health nurses within a series of antenatal home visits for teenage parents or parents with identified risk factors. The study was an Australian targeted home visiting programme as part of a Miller Early Childhood Sustained Home-visiting (MECSH) randomised control trial (Kemp et al. 2008). Five child and family nurses, who have some similarities with the UK HV role, provided antenatal home visits to 91 expectant mothers and their families. All the nurses were highly skilled in therapeutic relationship building and strengths based approaches of the American Family Partnership model (FPM) as delivered under the Family Nurse Partnership (FNP) programme in the UK (Davis and Day 2010).

The child and family nurses recorded on a checklist every intervention they provided for each expectant mother and family they visited. The checklist consisted of 52 different interventions. Planning and goal setting interventions by the child and family nurses were cited as providing evidence of partnership working especially when related to the care givers own aims, goals and aspirations. It was the only paper to give insight into the HV or equivalent health professional's role and interventions during a targeted antenatal home visit. However, it highlights a gap in the literature about the HV role within a universal home visit suggesting future investigation would be beneficial.

The FPM is an internationally recognised evidenced based partnership practice model that influenced the MECSH trial (Kemp et al. 2008) and has been adopted in the UK (known as FNP (Family Nurse Partnership) by health visiting services, and New Zealand Plunket Society within universal and targeted public health service provision (Day and Harris 2013; Robinson et al. 2013). FNP focuses on goal setting with teenage parents by using the FPM strengths based approach of therapeutic relationship building in combination with parental expertise. Together they help facilitate change to improve parental health and wellbeing and subsequently improve their children's health and wellbeing outcomes (Day and Harris 2013;

Robinson et al. 2013). It can be seen that through the model of working in Kemp et al.'s study (2006) that relationship building is a large part of the child and family nurse's role. So too were aspects of the FPM approach recognised in Monaghan and Owen's study (2012) in relation to supportive relationship building. Although planning and goal setting interventions were cited as providing evidence of partnership working by Kemp et al. (2006) and Monaghan and Owen (2012) they did not elaborate on how the practice of partnership working presents in HV practice during those processes. Partnership working would benefit from further exploration, as also has been highlighted within HV practice by Bidmead and Cowley (2005). It would also be useful to know how much expertise is expected of teenage parents in order for change to be facilitated.

Child and family nurse, FNP and HV roles require comparable training at postgraduate level in similar topics relating to child and family health and wellbeing (Scottish Government 2024; NMC 2022) However, the child and family nurse role varies to the HV role in relation to differing programmes of service delivery. The Australian public health service provision was not generalisable to a UK health care setting.

The FNP model has demonstrated the value of sustained, emotionally attuned relationships between practitioners and young mothers (Davis and Day 2010; Day 2013; Day and Harris 2013). This evidence has informed universal health visiting policy and practice by reinforcing the importance of HVs building trust based, therapeutic connections particularly during the antenatal and early postnatal phase, where continuity and empathy are central to engagement. (Scottish Government 2015a). The FNP programme's individualised structured yet flexible approach centres on each family's unique strengths and aspirations (Davis and Day 2010; Day 2013; Day and Harris 2013). The approach has encouraged universal HV services to adopt more responsive and personalised practices. As a result universal HV practice puts children and families at the centre of care and support where timely early intervention and appropriate support aims to prevent escalation of health and wellbeing or safeguarding challenges. Health and wellbeing goals are co-created with families, fostering empowerment and promoting health and wellbeing outcomes

(Scottish Government 2015a; Scottish Government 2022a; Scottish Government 2022c).

HVs within the universal programme form longer relationships with families up until their children go to school between 4 and 5 years of age, unlike the FNP service in Scotland who work specifically with teenage parents under the age of 20 years, up until their children are two years of age. HV and FNP caseloads also vary. FNP service in Scotland have maximum caseloads of 25 families per whole time equivalent FNP professional compared to caseloads ideally being between 100 to 400 families per whole time HV depending upon the area of deprivation the HV works in (Robinson et al. 2013; Scottish Government 2024). No further information could be found on comparisons about the differences in HV and FNP practice and how they impact upon relationship building with families which suggests is an area that requires further exploration.

FNP literature identified in the initial non-committal literature review (Penfold 2015) was excluded as it did not meet the search criteria as it was a targeted intervention with no specific evidence relating to the antenatal home visit. However, FNP is referred to in the second part of the literature review (see Chapter 6) when the theory that developed from the data in the study identified a need to compare with existing theories such as FNP during the theoretical sampling process (Glaser 1998).

Engagement with partners of expectant mothers was limited in the literature. Curtis and Davidson (2013) gave their survey to community midwives to distribute to expectant mothers. Although mothers were asked about whether they wanted their partner at the HV contact, views from partners were not sought. Monaghan and Owen (2012) offered their pilot to expectant parents, the uptake was from 14 expectant mothers and three partners. There was no information as to how expectant parents were recruited to the study. Government directives in the UK recognise the need to engage both parents so that whole family wellbeing and need can be assessed and addressed (DH 2011; Scottish Government 2015a). What the

evidence from these studies suggests is that further research is required on how to engage and relationship build with all expectant parents.

The initial contact between HVs and parents within universal services is concerned with familiarising themselves with each other (Cowley et al. 2013). Parents decided how far to allow HVs access to their lives. Qualitative analysis of the relationship between HVs and parents (Bidmead 2013) highlighted key stages in relationship development. These included initial introductions, during which HVs explained their role, set ground rules, alleviated parental concerns, and discussed parental expectations. Effective relationship building involved activities such as explaining, clarifying, understanding, negotiating goals and aims, formulating strategies, implementing plans, and conducting reviews.

Additional details of Bidmead's (2013) study were unavailable. It therefore could not be ascertained as to whether the stages of relationship forming and building related to HV antenatal or postnatal encounters with parents. The antenatal HV contact is usually the first face to face encounter by expectant parents with a HV (Christie 2016) yet little is known about relationship building and when and how it takes place.

Further exploration of antenatal HV interactions could offer valuable insights into the process of relationship building and determine whether they align with the findings of Bidmead and Cowley (2005).

2.2.2 Timing and location of the HV antenatal contact.

Timing and location of the HV antenatal contact were mentioned by all the papers in the review. Contacts related to antenatal education sessions at children's centres or GP practices, or home visits, or were unspecified. Timings of the HV contact are addressed prior to exploring the types of antenatal contacts within the literature.

Timings of the antenatal contacts vary across the UK with each Government providing a directive that is interpreted locally. Northern Ireland has flexibility on

contact being any time after 28 weeks of pregnancy (DHSSPSNI 2010), Scotland being more prescriptive at between 32 to 34 weeks of pregnancy (Christie 2016; Scottish Government 2015a). Wales do not deliver a universal antenatal home visit but do provide a face to face home visit as part of their early years Flying Start programme, targeted at areas of deprivation, at 24 weeks of pregnancy (Welsh Assembly Government (WAG) 2013). Contact in England is between 28 and 36 weeks of pregnancy (DH 2009) although Christie (2016) highlighted several NHS Trusts had been implementing an antenatal home visit for women between 26 and 32 weeks of pregnancy suggesting that local implementation of the directives have some flexibility.

In their survey of what expectant mothers wanted from a HV antenatal contact, Curtis and Davidson's (2013) timing of their antenatal sessions were more about the time of the day or week to hold the contact rather than at what stage of pregnancy the mothers were at. Of the respondents, who were between 28 and 34 weeks pregnant, 48% chose during the daytime whilst 38% of the respondents requested weekend contacts. Expectant mothers are often still working when antenatal classes commence and miss out on opportunities to gain information from HVs and midwives about the birth and feeding (Cowley et al. 2007). There were no reasons highlighted by Curtis and Davidson's (2013) respondents as to their choices so it was unclear whether work was a factor or whether mothers at different stages of pregnancy had differing needs for appointments at certain times.

Monaghan and Owen (2012) implemented their pilot universal HV antenatal home visit in the Northwest of England at 36 weeks, later in pregnancy compared to Government directive due to the deadlines for reporting their pilot as part of a DH (2011) *Call to Action* development group. The findings lacked detail of the evaluation by expectant parents and HVs suggesting an area to investigate. As the home visit was planned for future delivery at an earlier stage of pregnancy, evaluation at that stage needs to be considered.

The four Governments across the UK recognise the importance of supporting children across their life span, including the antenatal period, which is reflected in

their more recent directives for the antenatal contact within universal HV service provision to be in the home (Christie 2016; DH 2009; DH 2011; DHSSPSNI 2010; Scottish Government 2015a). Prior to Scotland's directive to move towards a HV antenatal home visit, antenatal contact locations were unspecified and could be a telephone call, letter, or contact outside of the home such as GP surgery or midwifery clinic (Christie 2016).

Curtis and Davidson (2013) and Monaghan and Owen (2012) provided different locations for their HV contacts, both being influenced by the Healthy Child Programme in England (DH, 2009: DH 2011) using contacts that considered the needs of the area and parent centred approaches.

Curtis and Davidson (2013) piloted a three session antenatal course with the HV running the first session at the local children's centre during the day in response to parental feedback where the majority of respondents stated meeting other expectant parents was moderately important to them, and small groups were considered an option to receive antenatal information (27% of respondents). However, this approach appeared to conflict with the fact that the majority of respondents had asked for individual face to face contacts with their HV at the GP surgery (59% of respondents), rather than at home or at a children's centre (a combined response of 36% of respondents).

Curtis and Davidson (2013) received no attendees at their antenatal session which they stated had reinforced the study findings that groups were not wanted by the respondents. The pilot HV antenatal contact appeared to conflict with the aim of their study to identify the needs of clients and listen to what they want in providing the HV antenatal contact. Following the pilot Curtis and Davidson's (2013) recommendations were for first time parents to either be seen at the GP surgery by the HV when they have their appointment with the midwife or be seen at home which appears to respond more closely to the findings of the study.

The reason for the move to HV universal antenatal home visits being in the home has partly been influenced by the growing evidence base on targeted home visiting

interventions commencing in the antenatal period and continuing with the same care provider into the postnatal period such as FNP and MEC SH programmes (DH 2009; DH 2011; Elkan et al. 2000; Kemp et al. 2006; Kemp et al. 2008; Monaghan and Owen 2012; Scottish Government 2015a). Drawing on literature from postnatal mothers wanting face to face contacts with HVs identified the home environment as an ideal place for relationship building and a safe space for discussing sensitive issues such as domestic violence (Hall and Elliman 2006; Lee 2013; Brodribb and Miller 2014). Some women in great need of support and advice in the antenatal period had not undertaken antenatal classes as they were scared, being unwilling to share their feelings with strangers (Christie and Bunting (2011). Home visits therefore are ideally placed for engaging women who are in greater need of the support of the HV service (Christie 2016).

2.2.3 Content of the HV antenatal contact.

Most of the articles mentioned content of the HV contact either from the perspective of what parents or HVs want the visit to contain or what interventions occur at the visit. Due to the sparsity of literature relating to the content of the universal HV home visit, evidence was sought from targeted interventions to provide more insight about them.

The antenatal home visit has been identified as an ideal opportunity to promote early intervention, reduce health inequalities, and discuss health promotion topics relating to core public health issues such as: parenting and promoting bonding and emotional attachment to the baby, prevention of sudden infant death syndrome (SIDS) and safety, financial inclusion, domestic abuse, immunisations, maternal emotional health and wellbeing, infant nutrition including the benefits of breastfeeding, tobacco control and substance misuse, oral health, discussion about the general wellbeing of the baby parents and family, and providing relevant information according to the needs of the family (DH 2009; DH 2011; Scottish Government 2015a; DHSSPSNI 2010).

In the planned research area, at the time of the literature review, the implementation of the HV antenatal home visit was yet to be fully rolled out nationally. Antenatal home visiting was not a priority for HV services prior to the HV implementation plan (Scottish Government 2015a) as highlighted in a *Service Review for All Children 4* (NHS Quality Improvement Scotland (QIS) 2010). Staffing shortages, mounting child protection work and financial pressures within the health boards meant that only 54% of HVs visited expectant women during the antenatal period in 2010. It was difficult to source any literature about the antenatal visit from a practice perspective in Scotland.

In England, expectant parents who had not yet experienced an HV antenatal contact expressed a desire to discuss topics such as baby development, feeding, maternal and child health, safety (including sudden infant death prevention), basic care, and the role of the HV during the anticipated contact (Curtis and Davidson 2013).

In the Getting to Know Your Baby HV antenatal pilot in Northwest England, HVs aimed to build supportive relationships with expectant parents using a motivational interviewing approach. Their goals included promoting parental bonding and attachment to their babies, preparing parents for the transition to parenthood, and facilitating the early identification of needs to provide appropriate support and referrals, if necessary (Monaghan and Owen 2012). During the antenatal home visits, needs assessments were conducted to identify any concerns, issues, or risks. Support and referrals to other agencies were offered where appropriate, with examples including identifying men with depression and women experiencing domestic abuse through the use of a specific screening tool. Topics of discussion were aligned with Scotland's core themes for the universal antenatal visit, such as preparing for parenthood and fostering parental bonding and attachment with their babies (Scottish Government 2015a).

The HVs in the pilot had been trained to deliver a motivational interviewing approach which the HVs evaluated as providing a family centred approach, using similar processes that Kemp et al. (2006) describe in relationship building (section 2.2.1). They also provided supportive relationships to parents. Parents who did not get an

antenatal visit were asked for a list of topics they would have liked to discuss with the HV but unfortunately no additional information about the topics was provided.

The antenatal contact often marks the first opportunity for a HV to observe the home environment, as antenatal care within universal services is typically provided by midwives through clinic-based appointments prior to this point (Scottish Government 2011b). Inadequate housing can significantly impact children's health, emotional wellbeing, educational outcomes, and future opportunities. The antenatal home visit offers a valuable opportunity to evaluate the home environment (Bidmead and Whittaker 2008) and to determine where the assessment of need takes place (Monaghan and Owen 2012). However, the limited evidence regarding whether such evaluations occur during HV visits, as well as the specific components of need assessment, highlights the need for further research in these areas.

Many interventions occur in targeted antenatal home visits by equivalent roles to HVs. In Kemp et al's study (2006) more than 50% of mothers and their families received interventions from child and family nurses within six of eight identified areas that included: parentcraft preparation; maternal wellbeing; maternal mental health; family wellbeing; planning and goal setting; and environment and resources. Mothers averaged 27 years of age and 26 weeks gestation. The most common risk factors identified were maternal depression (45% of the 91 mothers) and family depression (61 % of eligible consented families). Visits averaged 2.3 in the antenatal period from a range of 0 to 11 visits and the more visits that took place the more comprehensive the care that occurred. The MECSH trial is a targeted programme compared with a universal home visit. It has a wide variety of interventions to address a number of risk factors and needs of teenage parents or families, as highlighted by Kemp et al's study (section 2.2.1). It is not known what interventions would be required for universal families where only one HV contact takes place in the whole antenatal period at a later stage of pregnancy (Scottish Government 2015a). More information is therefore required about what interventions one universal HV home visit would provide.

The HV perspective about the targeted interventions occurring at an antenatal visit were gathered but there was no information on when or how the interventions within the visit took place. Parental perspectives about the interventions were not captured, indicating further research is required in these areas.

2.3 Chapter 2 Summary of Literature Review

The HV antenatal home visit often serves as the first interaction between HVs and expectant parents, yet limited information is available about its process. The literature provides little evidence on how HVs engage partners of expectant parents or successfully connect with expectant mothers, despite understanding their preferences for antenatal contact. There is also a lack of clarity surrounding the dynamics of relationship building during the visit, including how supportive relationships or partnerships develop, the roles of HVs and expectant parents in these interactions, and parental perspectives on them. Additionally, while the home environment offers an opportunity for assessment during the antenatal contact, it remains unclear how and when needs assessments are conducted and how they are demonstrated in practice. Some HV interventions have been documented during these visits, but their timing, execution, and specific content within a universal home visit are not well understood.

The HV antenatal contact is regarded as an important face to face interaction for expectant mothers, whether held at a GP surgery, children's centre, or in the home. These visits are tailored to fit around the lifestyles and work commitments of expectant parents and are typically independent of their stage of pregnancy. Antenatal contacts may take place as part of parentcraft sessions with midwives at children's centres or through home visits, with the timing and format shaped by parental needs and the demographics of the area. Government directives and evidence from targeted home visiting programmes have influenced both the timing of these visits and the discussion topics, which focus on early intervention and reducing health inequalities. Despite expectant mothers expressing preferences regarding the nature of the contact, HVs often encounter challenges in engaging

them effectively. While expectant parents seek information on the HV role, baby development, health, care, and safety, HVs aim to assess needs and address topics related to risk factors and improving health and social outcomes.

At HV antenatal home visits, HVs focus on building supportive relationships and fostering partnerships with expectant parents. Partnership working involves HVs planning and setting goals that incorporate parental objectives.. Using motivational interviewing techniques, they adopt a family centred approach. Universal antenatal visits include key interventions such as assessing need, identifying expectant fathers with depression, and using specific tools to identify expectant mothers experiencing domestic abuse. The home environment provides an ideal setting for these assessments. Targeted antenatal home visiting programmes offer valuable insights into various home based interventions, including preparation for parenthood, parental bonding, attachment, and overall child, parent, and family wellbeing. The frequency, intensity, and content of visits adapt to increasing levels of need, often leading to referrals to other services.

The current gap in knowledge about HV antenatal home visits for core families suggests further research is necessary. Future studies should investigate how HVs engage expectant parents to provide antenatal home visits, as well as explore the types of interventions involved, including relationship building and needs assessment. Additional focus is needed to understand the roles of HVs and parents during these visits and to examine parental perspectives and views on the process.

2.4 Conclusion

This chapter presented a non-committal literature review and explored current understanding about the HV antenatal visit. There is evidence that the HV antenatal contact can be flexible as to where and when it occurs. Policy in Scotland however is more directive stating the contact is at home at 32 to 34 weeks of pregnancy and there is a clear framework and guidance on the content of the visit (Scottish Government 2015a). It is uncertain how the social process of the visit presents in

practice, and how the guidance is delivered within HV practice. There is some evidence of relationship building and identification of need occurring at the visit but further research is required on HV and expectant parent roles within the visit and their perceptions and views about it. Clarity on what interventions happen and how they develop at the visit is required especially in relation to relationship building and assessment of need.

The limited evidence available on universal HV antenatal home visits highlighted the necessity for the research and shaped the focus of the thesis. This study aims to address gaps in existing knowledge and contribute to informing clinical practice regarding the HV antenatal home visit.

The next chapter describes the development of the research question and explains the methodological choices to answer the research question.

Chapter 3: Research Methodology

3.1 Introduction

This chapter is the research methodology chapter which outlines a detailed justification for the selected approach, drawing on supporting evidence from the literature. To address the study's research question, a qualitative research design utilising a CGT framework was chosen.

Grounded theory seeks to deepen understanding of a phenomenon by collecting data and constructing a theory based on interconnected concepts that explain the phenomenon (Glaser and Strauss 1967). This chapter discusses how the research question shaped the methodological choices and provides justification for adopting a qualitative grounded theory approach. It also examines the purpose and nature of the research, the researcher's ontological and epistemological perspectives, and the various research methods available. The chapter concludes by affirming the adoption of a Glaserian CGT approach, drawing on the seminal work of Glaser and Strauss (1967).

This chapter explores the researcher's role, as well as their philosophical perspectives and beliefs, and is therefore presented in the first person.

3.2 Research Question

The research question was:

What are the experiences and perceptions of expectant parents and HVs about the process of the HV antenatal home visit?

The research question was developed from a variety of areas. Firstly a practice interest in the area of HV antenatal home visiting following a national directive on a

programme of HV service delivery involving antenatal home visits for all expectant parents (Scottish Government 2015a) (section 1.3). Secondly, discussions with other HV colleagues about experiences of undertaking the antenatal home visit, being role models for trainee HVs in the clinical area and sharing best practice about the visit gave impetus for investigating the visit further (section 1.4). Thirdly, the national guidance framework for the visit was explored to identify topic guides and application to practice (Scottish Government 2015a). Lastly, a non-committal review of the literature revealed a significant lack of evidence regarding the universal HV antenatal contact (Chapter 2: Literature Review).

Further research was recommended from the literature review around the social process of the visit including how HVs engage with expectant parents, what their roles are within the process and how relationship building develops. Little is known from a HV and expectant parent perspective about the social process that occurs. Exploring the perceptions and views of HVs and expectant parents about the HV antenatal visit would discover new meaning and understanding about the social process that occurs at the visit (Glaser 1978).

Exploration of the delivery of the national practice guidance at the HV antenatal visit was also advised from the literature review, including assessment of need (Scottish Government 2015a). The recommendations derived from the literature review guided an in depth exploration of the phenomenon of the HV antenatal home visit, aiming to uncover new insights, formulate theory, and contribute to the generation of new knowledge.

The research question aimed to investigate the experiences and perceptions of the universal HV antenatal home visit from the perspectives of expectant parents and HVs, with the goal of uncovering new insights and understanding. The research methodology and data analysis approach were guided by the research question to ensure it was effectively addressed. The following section provides a rationale for adopting a qualitative methodological approach.

3.3 Justification for Utilising a Qualitative Methodological Approach

Choosing the right methodological approach is vital as it is the framework for how research methods are applied from data collection, analysis of data, generating knowledge and relating it to clinical practice (Creswell 2014; Lacey 2015). Methodological approaches are determined by how social reality is viewed often known as a *worldview* (Cresswell 2018) which is:

“a basic set of beliefs that guide action” (Guba 1990 p. 17).

Paradigms are used to describe different schools of thought about social reality from within different disciplines, the relationship between the researcher and reality and what is deemed to be acceptable knowledge which then informs what should be studied (Bryman 2016; Creswell 2013; Creswell and Creswell 2018). Therefore, it is crucial to evaluate various approaches at the inception of a research study, alongside examining the role of the researcher, their philosophical perspectives, and beliefs, as well as the potential impact these factors may have on the study (Bryman 2016; Creswell 2013; Creswell and Creswell 2018).

Quantitative and qualitative paradigms represent two main approaches, each established in distinct historical and scientific traditions and characterised by unique philosophical perspectives (Bryman 2016; Creswell and Creswell 2018; Farrelly 2013; Lacey 2015; Punch 2013; Topping 2015). Both paradigms focus on addressing questions related to the nature of social reality (Bryman 2016). Both approaches are applicable to nursing research (Topping 2015) and are regarded as valuable in supporting the selection of the most appropriate methodological framework for this study.

Quantitative research follows the positive tradition developed from the biomedical sciences. It is often known as the scientific method as it follows the belief that the world is unchanging and predictable, and where truths arise from what can be studied as objects or observed and measured, guided by experience or experiment

(Topping 2015). Positivist beliefs are that scientific methods used in the natural sciences should be appropriate for studying social phenomena as it is possible to deduce universal laws to explain them (Bryman and Becker 2012; Creswell 2014; Topping 2015). For example, a social network is viewed as an independent object or entity that people participate in but which they can have limited impact upon. It is viewed as no more than a collection of connections between individuals and groups (Bryman and Becker 2012).

Quantitative research employs a deductive approach to establish the connection between theory and research. In this methodology, research questions are derived from an existing body of knowledge and subsequently tested to evaluate their accuracy (Bryman and Becker 2012). Existing theories are tested from formulation of a hypotheses about them, or statistical testing, using numbers, applying measurements and procedures to social life (Creswell 2014). Although measurements are technical tools and can be seen as very scientific, they do have some similarities to natural life and the frequency of what people do (Punch 2013). Quantitative research methods are often more associated with uncovering large scale social trends and relationships between variables, which depicts a static social reality (Bryman 2016).

Mathematics is seen as the science within positivism that has the potential to explain and predict human actions. Mathematics is reflected in quantitative research designs with their main purpose being to objectively measure concepts or variables in the data and the relationship between them. They are measured through statistical and numerical procedures, as reflected in the data analysis methods that are utilised (Creswell and Creswell 2018; Lacey 2015; Punch 2013). Examples of quantitative research designs include experiments, observational studies, using surveys with questionnaires, and epidemiological studies of incidence and distribution of disease (Cresswell 2018; Lacey 2015).

Due to the limited information available about the HV antenatal home visit, there are no existing theories to be tested about the phenomenon, or statements that require statistical testing (Creswell 2014). Observation could be a way of gaining information

about the HV antenatal home visit from the examples of quantitative research designs. However, within a quantitative approach, factors about the phenomenon need to be known within observations so that they can be compared or tested to identify trends or associations (Lacey 2015). There are very few factors known about the HV antenatal visit requiring an exploratory research approach rather than testing or comparing. Observation from a quantitative research approach would therefore be unsuitable.

Conversely to quantitative research, qualitative research takes an interpretivist perspective stemming from the social sciences, where greater attention is paid to the roles individuals play in constructing their social world (Bryman and Becker 2012). Individuals interpret the social environments they live in, where meaning and understanding comes from their actions and behaviour (Topping 2015).

Interpretivism focuses on understanding how individuals perceive and interpret the social world in which they live and work, emphasising the subjective meanings they assign to their experiences through interactions with others (Creswell and Creswell 2018). Interpretivism recognises that there is no single interpretation, truth or meaning of the social world, that human beings are different, so too are the societies and cultures they live in (Topping 2015). Those societies and cultures are influenced by social and historical perspectives (Creswell and Creswell 2018). Research approaches taking an interpretivist stance therefore need to occur within the natural setting, gathering information and insight about it as well as allowing interpretation of human interactions within it (Creswell and Creswell 2018; Topping 2015). However, researchers have their own perceptions of their social world, which interpretivism acknowledges. In order to capture the meaning of individuals they are researching, researchers recognise that their preconceptions must be prevented from influencing the research or discussed in relation to their influences for the data (Punch 2013).

Qualitative research methodologies use words, narrative, documents, and graphic materials as their data sources. They explore situations, experiences or cultures in

depth, considering their complexities and contexts, and are attuned to the unfolding of events overtime and the connection of participants to their social settings (Bryman 2016). Data analysis is transformative and interpretive (Richards and Morse 2007). Analysis involves organisation of the data, identifying themes and concepts and relationships that reflect the researchers' interpretation of patterns across the data, and on occasions developing a theory about them (Lathlean 2015; Seers 2012).

There is a limited amount of information available regarding the HV antenatal home visit, particularly in relation to the social context of the setting and the nature of interactions between HVs and expectant parents. Utilising a qualitative approach would enable an in depth exploration of the context of the HV antenatal home visit and the experiences of the HVs and expectant parents through their interaction with each other and their connection to the home visit (Bryman 2016). The qualitative approach was therefore considered as more appropriate than a quantitative approach for the research study.

Considerable debate has existed about quantitative and qualitative methodologies in relation to their philosophical viewpoints and historical backgrounds with advocates and critics for both (Franklin 2012).

Since its inception in the mid-19th century, health visiting has evolved and adapted in response to shifting professional roles, boundaries, and perceptions of the field. Its development has encompassed a broad scope, spanning health, education, and social care sectors (Baldwin 2012). Health visiting has been influenced by social sciences and rather than being divided about the use of the two research methodologies has embraced them both, strengthening research enquiry and knowledge within a specialist branch of the nursing profession (Topping 2015).

Qualitative research has featured within HV practice research over the past 40 years or more alongside quantitative evaluative studies. The variety of studies identified in a literature review of key interventions in HV practice processes and outcomes for children and families provides strong evidence of this (Cowley et al. 2013).

In addition to the consideration of the two main methodological approaches, my worldview as a researcher was contemplated and the influence that it may have had on the research study. Research is guided by the researcher's understandings of the world, how it should be studied and their feelings and beliefs about it (Bryman 2016; Byrne 2016; Creswell 2014; Crotty 1998; Denzin and Lincoln 2011). My ontological perspective, or understanding of reality influencing the research, is linked to social constructivism (Cresswell 2014) shaped by schooling, a career within nursing, and HV practice in health and public sector services.

The social constructivist philosophy as described by Creswell (2014) and Charmaz (2006) believes there is no single truth, and that reality is created. It uses an inductive process where people seek meanings of their experiences directed towards objects or things. A theory of meaning is gathered by being in the lived, social world and making sense of it with others in that world. Meanings are many and varied and seen as complex. A person's background, education, and social experiences guide them to the philosophy they believe in (Creswell 2014). A background in the nursing profession since 1981, and HV practice since 1991, have influenced my social constructivist viewpoint from an educational and social perspective. The profession encourages HVs to personally understand the complexity of their clients meaning of the world within their social and historical context, as laid out in the 1970's principles of health visiting that still stand today (CETHV 1977; NMC 2022). As a practising HV, insight is gained into the clients' worlds and their understandings of it. Making sense of the meanings they have shared in practice occurs by being 'salutogenic' or 'health creating', 'human valuing', and 'acknowledging the person in situation', known as 'human ecology' (Cowley et al. 2015, p.13).

A social constructivist worldview favours the use of inductive research methods that focus on meaning, which can help interpret the complexity of the process of the universal HV antenatal home visit and are qualitative in nature (Birks and Mills 2015; Bryman 2016; Charmaz 2006; Creswell 2014; Urquhart 2013).

My ontological perspective is influenced by social constructivism. Reflection on my epistemological stance, or beliefs regarding how knowledge about the world is acquired, was undertaken to examine its influence on the implementation of the research within the study. My view is interpretivism and the significance of understanding peoples' perspectives within the context of their lives (Bryman 2016; Punch 2013). Within research, the social world and my actions and beliefs are intertwined, both impacting on each other, unable to be independent or unaffected by each other (Crotty 1998). The social world is not governed by patterns or phenomena in the natural world that are consistent, predictable, and follow universal laws and therefore cannot utilise natural science research methods (Ormston et al. 2013).

Ontologically I favour inductive methods, although when gaining knowledge there is an awareness that both inductive and deductive methods are required within qualitative research (Blaikie 2007). An inductive approach observes the world and searches for observations and patterns from those observations to understand other's perspectives (Topping 2015). Equally, deduction is required later in the research process as analysis occurs and research findings are contextualised with existing knowledge and other theories, leading to the development of new theory within the study (Ormston et al. 2013).

From an epistemological standpoint, my aim is to interpret others' perspectives through an inductive approach that facilitates the development of theory grounded in the data. This approach highlights an open and transparent research process, recognising the integral roles of both the participant and the researcher (Lacey 2015). As a researcher, I inevitably influence facts, values, and findings (Crotty 1998). The possibility of conducting objective value free research is relatively unachievable (Bryman 2016). Acknowledging that research cannot be entirely value free (Bryman 2016; Ormston et al. 2013), I endeavoured to ensure transparency regarding my assumptions, biases, and values. This was achieved through the application of theoretical sensitivity (section 4.6.3), reflexivity (section 4.12.2), and memoing (Section 4.6.4). I was mindful about how these assumptions affected the way data were collected and analysed. I also aimed to take a neutral and non-

judgemental approach to the research process, considered by some researchers as having a position of '*empathetic neutrality*' (Ormston et al. 2013, p.8). After exploration of the research literature, consideration of the characteristics and traditions of the philosophical paradigms of quantitative and qualitative research designs and my world view (Bryman 2016; Creswell 2013; Gerrish 2015; Ormston et al. 2013; Punch 2013), a qualitative design was chosen.

The research question was exploratory in nature due to the paucity of information and lack of existing theories about the HV antenatal home visit. There was no phenomenon or variables to measure from a quantitative approach. The research question dealt with human social processes and the meaning and understanding of HV and expectant parents' individual experiences which is where qualitative approaches are often applied (Topping 2015). My social constructivist world view favours inductive approaches that search for observations and patterns to understand other people's perspective of their lives. My worldview, aligned with the research question, favoured inductive research methods, such as observations and interviews, which are characteristic of a qualitative research approach. A qualitative methodological approach facilitated an in depth discovery of how HVs and expectant parents interpreted the phenomenon of the HV antenatal contact within its social context (Lacey 2015).

3.4 Choosing a Qualitative Approach

Over the past six decades, an extensive array of qualitative methodologies has been developed, providing researchers with a comprehensive range of approaches to undertake their studies (Creswell 2013). Among these, the five principal qualitative research methods are narrative inquiry, phenomenology, ethnography, case study, and grounded theory (Creswell 2013).

Within nursing and health care case study, ethnography, phenomenology, and grounded theory are the most common research methods (Bourgeault et al. 2010).

They will be considered as to their suitability to answer the research question and the reason why grounded theory methodology has been adopted. A decision to use Glaser's classical grounded theory is then justified.

3.4.1 Case study

Case study has its origins in the study of humanity, or anthropology, including influences from social and political sciences (Topping 2015). It is an investigation of real world phenomena in which the distinction between the phenomena and their contextual settings remains ambiguous (Coronna 2010). Case studies provide a detailed examination and analysis of a single case or multiple cases, addressing the intricacies and complexities inherent in challenging social contexts (Creswell 2014; Dawson 2013; Denscombe 2014; Starks and Trinidad 2007). A HV practice example being Appleton and Cowley's (2008) case study of knowledge use within HV assessments of families.

The objective of the HV antenatal research study is to explore what the key issues are for expectant parents and HVs who experience the HV antenatal home visit. Not enough is yet known about the phenomenon of the HV antenatal visit or the context. A narrow, in depth analysis of a variety of aspects of the antenatal visit in the form of a case study at this exploratory stage is therefore not what is required and would not warrant using a case study approach.

3.4.2 Ethnography

Ethnography is a core qualitative research method in nursing research, noted for its distinctive capacity to offer deep and contextual understanding of the lived experiences of individuals and groups in their natural environments (Beck 2013). Ethnography like case studies has its roots in cultural anthropology exploring the

culture and rules that defines the individuals and group members from other people outside of the group (Denscombe 2014). Using an immersive approach it goes beyond the description that case studies offer, exploring meaning and understanding of individuals and groups by uncovering underlying social and cultural contexts that shape their experiences and behaviours (Beck 2013; Denscombe 2014).

Ethnography requires lengthy periods of times within the group or society for the researcher to familiarise with the group, gain their trust and holistically study relationships, processes, connections, and interdependency amongst all the interconnecting parts of the study (Creswell 2014; Denscombe 2014) as recognised in Ling and Luker's (2000) 2 year ethnographic study that explored HV perceptions of child protection.

The HV antenatal research study wanted to find out more than description so being able to provide meaning was an appeal of ethnography. However, the HV antenatal research study does not have a defined group or society to research, the participants coming from a variety of backgrounds or social groups. The available research time within a clinical doctorate study programme in addition to the lack of appropriate study group deemed an ethnographic approach unsuitable for the study.

3.4.3 Phenomenology

Phenomenology is the study of how a person makes sense of the world around them (Bryman 2016; Galvin and Holloway 2015). It builds on the traditions of philosophers who sought to understand human existence and its relationship with the environment, capturing the essence of lived experiences (Beck 2013). There are two distinct phenomenological research approaches. Firstly, descriptive phenomenology based upon the 1913 work of German mathematician Edmond Husserl (1859-1938) considered the founder of 20th century phenomenology. (Husserl 1980). Descriptive phenomenology seeks to capture the core essence of

experiences as they are lived by individuals, free from any researcher interpretation or influence (Galvin and Holloway 2015). Secondly, interpretive phenomenology based upon the philosophical hermeneutics foundational work of Martin Heidegger(1899-1976) in 1927 (Heidegger 2005) and Hans-Georg Gadamer (1900-2002) in 1960 (Gadamer 2004) who provided a framework for understanding human experiences in a deeper, more interpretive way, emphasising the meanings and essential qualities of those experiences within their contexts (Bryman 2016). Interpretive phenomenology goes a step further than descriptive phenomenology by considering the context and the researcher's own perspective (Beck 2013).

Hermeneutic phenomenology is a popular version of interpretive phenomenology within nursing and health care, capturing the depth of human experiences especially in health and illness contexts (Beck 2013; van Manen 1990). An example in HV practice is Taylor et al. (2017) who utilised hermeneutic phenomenology to study how HVs experienced and managed their emotions with families to safeguard children.

Phenomenology was considered as a potential approach to the HV antenatal study being a research design that had been experienced in previous Masters level academic research. Phenomenology could gain understanding of the HV universal antenatal home visit by focussing on how it was experienced by expectant parents and HVs (Beck 2013; Bryman 2016). It could provide a description of how they saw it, experienced and understood it, and interpreted it (Beck 2013; Bryman 2016; Creswell 2014; Denscombe 2014). Phenomenology investigates the subject matter and reveals the essence of subjective experiences but does not extend to providing causal explanations or engaging in interpretative analysis (Galvin and Holloway 2015). To address the research question comprehensively, it is necessary to explain the HV universal antenatal home visit through the experiences and perceptions of participants, making phenomenology an unsuitable approach for this purpose.

3.4.4 Grounded Theory

As outlined by Glaser (1998), grounded theory is widely recognised as a general social research method frequently applied in qualitative studies utilising symbolic interactionism. However, it shows no preference for a qualitative or quantitative research paradigm (Holton 2008). The iterative and systematic methodology of grounded theory is suited to the qualitative nature of HV antenatal research, as it facilitates explanation and enhances understanding of the phenomenon by generating theory established in the lived experiences of HVs and expectant parents (Glaser and Strauss 1967).

Grounded theory's foundation in symbolic interactionism, pioneered by the pragmatist George Mead (1863-1931) from the late 1800's (Mead 2015) is crucial for understanding how HVs and expectant parents' social lives are constructed, maintained, and changed through the meanings they attach to the HV antenatal visit and the interactions occurring between them. Language, as the primary symbolic system distinguishing humans, expresses these meanings (Mead 2015). Capturing the interplay between expectant parents and HVs in their social context ensures the resulting theory is deeply embedded in the reality of their experiences (Glaser 1998).

Understanding a phenomenon occurs by generating theory from analysing data about it, which mirrors the research question purpose to uncover and explain social processes and interactions during HV antenatal visits (Glaser and Strauss 1967). According to Glaser (Glaser 1998; Glaser 2007), any form of data, or a combination thereof, can be used in the process of theory generation. In this study, data collected from HVs and expectant parents served as the foundation for developing the theory.

Grounded theory research begins with a specific area of interest, in this instance, the HV antenatal visit. Data collection focuses on addressing the research question related to the research study with theory emerging from the analysis of the collected data (Glaser 1978). Rather than confirming previous hypotheses or theories, information about the HV antenatal visit phenomenon develops from the data, free from preconceived ideas (Glaser and Strauss 1967).

Theory development in grounded theory occurs on three levels: forming categories from data, developing a core category from the categories, and generating substantive theory (Glaser 1978; Glaser 1998). This process is particularly relevant to understanding the HV antenatal home visit phenomenon.

The first level forms categories from data from HVs and expectant parents analysed through constant comparative analysis (section 4.6.1). Each piece of data is compared line by line, leading to the development of ideas or concepts, which are then coded. The second level, developing a core category, occurs through continued constant comparative analysis, where initial categories are compared and analysed further to identify a core category. The overarching concept of the core category represents the similarities between all identified categories. The third level involves generating a theory specific to the substantive area of interest, in this case, the HV antenatal home visit. The substantive theory emerges from the developments in the first two stages and provides a detailed explanation of the HV antenatal visit phenomenon, how expectant parents and HVs interact and their experience of the visit. Importantly, the theory is uniquely applicable to the HV antenatal visit and is not intended to be generalisable to other areas. By systematically following these three levels of theory development the resulting theory is deeply rooted in the lived experiences of HVs and expectant parents, providing valuable insights into the dynamics of HV antenatal visits for both practice and future research (Glaser 1999).

Grounded theory encompasses four interconnected components that operate concurrently: data collection and analysis through a constant comparison method, memo writing to facilitate the development of categories, sampling to support the construction of theory, and the process of theory development (Birks and Mills 2015; Glaser 1978; Glaser 1998; Glaser and Strauss 1967; Holton and Walsh 2017; Urquhart 2013). The central purpose of grounded theory is to enhance understanding of a phenomenon by constructing a theory derived directly from the collected data (Glaser and Strauss 1967).

Grounded theory was appropriate for the HV antenatal study due to the paucity of information known about it (Birks and Mills 2015). The social phenomenon surrounding the universal antenatal home visit by HVs necessitated further exploration and understanding, facilitated by the development of a theory with explanatory value (Birks and Mills 2015; Glaser and Strauss 1967). Grounded theory employs a systematic process of data collection and analysis, making it particularly suitable for novice researchers (Birks and Mills 2015). This approach prioritises the primary concerns or issues of research participants by employing constant data comparison, developing categories, and constructing theories based on these categories (Birks and Mills 2015; Glaser and Strauss 1967; Urquhart 2013).

As noted in the exploratory research question, no specific issues or concerns related to the HV antenatal visit were identified prior to initiating the study. Grounded theory facilitates the identification of such concerns and the formulation of a theory to address them (Glaser and Strauss 1967). Therefore, grounded theory was determined to be the most appropriate qualitative research approach for the HV antenatal study.

3.5 Justification of a Grounded Theory Approach

The selection of the most suitable qualitative approach for the HV antenatal study was guided by the research question, a critiquing of the various qualitative research approaches, consideration of researcher worldview, guidance from clinical doctorate supervisors and networking with other academic researchers. The purpose of conducting the research was to examine the experiences and perceptions of HVs and expectant parents regarding the HV antenatal home visit, with the aim of developing a theory about the phenomenon and contributing new insights for clinical practice. A grounded theory approach could provide further understanding and explanation of the HV antenatal visit through development of a theory about it.

The research question significantly influenced the selection of the methodology, providing justification for the use of a qualitative approach grounded in theory. Grounded theory highlights the generation of theory from data, facilitating a more comprehensive understanding of the HV antenatal visit phenomenon (Glaser and Strauss 1967). While grounded theory methodology has evolved, the core principles remain. These include theory development through inductive reasoning, concurrent data collection paired with constant comparative analysis, memo writing for category development, and theoretical sampling (Birks and Mills 2015; Elliot and Lazenbatt 2005; Glaser and Strauss 1967; Holton and Walsh 2017; Urquhart 2013). For a novice researcher, the rigorous and systematic approach was particularly appealing as it provided a clear, step by step framework for data management, insight generation, and continuous refinement of the research focus, ultimately developing a deeper understanding of the phenomenon under study (Glaser 2012).

The consideration of grounded theory methodology was central to determining the most suitable approach for the HV antenatal study. It is imperative for nurses to identify high quality research to ensure their practice is grounded in robust evidence (Elliot and Lazenbatt 2005). However, inconsistencies and issues regarding credibility have been observed in numerous nursing studies employing grounded theory methodology (Becker 1993; Benoliel 1996; Wilson and Hutchinson 1996). Common failings include reliance on broader qualitative research methods without understanding the core principles of grounded theory, inappropriate use of theoretical frameworks, failure to employ theoretical sampling, and the absence of simultaneous data collection and analysis (Becker, 1993 Benoliel 1996).

Many studies claiming to use grounded theory were merely descriptive in nature (Becker 1993). Similarly, Wilson and Hutchinson (1996) identified frequent errors such as mixing qualitative methods, deviating from fundamental characteristics of grounded theory, producing non context specific analyses, integrating concepts without grounded interpretation, and misrepresenting grounded theory as an analytical method rather than a comprehensive methodology. Assessing the quality of research presents its own challenges, particularly as criteria for evaluating quality

differ across various grounded theory methodologies, such as those developed by Glaser or Strauss and Corbin (Elliot and Lazenbatt 2005).

Finding issues using grounded theory within research studies raised concern about whether it was the right choice for the HV antenatal research study. However the pull of developing a theory from the data was a draw along with generating concepts that named patterns in the data (Glaser 1978; Glaser and Strauss 1967). Grounded theory also fitted with my level of maturity in relation to personal abilities and skills, and creative flexible thinking (Noble and Mitchell 2016). Staying true to the core principles of grounded theory by applying it to the HV antenatal study and following its rigorous and structured procedures, provided an incentive to use it and help prevent the previously identified pitfalls (Glaser 2009).

Grounded theory methodology is popular and used across nursing and other health professions, social sciences, and other academic disciplines (Birks and Mills 2015; Hernandez 2010; Holton and Walsh 2017; Urquhart 2013,). Findings of research studies need to be meaningful to clinical practice for nurses (Artinian et al. 2009). Glaser (1999) suggests that nurses are turning to grounded theory to produce findings that improve health care after being disillusioned by traditional research methods in the field that do not improve outcomes.

Grounded theory has been promoted by Dame Sarah Cowley, a seminal writer of HV practice who has published articles promoting and explaining its use, as well as developing grounded theory studies that support change in HV practice (Cowley 1991; Cowley 1995; Coyne and Cowley 2006; Coyne and Cowley 2007; Heath and Cowley 2004). Currently there are examples in HV practice that continue to uphold this popular qualitative research method, such as a study by Abdu et al. (2016) on service user's perceptions influencing HV practice, their findings being meaningful to their work (Artinian et al. 2009). The appeal for using grounded theory was therefore intuitive when considering the HV antenatal study.

An additional benefit of grounded theory is its emphasis on discovery, as it enables the researcher to construct a theory rather than merely testing out existing ones, thereby promoting creativity throughout the process (Noble and Mitchell 2016). Developing a theory during the process of discovery will provide new evidence to help inform HV practice about the antenatal home visit as well as developing the research skills of the researcher (Glaser 1978). Grounded theory through a process of induction generates concepts and theory from empirical data of social interactions and social processes related to phenomena being examined, rather than testing theory by deduction (Glaser and Strauss 1967). Being so close to the data encourages a process of discovery, gaining rich insights, allowing themes and interpretations to naturally develop from the HV antenatal study data using creative and inductive processes (El Hussein et al. 2014). Producing a strong theory grounded in the data will provide new evidence about the social process of the HV visit to inform HV clinical practice (Glaser 1978; Urquhart 2013).

Theory that develops from constant comparative analysis of data can be substantive or formal. Formal theory links substantive theories to generate and sustain a wider area of social enquiry (Glaser and Strauss 1967). The HV antenatal study correlated more closely to a narrower area of social enquiry relating to one specific area and context of real life where no previous substantive theories existed. The development of a substantive theory was therefore more appropriate for the study.

Qualitative research methods, such as case studies, ethnography, phenomenology, and grounded theory, are extensively utilised in nursing and healthcare research. Grounded theory is particularly valued for its systematic and iterative process, which enables the development of theories grounded in empirical data. While ethnography is valued for its in depth, contextual exploration, and phenomenology for its focus on lived experiences, grounded theory was selected for the HV antenatal study due to its capacity to deliver a thorough explanation of the phenomenon under investigation. Its structured procedures and clear framework made it especially advantageous for a novice researcher, offering practical guidance throughout the research process.

3.6 Justification of a Classic Grounded Theory Approach

Selecting the most suitable research method can be a complex task due to the intricate nature of philosophical debates and the varied applications of grounded theory within research literature (Breckenridge et al. 2012). Since its inception by Glaser and Strauss in 1967, grounded theory has experienced various adaptations and refinements. This thesis does not attempt to address all existing variations but concentrates on three prominently recognised approaches.

The first approach is Classic Grounded Theory (CGT), also known as the Glaserian method, which is viewed as the original and most unaltered version, building on the groundbreaking work of Glaser and Strauss (Glaser and Strauss 1967; Glaser 1992; Holton and Walsh 2017). The second is Straussian grounded theory, which was the first significant departure from the original, introducing structured guidelines and a defined coding paradigm (Corbin and Strauss 2008; Strauss and Corbin 1990; Strauss and Corbin 1994; Strauss and Corbin 1998). Constructivist grounded theory is the third variation which takes a social constructivist and interpretive approach, emphasising the researcher's active involvement in the analysis process, rather than the more detached stance observed in CGT and Straussian methods (Charmaz 2014; Bryant and Charmaz 2007).

An evaluation of the philosophical foundations and methodological details of these approaches ultimately led to the decision to adopt the Classic Grounded Theory (CGT) or Glaserian method for this research study.

Neither Glaser nor Strauss articulated their philosophical orientation. When Glaser developed his approach from their original work together (Glaser and Strauss 1967) he concentrated on writing about the grounded theory method rather than the methodology, dismissing potential links to any specific philosophical or disciplinary position (Glaser 2005). His viewpoint has received criticism for being unrealistic and inexperienced (Bryant 2009). From Glaser's work however, his post positivist inclinations were evident. He contended there is a social process underlying a

phenomenon of interest and the quest for the 'reality' of it is out there in the research field, that reality remaining independent of the researcher (Glaser 1978).

Glaser seems less aligned with my social constructivist viewpoint, which sees knowledge as constructed through interactions and social processes (Birks and Mills 2015; Bryman 2016; Charmaz 2006; Creswell 2014; Urquhart 2013). However, his emphasis on emergent theory from data still allows for the exploration of participants' meanings and interactions, providing the researcher remains open and reflexive, which was a reason for considering a CGT research approach (Glaser 1992).

Strauss and Corbin's approach to grounded theory methodology implies a more post positivist position compared to a CGT approach. They do not contend the view that reality exists but were cautious of the researcher's ability to fully understand it, questioning their ability to build a theory that describes a phenomenon exactly as it is. Instead, they aimed to illustrate a close representation of reality from an objective, practical position, while accepting the likely influence of the researcher's subjectivity on the research process (Strauss and Corbin 1990; Strauss and Corbin 1994; Strauss and Corbin 1998). Strauss and Corbin's approach allows for a more reflexive stance, where the researcher's background and prior knowledge can inform the research process. It aligns closely with social constructivism, which values the interplay between researcher and participants in constructing knowledge and was initially seen as a possible method to use before the research method was considered in more detail (Birks and Mills 2015).

Charmaz (2014) embraced a constructive philosophical position with an interpretive approach to grounded theory, seeing reality as dynamic, with people constructing local meaning within their immediate context. Charmaz differed from both Glaser and Strauss on how to approach acquiring knowledge about reality, seeing it as a collective approach between researchers and participants, encouraging multiple interpretations of phenomena of interest. Charmaz also encouraged researchers to find out from participants how they made sense of their own and researcher's interpretations of phenomena (Charmaz 2006; Charmaz 2014). Charmaz embodies

the social constructivist viewpoint which was considered as a very favourable approach prior to consideration of the application of the research method to the HV antenatal study.

In relation to the grounded theory research method, Glaser uses induction as the main analytical tool whereby the researcher develops a theory from an inquiry and observation about a specific area of interest in the research field. He emphasises the researcher should approach the field without any hypothesis holding back preconceived ideas and knowledge to allow the theory to be discovered (Glaser 1978). In order to explore the HV antenatal visit in an unbiased way, Glaser's approach ensures a resulting theory is grounded purely in the participant's experiences which is what the research question focusses on and is therefore a favourable research approach for the study.

Strauss and Corbin take a different stance during the development of theory. They use induction, but also deduction, by testing abstract ideas against emerging data during analysis. Previous researcher experience and knowledge can be used in developing theoretical sensitivity but not in data analysis (Strauss and Corbin 1990; Strauss and Corbin 1998). Their systematic approach to conducting grounded theory research was implemented to minimise subjective researcher bias and achieve maximum objectivity. Strauss and Corbin guide researchers on how to systematically gather and analyse data while maintaining objectivity and creativity, through their development of a conditional matrix coding tool designed to help see interconnections of concepts and the emerging theory (Strauss and Corbin 1990). However, the tool enforces a rigid framework within the data analysis process, compelling the data to conform to predetermined categories and thereby limiting the spontaneous development of concepts and theories derived directly from the data (Glaser 1992).

Although Straussian procedures are more clearly defined than those of a CGT approach (Cooney 2010), realising the coding paradigm can become cumbersome if it does not fit the data (Cooney 2010; Holton 2007) was a deciding factor against adopting the approach, despite the philosophical approach being favourable for the

HV antenatal study. Being unable to relate conceptually to Strauss and Corbin's elaborate phases of coding was another factor, agreeing with Glaser (1992) that their approach limited the emergence of theory and forced the data from preconceived ideas. Grounded theory should remain open and flexible and allow for genuine conceptualisation to develop from the data without preconceived frameworks, ensuring theory is grounded in the data (Glaser 1978). Therefore a CGT approach was preferred over Strauss and Corbin's research methods.

Charmaz emphasises the iterative process of data collection and analysis, combined with the collaborative relationship between researchers and participants, is fundamental to developing grounded theory as a constructivist venture (Charmaz 2014). In addition to induction and deduction, she uses abductive reasoning to re-examine data and address unexpected observations, with the researcher's personal and professional knowledge enriching the theory (Charmaz 2014).

Being influenced by social constructionism, Charmaz's constructive grounded theory had immediate appeal based upon popularity of constructivism within social research and the value placed on inductive creativity within grounded theory methodology (Breckenridge et al. 2012). Upon deeper analysis of her approach and perspective, which suggests that categories and theories are intentionally constructed rather than organically emerging from the data, it did not resonate fully with my viewpoint. Glaser's position on theoretical sensitivity and the natural development of theory, which emphasises emergence rather than forcing of data (Glaser 1978; Glaser 1992) appeared more favourable. Charmaz's emphasis on revisiting the data could potentially introduce bias, shaping the theory more through personal experience and speculation than an objective reality (Strauss and Corbin 1998). As a result, this research method was deemed unsuitable for the HV antenatal study. Adopting a more objective role for the researcher to observe the emergence of data, as advocated in the CGT approach, was considered the better choice (Glaser 1978; Glaser 1992).

As CGT methodology purports not to be affiliated with any particular philosophical viewpoint suitable for quantitative and qualitative approaches (Glaser 1978), it was appropriate to adopt for the HV antenatal research study as it accommodated my social constructivist viewpoint and plan to use a qualitative research approach. The preference for allowing participants' experiences to be heard without excessive influence from the researcher was also another deciding factor (Glaser 1978). Additionally, the focus on allowing theory to emerge directly from the data, reducing preconceived notions, and ensuring the theory reflects the lived realities of HVs and expectant parents was instrumental in establishing CGT as the optimal approach for accurately capturing the essence of their experiences (Glaser 1978).

The various evolutions and adaptations of grounded theory create a challenge for researchers in selecting the most appropriate version. While methodologies can benefit from refinement and innovation, excessive modifications may lead to a divergence from grounded theory methodology altogether (Breckenridge et al. 2012; Bryant 2009). Researchers are ultimately responsible for determining the grounded theory approach that best suits their study (Holloway and Todres 2006). After evaluating the three main versions CGT, Straussian, and Constructivist, CGT was chosen as the preferred approach.

The choice to utilise the Glaserian or CGT approach was based on its strengths and the opportunities it offered for the HV antenatal study. The decision was influenced by the researcher's philosophical stance, the suitability of the approach for addressing the research question, the researcher's role, and the practical challenges of applying different methodologies (Birks and Mills 2015; Cooney 2010; Corbin and Strauss 2008). The Glaserian or CGT approach provided the necessary flexibility to enable an open and dynamic exploration of the phenomenon, aligning effortlessly with the aims of the HV antenatal study's research question (Urquhart 2013).

3.7 Chapter 3 Summary of Research Methodology

This chapter presented justification for the research methodology used in the HV antenatal study. Utilising a qualitative design, a CGT approach was adopted to address the research question about exploring the HV and expectant parents' experiences and perceptions of the HV antenatal home visit. An analysis of the relevant literature was undertaken to support the justification of the study's chosen methodological approach. The research follows the foundational principles of grounded theory established by the seminal work of Glaser and Strauss (1967) and further developed through Glaser's later contributions (Glaser 1978; Glaser 1992; Glaser 1998). This methodology was chosen as the most appropriate approach for this investigation. The HV antenatal study allowed an exploration of the phenomenon of the HV antenatal visit, concepts to develop and a new theory to be realised. The following chapter outlines the research methods employed to implement the CGT approach. It covers ethical considerations, sampling strategies, data collection and analysis, as well as the process of developing theory from the data.

Chapter 4: Research Methods

(Some sections in the current chapter refer to the researcher role, therefore they are written in the first person).

Building on the research methodology outlined in the preceding chapter, this section focuses on the research methods applied within a qualitative research design using a CGT approach. The methods outlined are tailored to address the study's research question, which explores the perceptions and experiences of expectant parents and HVs regarding the social processes associated with the HV antenatal home visit.

The chapter details the process of obtaining ethical approval from the University of Stirling NHS Invasive or Clinical Research Ethics Committee (NICR), the North of Scotland Research Ethics Service, and the local NHS Health Board Research, Development, and Innovation (RD&I) department. Additionally, it discusses the sampling strategies employed for data collection, which included observations and unstructured interviews. The data analysis process is also elaborated upon, encompassing coding, category identification, and the development of a core category through the constant comparative method. Finally, the substantive theory was constructed based on the theoretical processes identified during the data analysis.

4.1 Ethical Considerations

This section outlines the ethical considerations involved and the steps taken to obtain ethical approval from the University of Stirling NICR, the North of Scotland Research Ethics Service, and the local NHS Board RD&I department.

The research study was required to be conducted in a manner that ensured participants were protected from harm, exploitation, or any form of potential coercion (Miller and Birch 2012). There was also an awareness that the research study topic area related to pregnancy and the associated risks, such as miscarriage, stillbirth,

or premature births. Data collection involved observations of professionals practising in often unfamiliar environments within client homes, and interviewer lone working when interviewing expectant parents at a venue of their choice. Risks for both include the safety of HV or interviewer in the environment around the client's home or meeting place e.g. a high crime rate area. It also related to safety dealing with clients in the meeting, whose behaviour may potentially cause alarm, such as violence, or where they are showing signs of the influence of drugs or alcohol.

Ethical considerations related to anticipated risks to both participants and the researcher within the research study. Potential risks included identification of participants and their locations in the published account of the findings (Bryman 2016). Some of the recruited locations were rural with small populations and low HV numbers, where participants might have been more identifiable. There was a risk that participants could be identified or were identifiable from what they said and did in the observations or interviews, or from the demographic data they shared such as location, job role, or age. For expectant parents, there was a potential risk conversations might induce anxiety, evoking memories of previous pregnancies. The main risks for the researcher were the lone working aspect of undertaking the research and potential conflict of interest as a practising HV with a client caseload. The possibility of observing poor HV practice when undertaking observations of the HV antenatal visit were also considered. Each of the risks are addressed in turn.

4.1.1 Participant anonymity, confidentiality, and data management

Participant anonymity was protected until participants self-identified to the research team and was then aligned to research governance procedures for confidentiality. Participant information such as digital audio recordings and notes were allocated a number that only the research team had access to. Confidentiality was maintained by complying with the legal requirements of the Data Protection Act (2018) known as General Data Protection Regulation (GDPR) on safe handling, security, and confidentiality of participant data so that it is used fairly, lawfully, and transparently. The participant information sheet (Appendix 1, 2, 3) and privacy notice (Appendix 4)

provided further details on how confidentiality and anonymity would be maintained by the research team and assurances that any identifiable information would be destroyed at the end of the study.

4.1.2 Potential for disclosures about previous experiences evoking anxiety.

For participants there was the possibility that discussing the HV antenatal home visit might bring back memories of past HV or pregnancy experiences that could evoke emotional responses. They may have had difficult experiences with previous pregnancies e.g. miscarriage, stillbirth, premature births, difficult experiences of births, personal relationships or relationships with health professionals. The participant information leaflets (Appendix 1,2,3) clearly outlined actions that would be taken if the situation occurred: the researcher would listen to participants experiences if they chose to talk about them, offer to stop the interview, and give the participant the option of withdrawal from the study. The researcher would suggest they seek support from someone they trust e.g. GP, health professional, family, or friends as appropriate to help them deal with their emotions. In any situation of disclosure of abuse participant safety is paramount. If the person was in imminent danger the researcher would follow local NHS and council domestic violence and child protection policies and contact the HV line manager and child protection advisor for further advice to keep the person safe and receiving the most appropriate support. The actions taken would comply with the NMC code of conduct for HV practice (NMC 2018). However, in practice this did not occur.

4.1.3 Lone working

For the researcher, the main anticipated risk was the lone working aspect due to the nature of the research. Travelling was involved across a large geographical area to expectant parents who they had never met before. The local NHS and council lone working policy was applied to minimise any risks associated with lone working and protect their safety as much as possible. Actions included conducting interviews

where possible within working hours, keeping their electronic calendar up to date, informing research supervisors of dates and times and locations of observations and interviews, carrying a charged mobile phone, and ensuring a fully operational car. Attempts were made to prioritise recruitment of HV and midwifery teams geographically closer to the researcher's location, leaving more distant teams if further recruitment was required.

4.1.4 Potential for observing poor HV practice.

The HV role is a specialist community public health role, providing advice and support to families with children under school age to promote health, wellbeing and address health inequalities. The HV role in the research study does not involve undertaking any clinical nursing procedures (NMC (Nursing and Midwifery Council) 2022), therefore the risk of harm to others through their role is low, as reflected in the NMC fitness to practice published annual reports (NMC 2024). Poor HV practice, however, has the potential to be witnessed by the researcher during the observation of the HV antenatal visit. The researcher is in a role as observer, but they also have a duty as a nurse and specialist community health nurse registrant to comply with their code of conduct (NMC 2018). If poor practice is witnessed that could result in expectant parents, babies, other children or people being in imminent danger, the researcher would intervene as in the process highlighted in the HV participant information leaflet if the circumstances occurred (Appendix 1, p3). The situation did not arise during the research study.

4.1.5 Conflict of interest

The research study involved direct clinical contact, observing practising HVs within the same employing authority as the researcher who is a practising HV with their own caseload of clients. To avoid conflict of interest with the research study, their own caseload and those of their colleagues in their work team were excluded from

the study. Doing so minimised any pressure that midwives, HVs or clients in the researcher's work area may have felt if they were invited to take part because of the researcher's direct links to the study.

4.1.6 Ethical approval

The nature of a CGT study is that it is flexible, evolving, and unpredictable. It is a challenge at the ethical approval stage where detail about the nature of data and how it will be collected is required (Birks and Mills 2015). The study is part of a professional education programme leading to a Doctor of Nursing from the University of Stirling. Ethical approval applications were cognisant of adhering to the CGT process alongside ensuring the study met the requirement to be designed, conducted, and managed appropriately, meeting the needs of individuals, the public, and science and minimises harm to them. Ethical approvals are in accordance with UK wide and health board research regulations utilising the integrated research application system (IRAS) (Department of Health 2005; National Health Service Health Research Authority (NHS HRA) 2017; NHS HRA 2018).

Due to the exploratory nature of the study, a broad research approach was adopted, as outlined in the ethical approval documentation. Theoretical sampling was articulated, and an initial starting point for data collection was established (section 4.5). A flexible framework, incorporating both observations and interviews, was employed during the data collection process, allowing the study to adapt within the parameters of the ethical guidelines. Ethical approval was granted from the University of Stirling NICR Ethics Committee on 6th November 2018, with the University also serving as the sponsor (Appendix 5). Additional ethical approvals were granted by the North of Scotland Research Ethics Service on 17th January 2019 (Reference 18/NS/0144, Appendix 6) and by the local NHS Health Board RD&I Department on 19th February 2019 (Appendix 7).

As the recruitment process for expectant parents was very slow a substantive amendment was required six months after the research study commenced in the

field. A move from midwives recruiting expectant mothers and their partners to HV's undertaking the role was requested and standing operating procedures adjusted accordingly for HVs (Appendix 8 and 9). A substantial amendment was granted 9th January 2020 by University of Stirling NICR. Local NHS Health Board RD&I department were also consulted and agreed to the amendments.

Completing the ethics process was arduous and demanded a significant amount of time and extensive documentation. Securing initial ethical approval through the University of Stirling ethics committee, NHS REC, and the local NHS RD&I department took a total of six months. Even though the IRAS documentation provided standardised information to the ethics committees and RD&I department, the process remained lengthy.

The local Health Board RD&I department supports local delivery, development and governance of clinical research. Annual updates on the progress of the research study were provided to the RD&I department. The study was also involved in one of their randomised research project audits on 28th February 2020. The research work area and study site file were reviewed to ensure ethical consideration and research protocols were being adhered to, and data collection and storage were being carried out appropriately. Two areas required further action and were addressed: consent forms required version control and date added; the consent process required documentation as it happened. The audit was a valuable learning experience supporting the development of research skills in practice.

4.2 Participant Sample

The participant sample were HVs, expectant mothers and their partners within one rural Scottish Health Board. The wide geographical spread of the population, significant travel time and resulting financial implications of reaching some of the more remote parts were all deliberated upon when deciding on data collection locations. An initial sample was identified at the commencement of the study with theoretical sampling giving direction to further data collection.

4.3 Sampling Strategy

Sampling in grounded theory follows an iterative process that integrates both data collection and analysis, as noted by Glaser and Strauss (1967). In line with the conventional CGT methodology, theoretical sampling was employed to outline the approach to sampling. This involved selecting an initial sample for data collection and subsequently employing a theory driven, iterative process to guide decisions on the additional data needed and where to locate it (Glaser and Strauss 1967). Modern scholars frequently describe the initial sample selection process as purposive sampling, which is subsequently succeeded by theoretical sampling (Birks and Mills 2015; Breckenridge and Jones 2009; Flick 2018; Patton 2015). However, the term purposive sampling is not recognised in traditional grounded theory (Gentles et al. 2015) but has gained momentum in qualitative research methodologies (Patton 2015). Within the context of a CGT approach, the term initial sampling is preferred. A combination of initial sampling and theoretical sampling was employed in this study, resulting in the participation of 13 HVs and six expectant parents. The research question identified HVs and expectant parents as key participants, with data collection methods including observations and interviews requiring direct interaction with them.

4.3.1 Initial sampling

As is common in studies employing the CGT method, the initial stages of this research were characterised by limited knowledge regarding the type of data required, the number of participants and data sources, or the specific locations for data collection or generation (Birks and Mills 2015; Glaser 1978). Theoretical sampling emphasises the purposeful selection of participants based on the study's objectives, the research question, and the approach to data collection (Marshall and Rossman 2016; Patton 2015). According to Glaser and Strauss (1967) there must be some indication of where sampling should take place and what should be

sampled, even though the exact purpose and direction remain undefined. In this study, the concept of 'where' was derived from the research question:

What are the perceptions and experiences of expectant parents and HVs about the process of the HV antenatal home visit?

The initial decision to sample HVs and expectant parents is based upon a general sociological perspective that HVs and expectant parents are involved in the social process of the HV antenatal visit (Glaser 1978). It fits with the CGT method as it is a natural place to start where the possibilities of obtaining data are maximised (Glaser 1978). HVs and expectant parents are considered 'experts' in the HV universal antenatal home visit phenomenon and thus able to provide the best data (Corbin and Strauss 2015; Glaser and Strauss 1967; Ritchie et al. 2013). They were therefore identified as the starting point for data collection known as initial sampling (Flick 2018). A choice could have been made to have only HVs or only expectant parents to provide a substantive theory about that particular group. They are equally seen as participants of the visit and it would have been difficult make that choice. Within the confines of a time limited research study where ethical approval had to be obtained before any new participants could be interviewed or observed, a choice was made within initial sampling to have the options of interviewing all groups of participants involved in the antenatal home visiting process.

Relevant information from HVs and expectant parents led to decisions being made to collect further data from other HVs and expectant parents by utilising the process of theoretical sampling (Glaser 1978).

4.3.2 Theoretical sampling

Theoretical sampling is both iterative and deductive in grounded theory by serving two general strategies: to obtain slices of data to expand categories and relationships and to delimit and integrate the theory by specifying the core category and its major relationship (Birks and Mills 2015; Glaser 1978).

Theoretical sampling followed on from the initial purposeful sample, being essential for developing and refining the theory that develops from the data as described in the definition:

“The process of data collection for generating theory whereby the analyst jointly collects, codes and analyses his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges”
(Glaser and Strauss 1967, p.45).

The data collection and analysis from the initial sample of one observation and two interviews elicited codes. Data from the first two observations and interviews were collected and utilised as actual data. Field notes were generated, and the data from these sources were coded and analysed. Through memo writing about the coding, my thoughts were captured and developed in to conceptual ideas, and theoretical sampling was facilitated (Glaser 1978; Glaser 1992; Glaser and Strauss 1967). Theoretical sampling led to data sources from a variety of HVs and expectant parents through emerging gaps in the data as the sampling became more selective (Glaser 1978; Glaser 1998; Glaser and Strauss 1967). A decision was made to continue collecting data from more HVs and expectant parents as depicted in Table 4.1.

Morse (2008) proposes that participant selection evolves in response to the theoretical requirements of the study. In this case, it was necessary to continue interviewing and observing HVs and parents to further refine the concepts emerging from the data. By engaging subsequent participants in discussions on the identified concepts, their perspectives and experiences were gathered to contribute to the development of these concepts into defined categories (Glaser 1978; Glaser and Strauss 1967).

Theoretical sampling identified similarities and differences in the concepts, verified the usefulness of the developing category, and generated its basic properties (Urquhart 2013). See Table 4.2 for an example of theoretical sampling with coding relating to relationship building.

Table 4.1 Memos on codes and topics for interview

Memo 24/02/20 Coding and Topics for next interviews
60 codes from 2 observations and 3 interviews. Codes most referenced: Relationship building, including familiarity, parent being seen as expert about what they already know about parenting. Partnership working with parents. Sharing self has been mentioned by HVs with families to promote relationship building and trust in the HV. Explore information sharing further between HVs and parents. Part of HV role including assessing and knowledge of home and family situations and exploring how parents are planning and preparing for the baby's arrival. Providing support and advice to parents about managing their health, such as anxiety feeding, preparing for the baby. Explore topics further with parents and HVs.

Table 4.2 Example of theoretical sampling

Participant	Open Coding	Analysis	Theoretical sampling
A501 Observation A501HV Interview A501 EP Interview	Familiarity Relationship building Reassurance Sharing self Support Familiarity	Rekindling a relationship. Working in partnership to manage current pregnancy. Familiarity helps support anxiety and ongoing medical issues.	Differences noted between HV visiting first time parents compared to parents already known to the HV from previous pregnancies. Need to find more first time parents to explore how HVs promote themselves and their role and what is involved in relationship building. Find fathers/ partners or explore more with HVs about their involvement at the visit. Explore sharing information/sharing selves.
A701 Observation A701 Interview A701 EP Interview	Relationship building Sharing self /information Building Trust Familiarity Acknowledging Communicating	Unfamiliarity so promoting HV role/building a rapport. Once trust built by acknowledging and respecting parent they then asked advice of the HV.	
A502 Observation A502 HV Interview	Relationship building Familiarity Sharing self/ information	Familiar to HV, very relaxed approach. HV sharing experiences/information to promote parenting skills.	

The example demonstrates the open coding from the first three observations and interviews of the HVs and expectant parents involved in the observations. Theoretical sampling was then identified from data analysis on what further data was required to develop the codes further.

An example of subsequent open coding and theoretical sampling from the analysis of data from the remaining participants in relation to concepts associated with relationship building is demonstrated in Table 4.3. Through subsequent theoretical sampling, specific data were gathered during participant interviews in an iterative manner, which facilitated the further development of categories and contributed to shaping the core category. Selective coding emerged from the initial open coding process and evolved into subcategories, main categories, or directly influenced the core category (section 4.7.3). An updated topic guide, featuring additional headings designed to gather further data as guided by theoretical sampling, is provided in Appendix 18.

Theoretical sampling extended beyond merely pursuing leads in the data to determine subsequent data sources. Its primary purpose was to develop or integrate conceptual categories within the study (Glaser 1978; Glaser 1992). This approach served as a fundamental element of the constant comparative analysis process (section 4.6.1).

Detailed information regarding the participants' sample characteristics is provided in section 5.2.

Fully implementing theoretical sampling proved challenging, particularly in gathering data from certain groups. For instance, recruiting partners of expectant parents to share their perspectives and experiences posed significant difficulties, despite theoretical sampling indicating the need for further data from this group. The recruitment process imposed limitations on data collection, resulting in a low participation rate among partners of expectant parents. This issue was identified as

a limitation of the study, with a recommendation to explore alternative strategies for recruiting this demographic in future research.

Table 4.3 Example of subsequent theoretical sampling

<u>Participant</u>	<u>Open Coding/ Selective coding (in bold)</u>	<u>Analysis</u>	<u>Theoretical sampling</u>
A401 HV interview	Familiarity. Involving. Engaging with partners.	Rare to see partners, but good to explore relationships between parents with mother. But not establishing relationships, needs or experiences of fathers. Relationship building a building block for working with families. Can be difficult to engage with parents.	Partners not seen very much by HVs, also hard to engage with. Continue exploring what relationship building means to HVs, how they manage the visit and how information is shared between them to build the relationship. Recruitment of first time parents if possible and fathers/partners . See updated topic guide (Appendix 18) reflecting data required from further interviews
A101 HV interview A101 EP interview	Reassurance. Confidence building. Weighing up. Promoting HV role. Approachability. Involving fathers.	Benefits of getting to know father's roles and relationships/parenting needs, big part of assessment. Negative past experience of HV affected relationship building/ trust.	
A702 HV interview	Tailoring of conversations. Marketing/Promoting HV role. Building Trust and Approachability. Involving fathers. Questioning. Sharing self. Communicating. Planning and Preparing.	Involving fathers -more questioning, better picture of family life. Difficult to engage with mothers sometimes. marketing HV role/approachability. No sharing self, keeping relationship professional. Relationship with midwives sharing info helps HV be prepared to meet family Relationship building is gateway to assessment.	
A703 HV interview	Familiarity. Planning and Preparing. Support.	Preparing for support postnatally from a familiar professional. Impact of COVID 19 preventing meeting. Marketing HV role.	
A601 HV interview	Tailoring of conversations to individual families. Gauging.	Parent led conversations/ knowledge of HV service and previous experiences then sharing appropriate information.	
A603 HV interview	Information sharing Sharing self Communicating Partnership	Doesn't share self, keeping relationship professional but shares the excitement parents have. Relationship good with midwives helps prepare for speaking to parents, avoids duplication of information.	
A102 HV interview	Timing Support	Build relationship before birth linked to providing support postnatally.	
A301 HV interview	Introduction Sharing information	Promote role then be led by parental conversations COVID – relationships affected with parents and midwives, affecting support to families	
A602 HV interview	Relationship building through conversation Information Sharing	Informal conversations balanced alongside explaining HV role. Invites fathers, little uptake, lots of questions to HV when they do take part.	
A604 HV interview	Communication/ Information Sharing	Conversations led by parents.	
A102 EP interview	Weighing up Support	Previous negative experience. Keeping HV at arm's length. Affects information sharing compared it with the level of support required. If no support required then the relationship is more superficial	

Theoretical sampling in grounded theory is both iterative and deductive, aimed at expanding categories and refining the developing theory. From initial sampling it evolved to address gaps identified during data collection and analysis. Through memo writing and continuous comparison, theoretical sampling guided the selection of new data sources. It involved asking participants about identified concepts, comparing similarities and differences, and integrating conceptual categories.

Although recruitment challenges limited the full scope of the study, following the research process, and theoretical sampling, three HV antenatal home visits were observed involving three HVs and four expectant parents. A total of 13 HVs and five parents were interviewed. The interviews and observations developed the data collection (section 4.5) and analysis (section 4.6) as the theory was being built.

4.3.3 Participant inclusion and exclusion criteria

Within the CGT process, the sampling strategy identified expectant parents without any additional needs and HVs who had experience of antenatal home visiting as key informants that could help answer the research question (section 4.3.1). The inclusion and exclusion criteria were applied to assess the eligibility of HV participants and expectant parents for recruitment into the study. The criteria were ascertained by the ethical approval considerations (section 4.1) and the time and financial constraints of the study.

HVs were included if they carried out antenatal home visits but were excluded if they only dealt with expectant parents with additional needs or did not undertake any antenatal home visiting. See Table 4.4 for inclusion and exclusion criteria for HV participants.

Table 4.4 Inclusion and exclusion criteria- HVs

Inclusion Criteria	Exclusion Criteria
A HV who carries out antenatal home visits in the Health Board area.	A HV who does not carry out antenatal home visits
A HV who works in the Health Board area	A HV who only deals with expectant parents with additional needs (including family nurse partnership (FNP) professionals)

Expectant mothers and their partners were included if they were an adult (over the age of 18 years), expecting a baby over 28 weeks of pregnancy, living in the Health Board area of the study under the routine care of midwifery services. Participants needed to have the ability to speak and read English, as well as comprehend and provide written informed consent. See Table 4.5 for inclusion and exclusion criteria for expectant mothers and their partners. As a practicing HV and researcher, I was aware that HV services need to provide equity of access for all parents, regardless of their language or background, ensuring that services are inclusive and meet the diverse needs of families (Sturley et al. 2022).

While considering the need to be inclusive, the decision to exclude expectant parents who were unable to read or speak English, were visually or hearing impaired, or had mental health or other conditions that impacted their ability to understand and consent to the study was based on the practical constraints of revising documentation and the use and cost of translators within the time and financial limits of a doctoral study, rather than a reluctance to include participants who do not speak the majority language or are vulnerable in any way (Salway and Ellison 2015).

Table 4.5 Inclusion and exclusion criteria- expectant parents

Inclusion Criteria	Exclusion Criteria
Adult (18 years or older)	Less than 18 years old
Lives in the Health Board area	Has an antenatal plan which means they have additional needs
Receiving core (routine) midwifery care (green pathway).	Unable to read or speak English or are visually or hearing impaired or have any mental health or any other conditions that impact on ability to understand and consent to the study.

Being an exploratory study the inclusion criteria was a starting point for gathering data from expectant parents on the universal health visiting pathway. There is a possibility that some of the parent participants excluded from the study may have identified as having additional needs and therefore may not have met the criteria for the study.

4.3.4 Patient and public involvement in the research study

Patient and public engagement aligns research to real life needs by ensuring studies focus on issues that matter to those affected. As a result the community involved becomes more aware and knowledgeable about the research topic (Brett et al. 2014).

Using a grounded theory approach for this study emphasised the importance of understanding the real world phenomenon of the HV antenatal home visit through the lens of expectant parents (service users). Capturing their experiences signified service user involvement. In HV practice the term “service users” or “clients” is used rather than “patient” which is common in other health care settings.

The research design of this study was strengthened by gaining feedback from expectant parents from within the researcher’s work area, and out with the study area, on documentation produced for ethical approval. One first time and two expectant women volunteered to provide feedback and direction on the construction of the participant information leaflet, consent form and privacy notice. An excerpt from the research journal for the study captured their involvement:

4th April 2018 Research journal entry:

“Ethical clearance forms. Getting participant information sheets right so they are not too wordy, are easy to read and help promote recruitment to the study whilst covering ethical considerations is a mean feat. Expectant parents who attend a local charity family group in my work area offered to help give feedback, one first time and two second time expectant women. They agreed I could meet up with them at the end of one of the groups. Last week I

explained the study and provided the participant information sheet, reply slip and consent form. They took the leaflets to read and a today I met up with them to gain feedback. One of them had asked her partner for feedback so that their view was also considered although I did not meet him. They liked that I had a photo on the information leaflet and the time line provided clarity of both the observation and interview. Possible disadvantages or risk of taking part required was too wordy and with their suggestions reworded for ease of reading. With the more stringent data protection procedures coming in to place from May 2018 across the UK (GDPR), I still have the privacy document to compile which they are happy to read and comment on when completed”.

Once the privacy notice had been compiled in July 2018 one of the expectant second time parents gave feedback, while the other two expectant parents were unavailable at the time. It is important to be mindful of the challenges faced by service user involvement in research studies, such as a lack of training and preparation, which can make them feel unable to contribute meaningfully or feeling overburdened by their involvement (Brett et al. 2014).

Having service user involvement helped identify what was being done well in the research, as well as what required improvement so that appropriate, effective, and ethical research could be carried out (NHS Scotland 2025). Additionally, if people with lived experiences are engaged, studies often see better recruitment and sustained involvement in studies (NHS Scotland 2025). In this study poor recruitment was an issue despite some service user involvement.

Contact has been made with the research area Health Board research department patient and public experience group, to explore best ways to involve service users, in developing a final research report for publication following thesis completion. One antenatal group, and a parent carer group run by a charity in the research area have shown interest in being involved and will be contacted to help develop the report.

4.4 Recruitment

The research project was promoted at a Health Board wide forum for all HVs. Midwifery team leads and HV team leads were contacted. Consent was obtained to recruit HVs into the study and midwives to recruit expectant mothers and their partners. Recruitment was in two stages and across two zones within the Health Board. Zone 1 was geographically closer for travelling to and was recruited first. Zone 2 was further away with recruitment commencing 3 months later. Firstly HVs were recruited, then midwives attached to the HV teams were contacted to recruit parents. The whole recruitment and data collection process took a total of 22 months. See Figure 4.1 on the next page for the time line of recruitment and data collection for the study.

HV team leads were contacted and provided with recruitment packs consisting of participant information leaflets (Appendix 1) and invitation letters (Appendix 10) to distribute to an initial sample of 48 HVs (section 4.3.1). Twenty HVs showed initial interest in taking part, of which nine HVs were recruited. Midwives were contacted to recruit parents and were given recruitment packs to distribute to expectant parents (Appendix 2,11) and partners of expectant parents (Appendix 3,11) via a standard operating procedure (Appendix 8). Two parents were recruited. Three months after commencing recruitment in Zone 1 contact was made with Zone 2 to recruit there using the same process that initially identified 3 HV recruits (Fig 4.1).

Poor recruitment uptake led to a substantial amendment to the study (Appendix 12 and Fig 4.1 for timeline of recruitment) changing expectant parent recruitment from midwives to HVs. An updated standard operating procedure for HV recruitment of expectant parents was written (Appendix 9). A further 4 expectant parents were recruited following the amendment in Zone 1 whilst none were recruited in Zone 2. At the end of recruitment a total of 13 HVs and six expectant parents were recruited to the study. For recruitment figures see Table 4.6.

Figure 4.1 Timeline of Recruitment and Data Collection

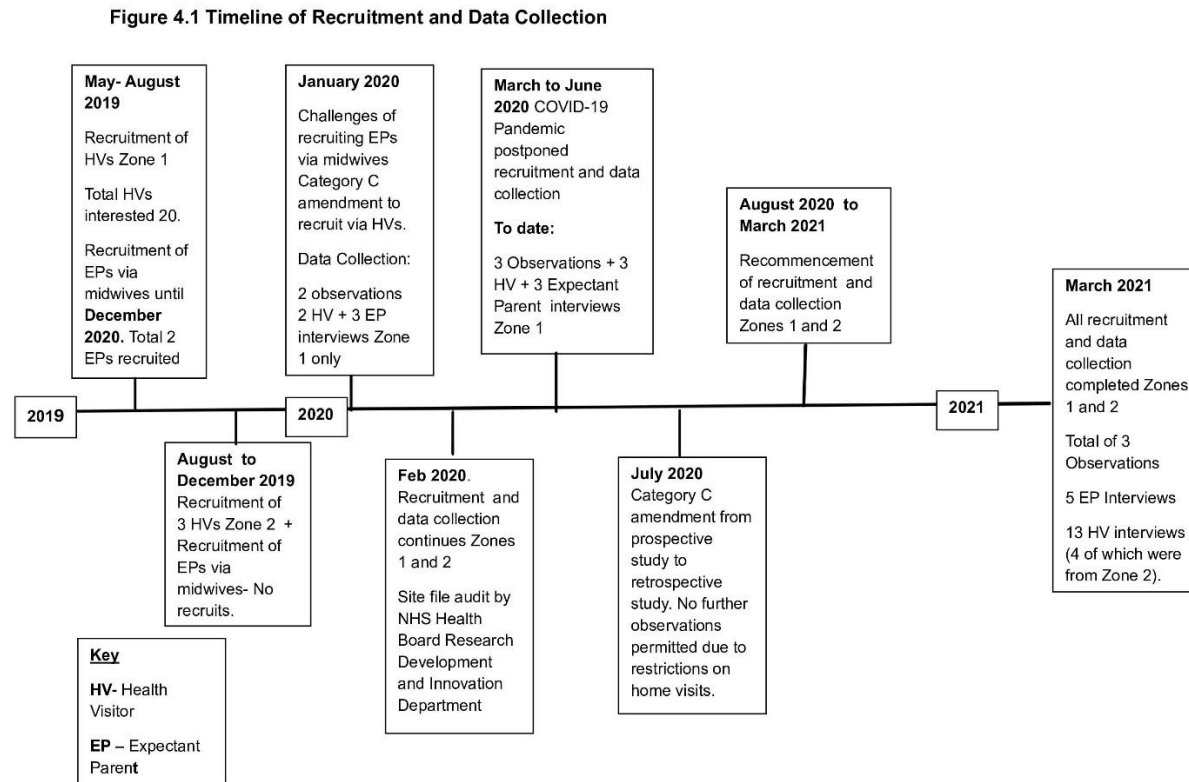


Table 4.6 Recruitment figures for HV antenatal study.

Area	Zone 1	Zone 2	Total	Comments
HV recruitment packs distributed by HV managers	42	27	69	16 HVs did not meet eligibility criteria Zone 1 / unknown for Zone 2
HVs recruited	9	4	13	
Expectant parents' recruitment packs distributed by midwives	38	Unknown	38	Staff shortages/ difficulty getting feedback
Expectant parents' recruitment packs via HVs	24	12	36	
Total of expectant parent recruitment packs	62	12	74	
Expectant parents recruited	6	0	6	

4.4.1 Recruitment challenges

Several challenges affected the recruitment process which included negotiating recruitment through a large geographical area comprising two distinct zones with differing organisational structures and processes, alongside the challenges of a global COVID 19 pandemic during the study. The challenges are discussed in turn.

4.4.1.1 Negotiating organisational structures and processes.

Recruitment of participants relied upon promotion of the study across two zones within a large organisation, one which was familiar and one not so. Promotion of the study at HV forums in person helped manage the situation along with seeking line manager support for promoting HVs and midwives to get involved in the study.

Part of this was that midwifery caseloads were based upon GP attachment whereas HV caseloads were geographically based, meaning identification of midwives to recruit expectant parents was not straight forward. This was managed by gaining agreement from HV line managers to utilise their administrative support to identify the expectant parents and inform the midwives. A process that relied upon good communication of antenatal bookings between midwives and HVs which varied across the organisation.

Motivation of line managers to promote the study and motivation of HVs and midwives to get involved in the study were also factors that may have affected recruitment, as found by midwives recruiting expectant parents as participants for other researchers (Daly et al. 2019). Motivation included intrinsic factors such as personal beliefs about robustness of the study and impact upon the baby. Extrinsic factors included the researcher's characteristics and the complexity of the research study (Daly et al. 2019). Meeting the midwives and team leads and promoting the study in person was a way of helping promote motivation, although meeting all staff within large teams was a challenge that was unachievable in such a large geographical area.

Due to staff shortages some HV caseloads changed during the study so the availability of potential expectant parents varied during the study. Recruitment numbers varied during the study due to caseload pressures, including staff absences, busy caseloads, and competing alongside other research projects seeking recruits within the organisation (Daly et al. 2019). Caseload pressures meant that some HVs were not prioritising antenatal visits and therefore although keen to take part in the study did not meet the inclusion criteria for the study. For the midwives and HVs who were recruiting expectant parents, gaining feedback on

how many recruitment packs were distributed was also an issue due to workload pressures and staff availability.

4.4.1.2 COVID-19 Pandemic

The total time taken for recruitment was 22 months which included a postponement of five months due to the COVID-19 pandemic March to July 2020 inclusive. Before research studies could recommence, NHS REC and local NHS RD&I departments requested information from researchers on their studies to check if they met requirements of Scottish Government guidance for post COVID-19 contact with individuals. Researchers were not able to visit people's homes and the Scottish Government had postponed HV antenatal home visits post COVID-19. The study could no longer proceed with observations or face to face interviews as home visits were no longer an option.

As no new antenatal contacts were possible, the study was changed to a retrospective study from a prospective one. A Category C amendment form was submitted to both the North of Scotland Research Ethics Service and the local NHS Board RD&I department, proposing changes that involved ceasing observations and conducting retrospective phone interviews with HVs who satisfied the inclusion criteria. Retrospective phone interviews were also offered to parents with children less than 18 months old who had experienced an antenatal visit. The amendment was accepted.

A total of three observations of the HV antenatal home visit took place and 13 HV interviews and five expectant parent interviews. One parent withdrew from the study following an observation, after being offered four interview dates. Their data from the observation remained as part of the study as documented in their consent form on use of data (Appendix 13).

A decision to stop recruitment was made when constant comparative analysis of data from the interviews and observations showed theoretical saturation had been

reached. It meant no new relevant concepts were being identified and the main categories showed variation and depth (Glaser and Strauss 1967).

4.4.2 Consent

Glaser opposes the use of consent forms, arguing that they undermine the rapport established between the researcher and participants and asserting that findings should be abstracted from the specifics of time, place, and individuals (Glaser 1998). This perspective is similarly shared by Glaser and Strauss (1967). However, since the 1960's researchers have an ethical responsibility towards their participants ensuring their participation in research studies are informed and voluntary (Birks and Mills 2015). Written informed consent was obtained for the research study prior to commencing interviews or observations with participants to ensure participants were fully aware of the study's nature, their involvement and their rights. The process promotes transparency, trust, and legal protection for both participants and researchers, meeting the legal and institutional requirements of institutions and ethics boards (Birks and Mills 2015; Creswell 2013).

The participant information leaflet provided an overview of the research, detailed its connection to a Doctor of Nursing educational programme, and revealed the researcher was both a student at the University of Stirling and a practising HV. The observation and interview processes were described, detailing observation of the HV antenatal home visit, and how they would be asked questions about their experiences of the HV antenatal home visit in the interviews. An explanation of how the information participants provided would be analysed and reported on was also included. The information clarified that participation was completely voluntary, and participants retained the right to withdraw at any time without justification or affecting their legal rights (Appendix 1, 2, 3).

Before each observation or interview, participants were asked to confirm that they had read and understood the participant information leaflet. They were also provided with an opportunity to ask questions and receive satisfactory answers. The

researcher provided a detailed explanation of the consent process and ensured it was properly documented. Written consent was obtained using a consent form documenting the participant's agreement to take part in the study and have observations and interviews digitally audio recorded and witnessed by the researcher (Appendices 13, 14, 15).

4.5 Data Collection

Building on the previous discussion of sampling methods, recruitment strategies, and obtaining consent, the following section explores the various data collection techniques, including observations, participant interviews, field notes, and documentation.

Qualitative research offers various data collection techniques, such as focus groups, interviews, observations, and documentation, with interviews being the most frequently used method (Creswell 2013; Ritchie et al. 2013). Observations, interviews and documentation are identified as core methods within grounded theory, (Glaser 2007; Glaser and Strauss 1967) with researchers showing a preference for the use of interviews (Tarozzi 2020). However, there is a paucity and vagueness of information about data collection methods in grounded theory as identified by Flick (2018) so data collection methods within qualitative research were referred to for guidance.

In this study, observation, interviews and field notes, were chosen as data collection methods. A combination of methods were selected, providing a rich variety of data to help answer the research question (Birks and Mills 2015; Ritchie et al. 2013).

Observations provided viewing of the phenomenon of the HV antenatal home visit and the elements of the process, such as behaviours and interactions as they occur (Ritchie et al. 2013; Tarozzi 2020). Interviews provided a detailed investigation of participant's personal perspectives and the personal context of the HV antenatal home visit (Ritchie et al. 2013). Field notes added to the context of the HV antenatal

home visit captured by observations by providing the researcher's perspective of the physical environment, interactions and nonverbal communications (Holton and Walsh 2017).

4.5.1 Observations

This section and the next refer directly to the role of the researcher within observations and interviews and therefore parts of it are written in the first person. Observations were used to view the phenomenon of the HV antenatal home visit and the elements of the social processes as identified in the research question (Tarozzi 2020). Observations provided direct access to the visit, an opportunity to be personally situated in the research setting, seeing, hearing and feeling every aspect of the visit (Salmon 2015).

Different terms have been used to describe the researcher's role during observations, such as 'non participant' and, more recently, 'participant observer' (Salmon 2015). In nursing research, participant observation has been categorised into three distinct roles: observer as participant, participant as observer, and complete participant (Parahoo 1997). The researcher's participation in this study did not precisely align with any of Parahoo's classifications but bore some resemblance to the role of observer as participant, as the researcher's role was known to participants, albeit with very minimal involvement.

The term 'non participant' appears debatable within ethnography and participation does not meet a single theoretical typology. Hammersley and Atkinson (2007) highlight all observers are participants but on a continuum from external to internal depending how immersed they are and to what degree participants are aware of their presence. Being an onlooker, an external participant that is not immersed fully in the internal social setting appears to sum up the participant observer role within this study, with the research participants being fully aware of the observer role (Hammersley and Atkinson 2007). Being an onlooker also adheres to the principles

of classic grounded theory so that the researcher does not interfere with the course of the natural setting (Glaser 1978; Glaser 1998).

The observation schedule (Appendix 16) was very loosely structured. It was devised in consideration of the exploratory nature of the research question and limited knowledge about the HV antenatal visit. Structured observations would force preconceived ideas, impacting upon the research process, by interfering with theoretical concepts developing from the data (Glaser 1998). A loosely structured observation schedule was a compromise to comply as much as possible with CGT principles but also to meet ethical committee requirements for an observation schedule.

Being a novice researcher the broad headings on the observation schedule gave reminders of areas to consider in the observation such as: description of the observation setting, what occurred, interactions and what happened, issues raised and opportunity to reflect on the observation and memo any conceptual thoughts.

The subsequent section offers a concise summary of the observation process during a HV antenatal home visit. At the outset of the visit I introduced myself to the participants, explained the observation process and answered any questions they had about it, then gained written informed consent (section 4.4.2). Participants were informed the researcher role was purely observational, sitting in the room observing the HV undertaking the antenatal visit with the expectant parent without taking part in the activities, taking notes and digitally audio recording the visit. All of the activities addressed the ethical issues of research participants being aware of their roles as research participants and being able to provide informed consent (section 4.4.2).

To minimise participation while assuming the observer role, I positioned myself away from the HV and expectant parents, out of their direct line of vision, but close enough to hear and see everything that took place. There was an awareness that using an audio recorder for both observations and interviews could potentially make participants nervous or influence the information they chose to share (Nordstrom 2015). While the risk could not be entirely mitigated, the digital audio recorder was

positioned conveniently between the participants, out of their direct line of sight, to make it less conspicuous. It was activated once the participants indicated they were ready. The HV and expectant parents proceeded with the visit, while I remained silent, observing and taking notes discreetly whenever feasible.

Each home situation was adapted to accordingly. In one home, which was open plan, an upper floor balcony area provided an ideal position for an aerial view. Being out of the participants' eye level minimised any distraction from my presence. At another home, the expectant parent insisted I position myself in the seating area with the HV and themselves, even though a nearby table and chair were suitable. With limited space in the room, decisions were made to reduce intrusion and satisfy the parent. Sitting at the end of a settee as far away from the HV and parent as possible and positioning my body away from them helped. To restrict distractions further, a decision was made not to take notes during the visit. The observation schedule was completed as soon as possible after the visit to capture everything remembered from the visit. Replaying the audio recording helped with recall of events (Artinian 2009; Tarozzi 2020).

Two of the observation visits had young children present. These children were a distraction not only for the parents and HV during the visit but also for my role as an observer, as they tried to engage my attention. I tried to ignore them, but on occasions, they would interrupt, and I had to focus their attention elsewhere. I am aware this impacted my ability to focus on the observational role. Undertaking observational research requires the observer to have strong observational skills (Morse 2016). Drawing on my experience as a HV, utilising observation skills and having a thorough understanding of the research topic and practice setting, along with an awareness of the unpredictability of children was essential in managing the situation.

See Table 4.7 for a completed page of one of the observation schedules, which captures participant interactions, sequences of HV actions and practices to contextualise the visit, as well as the mood, tone, and atmosphere of the HV visit.

Table 4.7 Example of completed page of observation schedule

Observation Schedule

IRAS Study Number 242281		Version 1 June 2018	
Date: 26.08.19 Time: 12.22 Duration: 30 minutes	Location Parents Home Rural	ID HV: A501 ✓ Consent: Obtained	ID P: A501 ✓ Consent: Obtained.
Description of setting: Lounge area of home, Settee and 2 chairs, lots of children's toys. Very tidy and clean. Mother present, 18-month-old child and HV. Workmen and father in hallway next door to the lounge cutting and laying a floor so lots of noise from cutting equipment and hammering. Event- when where why? Antenatal Home visit by Health Visitor for 2nd baby Atmosphere: Sense of familiarity, rekindling relationships with father and mother. Father familiar to HV, acknowledged HV and apologised for noise on entry to the home, prioritisation to get the flooring laid with help he had with him. Very noisy as workmen of father laying floor in hallway, conversation worked around the noise, difficult to hear at times. Demands of child varied on mother throughout visit and on HV at times, mother and HV juggling their conversation and focus when child communicated with them. Noisy child's toys as well as floor laying noise.			
HV Interaction with P including non-verbal: (who does what?) Sat near to each other, quite close, child between them, facing each other, good eye contact Interaction with child, showing tape measure she had played with before. Child tired, being shy. Did not respond to HV whilst mother left the room BP/Preparation for managing BP Child unsettled several times, both HV and parents helped child to play with toy, pressing toys to help child settle. Good eye contact, sitting near each other, both relaxed in each other's company Child getting tired, playing up, mother cuddling child Gave information on dental development. Issues raised: Stage of pregnancy Blood pressure- epidural helps bring down BP. Effects of medication. Asked to observe mums own BP reading. Preparation for going in to hospital/staying nearby hospital day before. Encouraged to stay in hospital as long as possible. Support from grandparents- looking after child. Explored feeding- how to stimulate milk supply/ support for breastfeeding. Universal pathway/ working with midwives.		P Interaction with HV including non-verbal: (who does what?) Comparing growth scan with growth of previous child Discussed medication relating to BP- benefits outweigh risk/change of medication. Speaking with consultation, 7 growth scans. All going well, baby growing well. Kept coming back to the BP when talking about plans for delivery. Child playing with noisy toy Mother left the room to get BP readings. Ran straight to mother when she came back in. Child getting more upset. Mother attempting to settle the child. Will try breastfeeding, milk came in day 4 with first baby. Anxious about all the delivery. Support from husband Discussed finishing work, taking some time before baby is due. Delighted with baby box. BP only hindering the pregnancy, everything else going well. Issues raised: Being a worrier, needs to be in control, not knowing what happens affects raised BP example of BP reading after growth scan lower than before How long in hospital How to breastfeed so milk comes in before day 4. Does not want to go in to labour, wants elective caesarean, due to infection. Tired, anaemic- Iron levels have been checked.	

These elements are qualities that researchers should aim for when conducting observations (Wästerfors 2017).

As well as the observation schedule, field notes and transcriptions of the audio recording provided a rich variety of data about the social phenomenon of the HV antenatal home visit (Wästerfors 2017). All the documentation from the observation attempted to give an accurate representation of the visit and provide credibility of the data provided (Baillie 2013).

Observations are a researcher's perspective on the phenomenon they study. In order to gain the participant perspectives, interviews were also used as a data collection method, highlighting interviews are necessary and complementary to the observation process from the data it gathers (Glaser (1998). The next section focuses on interviews followed by an examination of how the researcher's presence influences both observations and interviews.

4.5.2 Interviews

Interviews are a widely recognised method in qualitative research (Cresswell 2013), holding a vital role as a primary data collection technique in grounded theory (Glaser and Strauss 1967). They effectively capture the perspectives and lived experiences of expectant parents and HVs regarding antenatal home visits, allowing participants to convey their thoughts in their own words. The interviewer's role is to interpret both the factual content and the deeper meaning of participants' responses (Brinkman and Kvale 2018).

The interviewer functions as the primary research instrument, with the quality of the knowledge produced being dependent upon their expertise, sensitivity, and proficiency in the subject matter (Brinkman and Kvale 2018). Despite having skills in interviewing for HV practice purposes, research interviewing skills in grounded theory are different.

Skills in attuning to each participant and what they are saying, being theoretically sensitive to what that means for the developing theory (section 4.6.3) and directing the interview accordingly can be challenging (Birks and Mills 2015). Preparation for the challenge included developing skills in undertaking an audiotaped interview with a work colleague about an unrelated topic and debriefing with research supervisors. Following completion of the research study interviews, the use of reflection and memoing, and research supervisor feedback about the audio recordings of the interviews helped develop research interviewing skills further (Birks and Mills 2015).

The process of conducting interviews closely mirrored that of conducting observations in terms of addressing ethical considerations such as establishing familiarity with participants, explaining the purpose and procedure of the interview, and obtaining written informed consent (section 4.4.2). Those expectant parent participants that also took part in observations were interviewed in their homes, and their HVs were interviewed in their HV bases. All interviews were face to face until the COVID-19 pandemic. Due to the restrictions of in person meetings after the pandemic HVs and expectant parents were mainly contacted by telephone interview, with some through video calls (section 4.4.1).

With telephone interviews the loss of visual cues may result in loss of nonverbal and contextual data, which compromises interpretation of participant responses, probing and rapport building (Brinkman and Kvale 2018; Novick 2008). In this research study, via a telephone interview, a parent recounted past experiences of their first child's health issues and how that impacted on their subsequent relationship building with their second child's HV. It is possible the parent respondent may have felt more able to disclose sensitive information via a telephone interview capturing rich data in the process and therefore was a valuable data collection method (Novick 2008).

The interview process initially began with an unstructured approach and gradually evolved into a more semi-structured format as the study progressed, ensuring flexibility in line with theoretical sampling and data saturation (Glaser 1998).

Unstructured interviews commenced with a broad open ended question about the HV antenatal visit, with subsequent questions shaped by participant responses (Holloway and Wheeler 2010). Designed to remain flexible and non-directive, the interviews were guided by a topic guide (Appendix 17). Instead of listing specific questions, this guide outlined key areas for discussion, informed by existing literature and the Scottish Government's guidelines on the HV antenatal home visit (Scottish Government 2015a). The key topic areas consisted of: purpose of visit; interactions and relationships between people; discussion topics related to observations; public health topics; assessment and what is involved; and types of support and their significance.

The CGT approach of directing data collection in the interviews was through theoretical sampling (section 4.3.2). As previous observations and interviews were analysed, substantive coding identified concepts relating to the HV antenatal home visit as part of the constant comparative analysis process. Memoing alongside substantive coding identified concepts that required exploration with further participants to see if those concepts were also relevant to them (section 4.6.4 and 4.7.1) Memos provided further topics to include on the topic guide for interview. For an example see Table 4.8. Conversations between HV and parents about safety are highlighted. A memo relating to the observation identifies the concept of safety and the need to probe about it further at interview. An excerpt of the interview probing safety aspects with the HV involved in the observation is documented with a follow on memo identifying HV past experiences relating to cot deaths and shaken baby syndrome impacting upon their focus on safety within the visit.

The initial topic guide was developed during data collection. The addition of more points of discussion identified from HVs and parents who had been observed or interviewed were used for probing further participants. See Appendix 18 for an updated topic guide with subjects added.

Questions became gradually more focussed as the theory emerged using more semi structured questions and the research field narrowed as it moved towards identifying a core category (section 4.9). The level of structure within the interview

process was appropriate for the CGT method allowing for following where the conversation led and modifying questions as concepts developed during analysis (Birks and Mills 2015).

In addition to field notes, interviews and observations were digitally audio recorded and transcribed ready for analysis. Glaser (1998) advises against audio recording and transcribing, promoting the use of field notes only. His argument is that field notes capture the conceptualisation of data, whereas recording and transcriptions encourages a focus on time consuming description of data, provides unnecessary amounts of data and goes against the CGT approach. Whilst respecting CGT principles, audio recording and transcriptions allowed revisiting of the data to listen or visualise nuances and themes that may have not been noticeable in the interviews or observations (Artinian 2009; Tarozi 2020).

Table 4.8 Development of concepts and coding relating to safety

Table 4.8 Abbreviations: HV= Health Visitor. EP= Expectant Parent. R= Researcher			
Observation A502 25.02.20. Excerpt relating to safety	Memo 01.03.20	Excerpt from A502 HV Interview 03.03.20	Memo: 04.05.20
HV: You have got a moses basket, good. So, we recommend the baby is in your room for the first six months as well. “There is no cot bumpers in it at all is there? EP: No, it is a wicker basket. My gran always changes the lining on it for me, whether it has been pink or blue she has	Code: Safety. Safety featured in HV conversation. Different aspects of feeding and feed preparation	R: So, you are saying you are looking at what the house is like what are you looking for when you are kind of thinking about that? HV- Yes it is making sure it is baby friendly just asking simple questions about whether they have got things ready for the baby. In terms of if they are going to bottle feed is it suitable for sterilising, have they got all the equipment they need. Where's the baby going to sleep, is it going to sleep in their room, Have they got the baby box, those kind of	Some of the key topics are more important to the HV as they relate to the HVs previous experiences of traumatic episodes such as cot death, and shaken baby syndrome have influenced them in their practice in focussing on safety including safe sleeping. They also include safety around.

Table 4.8 (Continued) Abbreviations: HV= Health Visitor. EP= Expectant Parent. R= Researcher			
Observation A502 25.02.20. Excerpt relating to safety	Memo 01.03.20	Excerpt from A502 HV Interview 03.03.20	Memo: 04.05.20
always done it.....No, we have a cot bumper and everything for the cot bed. HV: So, they look nice but don't actually use them when they are asleep in it. All you need to put in is the baby. HV Have you got a car seat for leaving the hospital? EP - Yes, it is at my mums. The pram and the car seat is at my mums. HV:..... And have you got all your bottles and things like that? EP - Bottles, steriliser.	Observation storage and sterilisation, car seat, baby sleeping, moses basket and cot. Plan to probe further in HV interview.	logistical things. If they have got a dog is there a way to keep the dog separate from the baby, have they got baby gates up that kind of thing R-(Recounts main points to HV that they have mentioned)..... "and like you talk a bit about safe sleep and the importance of that. Tell me a bit more about that from your perspective, because that is a key one that you want to focus on"... HV- For me personally I think it is because I have, years ago not one of my cases but we did have a sudden infant death, a baby died of sudden infant death so I think I have always remembered that and it was horrific and I think that I am always anxious about talking about that trauma . When I worked on the children's ward we had a couple of cases of shaken baby syndrome so that is another one the one I talk about at the newborn visit, I know I don't talk about that now. I think when something like that happens to you, you remember it and it and sometimes that is why it makes you focus on things when you go and do a visit. If you experience something like that a sudden infant death I always think you are always a bit more paranoid about it.	animals, safe feeding practices Coding of interview, new codes: Anxiety Feelings relating to past experiences and impact on HV Influences past experiences influencing HV practice. Knowledge- HV aware of impact of cot death and shaken baby syndrome.

4.5.3 Researcher reactivity within observations and interviews

Researcher reactivity is a consideration in qualitative research during data collection. The reactivity effect is a situation when researchers are undertaking observations and interviews and their presence affects the participants who tell the researcher what they want to hear or deviate from their routines (Zahle 2023). Strategies were utilised to help minimise researcher reactivity as also utilised by Bolster and Manias (2010) in their observation and interview study in a hospital setting. They included spending time with participants prior to the commencement of data to enable participants to feel comfortable with the observer and interviewer role and observation and interview processes was one approach used. Another involved positioning myself unobtrusively in the observations, avoiding eye contact with participants where possible.

Researcher reactivity occurred during one interview when a HV participant asked for my opinion as a HV on two separate occasions in their interview, whether I used certain postnatal depression questions, and if I gave out all the public health information leaflets antenatally during the interview process. I responded with yes/no answers. The HV knew I was also a practising HV. It materialised after completion of the interview that they were a lone worker, fairly new in their position seeking clarification about the role. Minimising the reactivity is considered a traditional viewpoint to aim for reactivity free research, which in practice may not be possible (Zahle 2023). However, the more contemporary viewpoint is researcher reactivity may occur, so it is more about understanding it so it can be considered and factored into the analysis of the data (Hammersley and Atkinson 2007; Maxwell 2013). The researcher reactivity was recognised and captured on transcriptions of the audio recordings, field notes and memos and used as data in the data analysis process.

4.5.4 Field notes.

Field notes were documented after conclusions of observations and interviews, on leaving the participants. They were fairly brief in the moment reminders capturing the physical environment, interactions and nonverbal communications not revealed during transcriptions that may indicate potential concepts (Birks and Mills 2015; Holton and Walsh 2017).

Utilising constant comparative analysis potential concepts were identified by carefully reviewing the notes to help develop emerging codes and categories. A process of theoretical sampling further refined the concepts (section 4.3.2) and theoretical memoing (section 4.6.4). Examples of the researcher's field notes are provided in Table 4.9.

4.5.5 Theoretical saturation

Grounded theory data analysis follows a progressive approach, with theoretical saturation serving as the key indicator for determining when the theoretical sampling phase should conclude (Birks and Mills 2015). Theoretical saturation is reached when further analysis generates no new theoretical insights, and additional data fails to produce original codes (Glaser and Strauss 1967).

Theoretical saturation was reached when further data collection no longer contributed any additional properties or dimensions to a category and a judgement was made not to collect any further data (Birks and Mills 2015; Urquhart 2013). The final interview did not identify any new concepts therefore no new codes were generated. Data from the interview provided repetition of the main concepts of relationship building, assessment and managing the visit from their personal experiences, but provided a lack of diversity of the data so a judgment was made that theoretical saturation had been reached.

Table 4.9 Example of field notes

A101 HV Interview
It is relationship building that featured really strongly throughout. The challenges they face if they haven't got the relationship. She talks about the chasing her tail and getting the opportunity to see the parents. She talked of mainly seeing mothers, very little does she see fathers but finds the benefit of looking at the dynamics of the relationship as well when they are there. The summary from this is really about relationships and communication and expectations.
A502 Observation
Confined space. Mother wanted researcher to sit next to her on the settee, researcher did not want to get in the way of the conversation or be included in the conversation so sat back so not in mother's eyeline. Avoided eye contact with HV as well, as sitting diagonally opposite researcher. Experienced mother, current plans influenced by past experiences, especially last pregnancy. Some anxiety present and mother wanting to be in control of what is happening this time. She talks of what she is going to say to the consultant and what she wants. HV is very familiar with this mother and appears to be comfortable sharing her experiences with her. HV aware mother parents how she wants to, listens, and acknowledges her way and adds in latest guidance diplomatically to ensure current evidenced based advice is given.

It has been proposed that nine to 17 interviews is an adequate sample size to reach theoretical saturation in qualitative studies with relatively homogeneous research populations (Monique and Kaiser 2022). Within grounded theory interviews, however, an average of 25 was recognised to reach theoretical saturation (Thomson 2010). Precise recommendations are challenging to provide due to the significant variation in qualitative studies, involving diverse conditions and numerous factors (Morse 2000). These factors include the sensitivity and nature of the topic, the scope

of the research question, and the researcher's expertise and capabilities (Thomson 2010).

The HV study comprised of observations as well as interviews which added another dimension to consider. Three observations and 13 interviews was deemed sufficient, with theoretical saturation achieved once enough data had been gathered to reveal patterns, concepts, categories, properties, and dimensions of the study phenomena (Glaser and Strauss 1967). Theoretical saturation is not solely defined by the absence of new concepts, it also involves the thorough development of categories, ensuring they are well defined and encompass a variety of features (Monique and Kaiser 2022). It serves as a crucial element in steering the final phase of theory development (Birks and Mills 2015).

4.6 Data Analysis

The CGT methodology emphasises analysing data as it becomes available. This approach focuses on conceptualising the data rather than merely describing it, aligning with Glaser's perspective:

“all is data” (Glaser 1998, p.8).

This study reaffirmed Glaser's (1998) perspective on capturing the essence of the research scene by conceptualising data from interviews, observations, and documentation, while thoroughly analysing all data components.

The section details the data analysis process employing constant comparative analysis through coding, identifying categories, and developing a core category. It emphasises the emergence of a new substantive theory through theoretical conceptualisation of the data. The analysis followed a structured three stage coding approach consisting of open, selective, and theoretical coding (Glaser 1978; Glaser 1992; Glaser and Strauss 1967). During this process, codes are identified, structured into categories, and further interlinked through constant comparative

analysis. A detailed explanation of the coding methodology is referred to in section 4.7.

While Strauss and Corbin (1998) introduced more structured approaches to coding, this study adopted Glaser's perspective, which emphasises allowing codes to naturally develop from the data rather than fitting them into a pre-defined framework (Glaser 1978; Glaser 1992). This approach facilitated the formation of relationships between constructs, ultimately contributing to theory development (Glaser and Strauss 1967).

4.6.1 Constant comparative analysis

A systematic approach for developing codes and categories known as constant comparative analysis is a fundamental aspect of grounded theory (Chun Tie et al. 2019). This approach encompasses an ongoing cycle of data collection, analysis, and comparison to uncover concepts and develop theories (Elliott and Lazenbatt 2005). The process commenced with open coding where concepts were identified and coded and compared to form categories (section 4.7.2). Subsequently, selective coding refined the categories further and the connections between them, organising and linking them to establish the study's core category (section 4.7.3 and 4.9). This method involved comparing data within particular categories to assess its significance, either by expanding an existing category, creating a new one, or identifying a novel relationship (Urquhart 2013). Through the iterative analysis, conceptual understanding was enhanced, revealing overarching patterns and connections that go beyond individual cases, thereby fostering a more combined and unrestricted perspective (Glaser 1978; Glaser 1998).

Data collection, constant comparative analysis and theoretical sampling were conducted simultaneously becoming conceptually linked by informing each other during category development. See Figure 4.2 for a diagrammatical representation of the interplay between them. It demonstrates the three main areas of grounded theory as cogs turning together within a pulley system. The pulley represents the

development of the research which could not evolve unless the three cogs were turning together. Data collected from the first sample of participants (data collection cog) was coded and analysed (comparative analysis cog).

Theoretical sampling (theoretical sampling cog) was employed to identify data leads, select subsequent data sources, and develop conceptual categories (section 4.3.2). For grounded theory and constant comparative analysis to be effective, all the cogs needed to operate at the same time. The combined process of memo writing and theoretical sampling facilitated the refinement, alignment, and development of codes, ultimately leading to the construction of categories (Glaser, 1978).

The arrows outside the cog represented the process constantly moving using a process of induction and deduction that occurred throughout the research course as theory was developed. For example, categories, their properties and dimensions were established by inductive analysis and hypothesising, exploring relationships between concepts and developing conceptual categories was deductive analysis (Glaser 1978).

The process continued until theoretical saturation was reached and the substantive theory was developed. Memoing is represented as the purple colour of the pulley system. Memoing provided the momentum for keeping the pulley system moving by helping form relationships between the developing categories during data collection, analysis and theoretical sampling (section 4.3.2). The documentation of field notes informed and enhanced memo writing by providing raw data and contextual richness (section 4.5.4).

Constant comparative analysis emphasises that the conceptualisation of data and the development of conceptual relationships are fundamental to the explanatory strength of grounded theory (Glaser 1992).

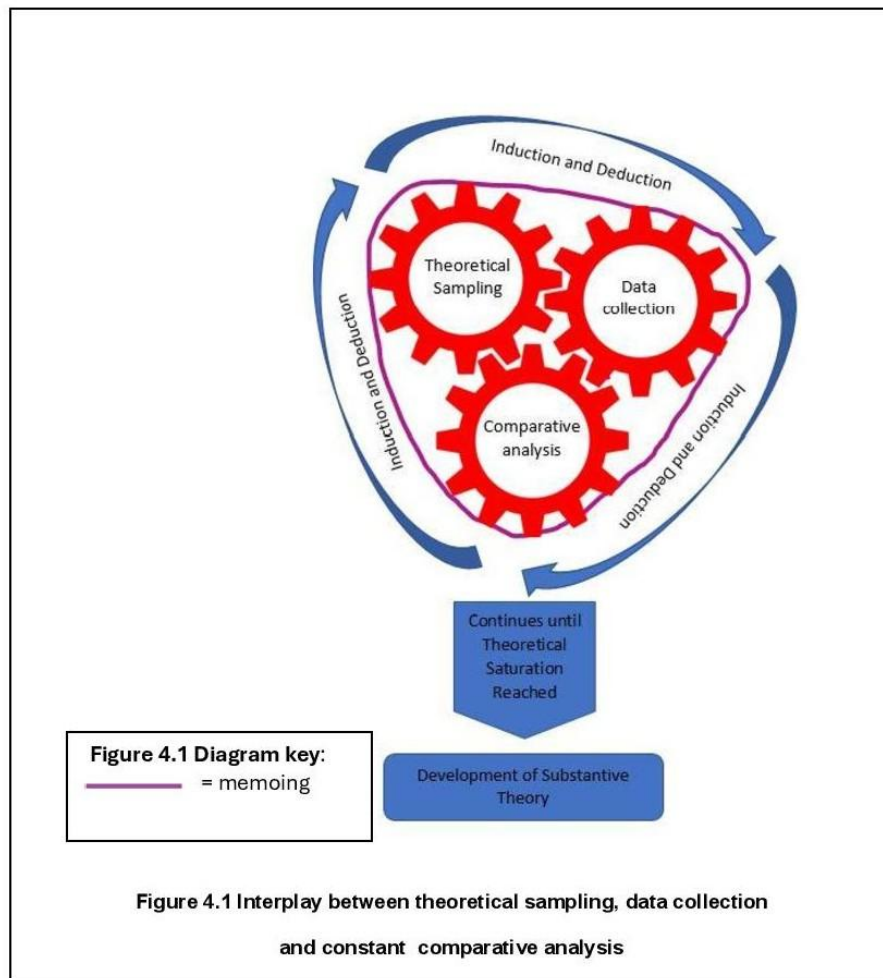


Figure 4.2 Interplay between theoretical sampling, data collection and comparative analysis

4.6.2 Computer software packages

The initial intention was to conduct data analysis without utilising any Computer Assisted Qualitative Data Analysis (CAQDAS) software tools. A spreadsheet was utilised for recording text, codes and memos during the open coding process. The amount of data soon became overwhelming to manage so software tools were then considered (Urquhart 2013). NVIVO 12 was chosen as the software tool to help

with data management and support data analysis, developed by an Australian company (QSR (Qualitative Solutions and Research) International 2018).

In grounded theory, Glaser argued that using computers in data analysis could lead researchers to focus on comprehensive descriptive coverage rather than developing a grounded theory, thereby hindering the intuitive skills essential for the grounded theory process. Nonetheless, he acknowledged that computerisation could be utilised, provided it aligned with the principles of grounded theory (Glaser 1998).

Mindful of his view and consideration of the unfamiliarity of the NVIVO software package despite some basic training, it was used mainly as a word processor and as a database for storing, exploring, managing, and retrieving data (Tarozzi 2020). Using it in this way supported intuitive skill development that the grounded theory process requires (Glaser 1998).

Transcripts of interviews and observations and field notes were imported to NVIVO. NVIVO was used for open and selective coding (section 4.7.2 and 4.7.3). Codes and memos of the codes were recorded from the data. Various functions on NVIVO provided visual representations of the relationships between codes and the relevant data and memos linked to them. NVIVO was utilised to quickly find and export texts with quotes for the findings chapter (Chapter 5: Findings).

NVIVO software was acknowledged as a valuable tool for supporting data analysis due to its flexibility in storing, organising, and accessing raw data. It served as a consistent reference during the later stages of conceptualisation, ensuring rigour in the development of categories (Solimon and Kan, 2004). However, NVIVO itself neither built theories or conducted the analysis, it was the researcher's responsibility to comprehend and apply the appropriate research methods during the analytical process (Morse 2016; Weitzman 2003), as outlined in the subsequent sections of the chapter.

4.6.3 Theoretical sensitivity

Theoretical sensitivity is a vital concept in CGT, underpinning the entire research process. It reflects the researcher's skill in identifying concepts within the data and linking them to the development of theory, all while preserving an unbiased and open minded perspective (Birks and Mills 2015; Chun Tie et al. 2019; Glaser and Strauss 1967). In this study, cultivating theoretical sensitivity throughout the research process ensured a targeted analytical approach focused on theory development, ultimately leading to the creation of an integrated and abstract grounded theory (Birks and Mills 2015). Uncovering concepts directly from the data and systematically refining them through ongoing analysis throughout the research process is how theory is developed (Glaser and Holton 2004).

Theoretical sensitivity was developed through practices such as reading, active listening, and engaging in creative and innovative thinking (Glaser 1978; Glaser 1992; Glaser and Strauss 1967). The process began by entering the research environment with minimal preconceptions (Glaser 1978). In order to reduce its influence on the study an unbiased review of existing literature on the HV antenatal home visit was performed. By staying engaged with the study data rather than referring to the literature it allowed the emerging theory to determine the relevance of any literature to the study (Urquhart 2013).

Setting aside preconceptions, being attuned to the data and keeping an open mind were integral aspects of the coding process. For instance, during open coding (section 4.7.2), every piece of data was treated as meaningful. Careful attention was given to the subtleties of words and phrases and recognising and extracting concepts as they appeared from the data, in accordance with Glaser's (1978) recommendations. In selective coding (section 4.7.3), categories were developed specifically related to the HV antenatal home visit. This phase required interpreting the data by revisiting categories and their content to establish plausible connections through constant comparative analysis (section 4.6.1). Over time, the ability to differentiate between more significant and less critical data was continually refined. Additionally, transferable skills from HV practice such as recognising, managing,

and analysing situations played a vital role in navigating ambiguity within the data and fostering the development of theoretical insights and conceptual ideas (Holton 2007).

During the analysis, intuition, attentiveness to the data, and perceptiveness were enhanced, particularly in the development of the core category (section 4.6.3). By refining and integrating main categories, the core category was identified, its characteristics defined to address the research question. Immersion in the data occurred from revisiting audio tapes, transcripts and field notes from observations and interviews, and theoretical memos, as a way of identifying how participants construct their meanings and understandings (Glaser 1998).

Theoretical sensitivity during theoretical coding was developed by applying existing knowledge of coding while enhancing the scope and depth of the theory through the discovery of codes derived from an exploration of the literature (Glaser 1978). Rather than being predetermined, codes emerged from the data, serving as the essential groundwork for constructing the theory (Glaser 1998).

4.6.4 Theoretical memos

Theoretical memos, as outlined by Glaser, are an essential aspect of the grounded theory methodology:

“The theorising write up of ideas about codes and their relationships as they strike the analyst while coding” (Glaser 1978, p 83).

In this study theoretical memos were utilised to capture and retain the development of ideas that could be lost if not written down and are useful in sorting data conceptually (Glaser 1978). They facilitated development of theories by exploring codes, categories, and the connections between them. This process also uncovered significant findings, enabling the emergence of distinct themes and the evolution of a theory (Urquhart 2013).

Glaser offered limited guidance on the criteria for effective memo writing (Glaser 1978; Glaser 1998). Instead, the approach to memoing followed more contemporary recommendations, emphasising the flexibility of the process and encouraging a personal method that captures spontaneity and the natural flow of thoughts while documenting analytical pathways (Birks and Mills 2015). Consequently, memos were composed throughout the research journey, from data analysis to theory development. Each memo was marked with a date, time, and brief title, with subsequent additions or modifications also documented with timestamps to reflect evolving thought processes and developmental insights (Table 4.10). The memos encompassed reflections on emotions and assumptions related to the research, the researcher's philosophical stance, procedural considerations, and decision making processes, such as insights on the COVID-19 pandemic and its influence on the direction of the study. Participant quotations were also included to support decision making. Collectively, the memos created a comprehensive audit trail of the research process.

Memos acted as a tool for reflection, documenting the researcher's insights and expanding on concepts gathered from observations and interviews and identified in field notes. They proved valuable in coding and category development, establishing connections between codes, and supporting and refining analytical decision making processes (Birks and Mills 2015). Additionally, memos guided theoretical sampling by addressing concepts and questions that arose from field notes on the data.

When constant comparative analysis commenced memos were quite brief. As more data was analysed the memos became more in depth theoretically, referring to wider sources of data, describing the meaning of conceptualised ideas and their theoretical direction as well as direction for theoretical sampling and for developing the substantive theory (Birks and Mills 2015; Glaser 1998).

Some memos were written about earlier memos as the level of abstraction raised confirming Lempert's (2007) view that memos are therefore additional data in the study. See Tables 4.11 and 4.12 for a memo developing the substantive theory.

Table 4.10 Memos regarding coding data

<u>Memos about Coding:</u>
24/02/20 19.30 Coding (codes in bold) Supervision session today. Open coding not as easy as I thought it would be. Memoing needs to be capturing a record of my evolving thinking. Consider using NVIVO to help me analyse and structure it. Coding and Topics for next interviews. 60 codes from 2 observations and 3 interviews. Codes most referenced: Relationship building, including familiarity, parent being seen as expert about what they already know about parenting. Partnership working with parents Sharing self has been mentioned by HVs with families to promote relationship building and trust in the HV. Explore information sharing further between HVs and parents. Part of HV role including assessing and knowledge of home and family situations and exploring, how parents are planning and preparing for the baby's arrival. Providing support and advice to parents about managing their health, such as anxiety feeding, preparing for the baby. Explore topics further with parents and HVs. 20/09/20 13.00 Coding Coding in Classic Grounded Theory: I've Done an Interview; Now What by Barry Chametzky (2016). This is a good article as it recognises how hard coding is. I am feeling currently that I am using themes rather than social processes but I will get the words down and work on them. Examples in the study are useful. Think about the social processes rather than actually the people or situation involved. I will try that. 24/05/2021 12:46 Coding Considering when open coding ends. I have explored saturation, data and theoretical saturation. Complex topic, differing views just within grounded theory. Use term theoretical saturation rather than data saturation as using CGT. Birks and Mills (2015) and Urquhart (2013) describe no more new codes yet Glaser and Strauss (1967) talk of developing the categories and the richness of data. I need to look at the categories in terms of the richness and diversity of the data when I code them I plan to do this from any coding from this point. My understanding of saturation is now clearer. I will be aware of coding and review whether new codes emerged. I also need to be mindful of not trying to fit data in to codes just so I do not make new ones. My codes are varied and some have similar meaning so I need to look at comparing them. I need to also make links to theoretical sampling which gives the diversity of the data that I have come to the point where I have nearly exhausted avenues to get any more data. Is it enough that I have so far? Richness of data within the codes will help determine where I am.

4.7 Coding

In classic grounded methodology, coding is a fundamental process that links concepts to the data for analytical purposes (Holton 2007; Urquhart 2013). Grounded theory methodology employs two forms of coding: substantive coding, which encompasses both open and selective coding processes, and theoretical coding (Glaser 1978; Holton 2007).

Open coding facilitated the identification of initial codes, which were used to develop categories and enable the emergence of the core category. These categories were grouped and connected through constant comparative analysis (section 4.6.1). Theoretical sampling and selective coding further refined and enriched these categories, contributing to the development of the core category.

Theoretical coding played a key role in constructing the study's substantive theory by conceptualising the relationships between the codes. Each of these codes is examined individually.

4.7.1 Substantive coding

Codes serve as the connection between data and theory. By breaking down the data and organising it into conceptual codes, the codes evolve into the theory that explains the patterns and phenomena observed in the data (Glaser 1978). Substantive codes encapsulate the empirical essence of the research area, derived directly from the data (Glaser 1978; Holton 2007). In the HV antenatal study, the data was conceptualised through an initial process of open coding, leading to the identification of a core category. This was followed by targeted data collection and analysis through selective coding to refine and saturate the core category and its associated categories (Holton 2007).

Table 4.11 Memos developing the substantive theory

<u>Developing the Substantive Theory : Memos and Journal Entries</u>
<u>13/11/2021 08:30 Main Categories and Core Category.</u> Research Supervision 25th October 2021 discussed possibility of <i>adjusting</i> as core category. Currently 12 categories that are guiding, feeding, gaining knowledge, giving and taking, supporting, tailoring, parenting, expectations, feelings, assessing, communication and managing. Communicating, assessing and managing are the bigger categories currently. Adjusting relates to communicating between HVs and parents and how conversations are adjusted to help relationship building and trust and approachability with the HV. Parents and HVs are adjusting gaining knowledge about each other from their conversations which helps inform the assessment process in the visit. Assessing is adjusted to the parental situation and how communication develops and what information is shared. Giving and taking is about HVs and parents giving information to each other as well as giving and taking advice which is adjusted to what information is shared between them. Feelings and expecting are linked to parental experiences and what participants expect from the visit and how HVs or parents adjust how they share information, engage with each other or ask for support. Parenting and feeding categories provide information about how parents adjust to parenthood, and how they are going to feed their babies. HVs in managing the visit adjust advice and support about those areas depending upon what information is shared and what parents know. Tailoring involves tailoring conversations to help relationship building, tailoring the assessment to the parents as well as advice and support depending upon what is assessed or asked for by the parents.
<u>15/10/22 19.40 Main Categories and Core Category.</u> From coding and constant comparative analysis 6 categories remain : 1. Relationship building main category that is the gateway to Assessment. 2. Assessment main category that assesses parental health and their situation and preparation for the baby's arrival. 3. Management of the Antenatal visit main category is about establishing relationships with parents and providing appropriate support and advice according to what parents ask or need. 4. Sharing information stands as a subcategory of all the main categories being part of relationship building, assessing and managing the antenatal visit. HVs and parents share information with each other in order to build their relationships. Information is shared by parents to inform the assessment process by the HV. Sharing of information is part of managing the visit by HVs by linking in with midwives and other professionals as well as the advice and support that the HV offers to parents 5. Tailoring is also a subcategory of all the main categories as HVs tailor their conversations to support relationship building, tailor the assessment to what parents talk about or what information is shared with them. In managing the visit advice and support is tailored to parental request or need. 6. Supporting and Guiding is about HVs supporting and guiding the relationship building process which in turn supports and guides the assessment process. In managing the visit parents guide HVs as to what advice and support they need and that HVs provide to parents.

Table 4.12 Further memo developing the substantive theory

<u>Developing the Substantive Theory : Memos and Journal Entries</u>
<u>15/10/22 19.40 Main Categories and Core Category (continued)</u> Main categories of relationship building, assessing and managing the visit captured in example from the data as well as aspects of adjusting, where HV allowed conversation to be led by parent, adjustment of advice and support based on assessment of current situation with maternal health and anxiety levels : Example from data: A501 Observation Field notes: <i>Familiarity with HV. Very relaxed visit. Mother's anxiety predominant in visit within conversation but not from mother's presentation. She was calm, possibly from knowing the HV well. She returned to talk about her blood pressure several times. Being out of control with this birth worries her. Focus of discussion and advice on the impact of her raised blood pressure on previous pregnancy and this one, managing her anxiety, as well as previous feeding difficulties last time and plans for this baby. (A501 Observation field notes).</i> The overarching Core Category is parents and HVs adjusting. Thoughts are that they are adjusting to <i>parenting</i> but that is more about the parents adjusting than HVs although HVs are helping them to adjust. Need to explore what the data is saying. Core category is usually the most relevant behaviour for participants according to Glaser (1998). Although relationship building, assessing and managing are all main categories the adjusting that goes on in each of the areas is the behaviour that stands out that links them all together.

4.7.2 Open coding

After the first observation, open coding was initiated to attach conceptual labels to the data. Open coding involves breaking the data down and coding it in various ways to generate a set of categories that can be integrated into a theory (Glaser 1978).

Line by line coding was applied, carefully coding each sentence to maintain closeness to the data. Each piece of text was given detailed thought, broken into parts, and compared through a constant comparative process, which helped evaluate the significance of each piece in developing categories (Glaser 1978).

To further immerse in the data and promote theoretical sensitivity, audio recordings of the observations were listened to, and the transcripts and field notes were read

prior to coding. The immersion helped remain open and free from preconceptions (Glaser 1978; Glaser 2013).⁸

Glaser recommends aiding the coding process by posing questions to the data, such as:

“What is this data a study of?” “What category does this incident indicate?” “What is happening in the data?” (Glaser 1978, p.57).

Despite these guiding questions, the initial stage of coding was challenging, a common issue for inexperienced grounded theorists (Holton 2007). An illustration of open coding is provided in Table 4.13.

Open coding began as descriptive but evolved into more analytical codes that provided meaning and patterns within descriptive incidents (Glaser 1992). The tandem process of coding and memoing (section 4.7 and 4.6.4) captured conceptual ideas about the coding, aiding pattern development, theoretical sampling, and data analysis (Holton 2007).

Table 4.13 Open coding example

Open Coding Example Section of A601 HV interview transcript

R = Researcher HV = Health Visitor. Coding words in **bold**

R. So what do you feel the purpose of the visit is?	Open Coding
Hv- I feel that it’s an introduction for the parents by the health visitor, and also vice versa because obviously you’re going to be going out hopefully in a few short weeks to meet those parents and their new born child and it’s better if you’ve already made an acquaintance with them, that they know you, they feel comfortable with you because obviously you’re going to be hopefully handling their young infant and they need to obviously know who you are.	Introduction/Relationship building in preparation for next visit Establishing familiarity between HV and parents Expecting to hold the baby Familiarity/Building Trust/ Relationship building Analysis- Relationship building antenatally, becoming familiar, needs to promote trust in parents. how do they do that?

Table 4.13 continued R. Ok, that's great, and what does the introduction involve? HV- Just going out and saying who you are basically describing what the health visiting service is, asking them if they have any questions, giving them an opportunity to be able to discuss any questions that they may have, gauging their level of comfort with the health visiting service. Obviously some people you can tell that they're not very keen on it, they might have had previous poor experiences, or they may have other family members who have had poor experiences with health visiting services and they're not keen so it's an opportunity to gauge them. You want to try and get to know a little bit about parents and be able to offer them the opportunity to for them, to get to know you a bit as well, and hopefully build up a level of rapport where there's trust, they appreciate there's going to be confidentiality and things. And you are basically asking them about how they plan may be to raise a child, perhaps parenting techniques that they may have. You might also ask them about their understanding of immunisations and whether they would plan to have their child immunised. And that gives you scope then to be able to offer additional support and information, maybe to correct any health beliefs that maybe you know about not immunising, the things you can offer an opportunity for them to be able to do their own research and maybe come to that conclusion	Introduction. Explaining HV role/Promoting HV role Asking/ parental control Disliking ? already decided based on own or others' views Appraising or weighing up whether they like the HV service or not. Experiences and influences from others. Relationship building/building trust and confidentiality Asking Planning for parenting Asking Appraising knowledge Deciding/planning Then sharing right information based on responses Acknowledging views Deciding based on gaining Knowledge/appraising/weighing up Analysis- promoting the service and role, acknowledging views and past experiences, finding out what know and plan for and adding information to support their decision making.
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4.7.3 Selective coding

Selective coding is a way of progressing the research by refining the open codes (Elliott and Lazenbatt 2005). In this phase, coding was focused solely on categories relevant to the research problem, unlike open coding, where all data was treated as significant. Selective coding involved transforming open codes into categories that captured the perceptions and experiences of expectant parents and HVs regarding the HV universal antenatal home visit (Glaser 1978).

Grounded theory's 'bottom up' methodology necessitated significant grouping during this phase. This grouping was aligned with the research phenomena and the patterns emerging from the data. With selective coding the codes are integrated and refined, until the focus narrows to categories directly related to the core category, which ties all other categories together (Glaser 1978). By the conclusion of open coding there were 159 codes that were then reduced to 12 categories through constant comparative analysis and selective coding. See Figure 4.4 for the 12 categories.



Figure 4.4 Reduction of codes on completion of open coding

The process was iterative, involving continual revisitation of categories and their content to interpret the data and examine potential connections between the studied concepts. This was achieved through the application of the constant comparative method (Glaser and Strauss, 1967). Refer to Table 4.14 for an example of selective coding.

Table 4.14 Selective coding example

Participant	Analytical Meaning	Open Codes	Subcategories	Category
A502HV	Sharing self to gain trust and engagement with parent.	Sharing self Information sharing Trust Approachability Promoting	Tailoring Information sharing Building Trust and Approachability Gaining Knowledge about each other	Relationship building
A603HV	Assessing family health and lifestyles through discussion	Assessing Weigh up Compare Sharing information	Information Sharing Tailoring Parenting	Assessment
A701HV	Relationship building is the gateway to assessment through building trust and approachability	Sharing self Communicating Planning and preparing Questioning	Tailoring Information sharing	Relationship building
A701EP	Asking advice about safety of baby	Knowledge Preparing Planning Safety	Supporting Information sharing Guiding	Managing
A101HV	Past experience impacted upon decision to use HV. Qualities of HV helped promote engagement	Baby's health Past experience Appraise or weigh up Relationship build	Supporting Relationship building	Managing
A301HV	Supporting families by finding out what they know and adding to their knowledge	Assessing Information sharing Appraising Communicating	Information sharing Supporting Guiding	Managing

The 12 categories were further refined into 3 main categories and a single core category. Figure 4.4 emphasises the main category of 'assessing' and its defining characteristics derived from the open codes. The diagram visually clarifies the integration of categories and their relationships to the core category as they evolve through selective coding. Each category was assigned a distinct coloured marking along with its corresponding open codes. As can be seen in figure 4.4 the markings demonstrate how the codes and categories intertwine and refine into focused categories.

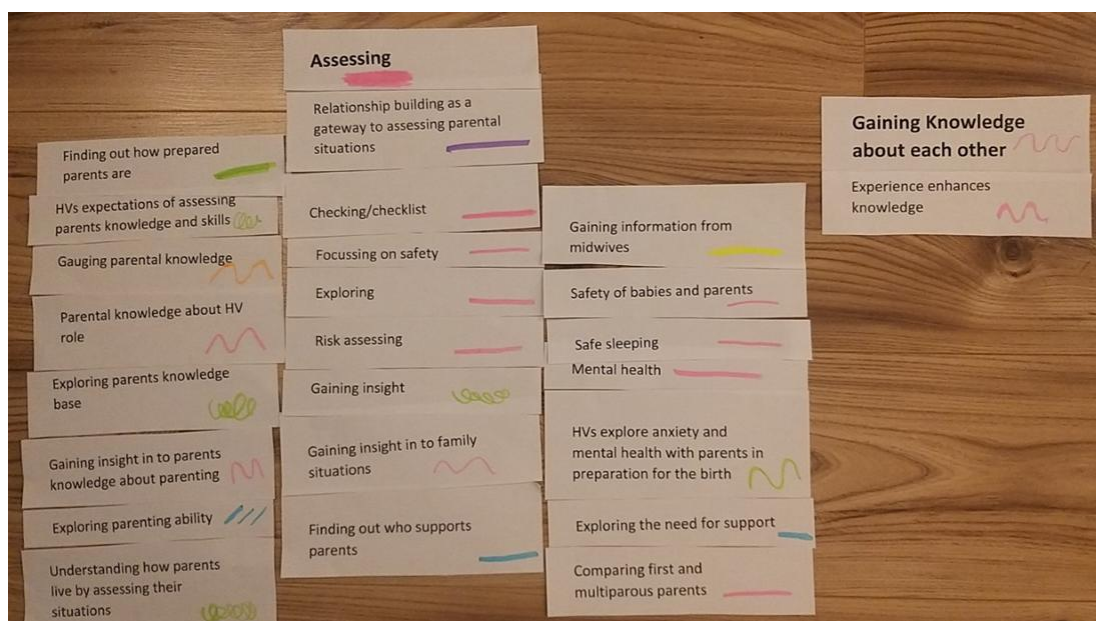


Figure 4.5 Open codes from main category of assessing

4.8 Main Concern

In CGT, the main concern represents the central issue or problem that participants face and aim to resolve. It forms the basis for developing a substantive theory (Glaser 1978; Glaser and Strauss 1967). This main concern ensures the theory is firmly rooted in participants' actual experiences and challenges (Glaser 1978). Identifying the main concern is often a lengthy process, requiring several months to over a year, depending on the complexity of the data and the iterative nature of constant comparison and coding (Artinian et al. 2009; Glaser 1978).

In this study, the main concern ‘the wellbeing of the unborn baby’ was not fully identified until second year of analysis. Table 4.15 provides an overview of memos documenting the progression of this concern.

4.9 Core Category

During the final stages of the selective coding process the core category emerged (section 4.7.3), where open codes were organised into subcategories, and the subcategories were further grouped into categories. This process contributed to establishing the study's core category: *expectant parents and HVs adjusting to support the wellbeing of the unborn baby during the HV antenatal visit*.

The refinement and integration of categories, which contributed to the development of the core category, were accomplished through theoretical sampling (section 4.3.2), constant comparative analysis (section 4.6.1), and theoretical memoing (section 4.6.4). The core category embodies a central phenomenon that naturally and frequently emerges within the research, links to all other categories, and highlights an overarching pattern (Glaser 1978). Figure 4.5 displays the core category along with the main and subcategories.

4.10 Theoretical Coding

Theoretical coding represents the final phase of the coding process in grounded theory, conducted after establishing the core category to link, refine, and construct the theory. At this stage, the emphasis is on recognising and refining theoretical codes, which play a crucial role in the construction of the theory (Glaser and Strauss 1967). Theoretical coding is defined as:

“the use of advanced abstractions to provide a framework for enhancing the explanatory power of a grounded theory” (Birks and Mills 2015, p.181).

Table 4.15 Memos capturing the evolution of the main concern

Memos	Open and selective coding
01/10/19 A501 observation and HV interview and EP interview. Maternal health impacting on baby, she was concerned about medication and affect on baby.	Affecting baby's health Health conditions
23/01/20 19.50 Memo: Safety Observation A701 and HV and EP interview. Parent focus on safe sleep and temperature control of baby, asked lots of questions and showed HV the cot HV asked about the mattresses and bedding in relation to cot death risks	Asking Discussing Showing Planning and preparing Safety
04/05/20 15.00 Memo: Safety/Past Experiences A502 Observation Mother's focus on safety of birth with current pregnancy. Worries related to previous still birth and maternal health problems since birth.	Safety Baby Birthing Past experiences Information sharing Sharing self Anxiety Feelings
10/04/2021 13:50 Memo: Past experiences A102 parent talked of their experience with their first child and pressure on them to ensure the baby achieved weight gain against centiles on a weight chart which caused a lot of anxiety and stress at the time which was still very memorable when their story was recounted.	Experiences Managing Affecting baby's health Past experiences Anxiety
Selective coding examples 21/05/22. 19.50 Memo Assessment: Comparing information sharing/safety Assessment appears to coincide with information sharing e.g. example of asking about safe sleep then finding out cot bumpers are planned to be used, then sharing information on promoting safe sleep, giving and taking of information. Assessing includes finding out the health and lifestyles of families, home conditions and support mechanisms in order to inform HV assessment of whether parents are prepared for their baby in terms of parenting and safe parenting practices. Topics of discussion include parental health, home environment, networks of support. I like the quote "Painting a picture" (A502HV) of what parents are like, how prepared they are for the baby and what they have planned for when the baby comes home. It is about assessing what is happening but also identifying how parents will manage after the baby is born.	
05/10/23. 18.45 Memo: Main concern I have been looking at what is the main concern of the parents and health visitors and this appears to be the wellbeing of the baby. Although the baby is not born yet HVs are finding out about what impacts on babies such as parental situations e.g., housing finances, physical and mental health, parental relationships and support network as well as planning and preparing for the birth of the baby All of these issues affect the wellbeing of the baby (Assessing the wellbeing of babies). Expectant parents focus on different aspect of wellbeing of the baby such as their own health and impact on the developing baby, focussing on a safe delivery following previous experiences (past experiences) such as stillbirth or tongue tie with previous babies and how they will after current birth (managing/decision making/support). Some HVs with their own previous experiences also focussed on different aspects of the baby's wellbeing depending on the issues that the experiences raised such as cot deaths or still births or domestic violence. I revisited all the interviews and observations and checked links to wellbeing of the baby to check I have no preconceived ideas about the issue of wellbeing and wanting to make it fit. Open coding had separated the data and was not until selective coding through constant comparative analysis occurred that wellbeing of the baby developed with a focus on safety. The narrative from the participants confirms my thoughts that wellbeing is a concern.	

Theoretical codes serve to integrate data and offer a broader perspective (Glaser, 1978). The process of theoretical coding acts as the mechanism to achieve this integration. These codes arise organically from the data and can also result from the researcher's analytical insight, provided they possess theoretical sensitivity (Urquhart 2013) (section 4.6.3). It is crucial that theoretical codes are not predetermined; instead, they must emerge naturally to ensure that the theory remains firmly embedded in the data (Glaser and Strauss 1967).

The study identified the following theoretical codes: '*building therapeutic and supportive relationships*,' '*assessing the wellbeing of the unborn baby*,' and '*managing the antenatal visit*.' These codes demonstrate the connections between the core category and the related categories, establishing a credible relationship between the concepts (Glaser and Strauss, 1967).

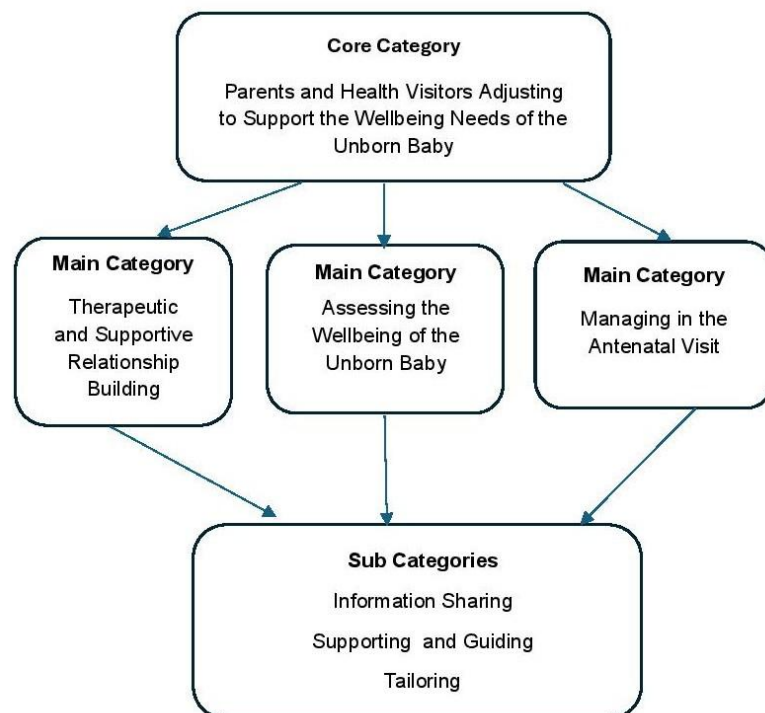


Figure 4.6 Core category, main categories and sub categories

Theoretical codes were continually refined as new insights emerged, enhancing the level of abstraction and contributing to the advancement of the developing theory. Codes acted as fundamental building blocks, ensuring cohesion and supporting the

theory's progression. As part of the theory development process, relevant literature was examined to evaluate its reliability and significance (section 4.13). The emerging theory was evaluated against existing research and theoretical models, allowing for greater depth and refinement while reaching a suitable degree of abstraction (Chapter 6: Discussion). The process of identifying and refining theoretical codes was instrumental in creating a cohesive substantive theory with both conceptual depth and explanatory strength.

4.11 Substantive Theory

The construction of a comprehensive theory through methods such as theoretical coding, organising data into categories, employing constant comparative analysis, and generating theoretically driven inquiries was enabled through utilising a grounded theory approach. Theoretical sampling (section 4.3.2) played a critical role in recognising categories, their characteristics, and the relationships that contribute to the construction of a broad theoretical framework (Holton and Walsh 2017).

Relationships between the core category and theoretical concepts was realised through theoretical coding (section 4.7) thereby providing a coherent structure to the emerging theory. Additionally, theoretical saturation (section 4.5.5) ensured a thorough examination of the categories, strengthening the focus and depth of the evolving theory (Glaser and Strauss 1967).

Constant comparative analysis can produce two types of theories: substantive and formal (Glaser and Strauss 1967; Glaser 1992; Strauss and Corbin 1998). Formal theory distinguishes itself from substantive theory by connecting multiple substantive theories to address broader sociological inquiries (Glaser and Strauss 1967). Substantive theory, embedded in specific empirical data, offers detailed and context specific explanations. Substantive theory, derived from specific empirical data, offers detailed and context specific interpretations. For example, in '*Awareness of Dying*' (Glaser and Strauss 1965), substantive theory classified different types of awareness and was subsequently utilised to develop a formal

theory through continuous comparison (Glaser 1992; Glaser and Strauss 1967). This method identifies consistent patterns within data, providing a robust conceptual framework that transcends specific contexts. It enables practitioners to generalise findings and apply theoretical insights across various scenarios, fostering a deeper and more universal understanding of patterns and relationships in their field (Glaser and Strauss 1967). Such broad applicability enhances practitioners' capacity to implement effective strategies and interventions in diverse situations (Glaser 1992).

However, this research study focussed solely on generating a substantive theory specific to the HV universal antenatal home visit, without extending to formal theory development. A substantive theory must be contextually relevant, well defined, developed directly from the research field and be deeply grounded in the data (Glaser and Strauss 1967). This study successfully met these criteria, enhancing both its conceptual depth and explanatory capacity. The resulting theory is substantive, uniquely tailored to the HV antenatal home visit study, without seeking to generalise beyond this specific context (Urquhart 2013). It culminated in the development of a new substantive grounded theory, as detailed in Chapter 5: Findings.

4.12 Research Quality

An established approach to evaluating the quality of qualitative research entails using criteria that align with recognised standards for best research practice. Considerations include contribution to the substantive field of practice, defensible in design, rigorous in conduct and credible in the claims made about the research (Spencer et al. 2003). CGT criteria outlines that research should exhibit '*fit, work and relevance*' (Glaser and Strauss 1967, pp. 237-250) as well as '*workability and modifiability*' (Glaser 1998, pp.18-19). Each of the terms are addressed in relation to the HV antenatal visit study followed by information about transparency of the researcher role in the research process, known as reflexivity.

4.12.1 Fit, work, relevance, workability and modifiability.

'*Fit*' refers to the precise alignment of data with emerging concepts, validated through continuous comparisons conducted via constant comparative analysis throughout the analytical process (Glaser and Strauss 1967) (section 4.6.1). This process was succeeded by theoretical memoing (section 4.6.4) and open coding (section 4.7.2), which facilitated the identification and comparison of codes. Subsequently, selective coding (section 4.7.3) was conducted to analyse the relationships among categories, linking and structuring them to establish the core category of the research study (see section 4.9).

The term '*work*' refers to the theory's capacity to effectively explain the phenomena under investigation, thereby establishing its '*relevance*' (Glaser and Strauss 1967). Theoretical connections are established to the substantive field of the HV universal antenatal home visit. The findings explain the perceptions and experiences of these visits for expectant parents and HVs (Chapter 5: Findings.). They also suggest potential improvements in how HV antenatal visits are conducted by applying new insights into how expectant parents and HVs adapt their roles to prioritise the wellbeing of the unborn baby during the visit. Additionally, the findings provide HVs with a basis for considering factors that affect relationship building, assessment, and management of the visit to ensure best practice (Chapter 6: Discussion).

'*Workability*' refers to the practicality and applicability of the developed theory. A theory is considered workable if it provides a useful explanation of the phenomena under study and makes sense of the data in a way that is meaningful and relevant to the substantive field of study (Glaser 1978; Glaser 1998). The production of theoretically sound findings and a practically useful workable theory ensured meaningfulness and relevance to both HVs and expectant parents. Practical insights and recommendations generated from the study can be applied to improve the HV antenatal visit process and help HVs better understand and manage their roles during the antenatal visit.

In Glaserian grounded theory, '*modifiability*' is fundamental due to its basis in inductive logic, making theories inherently adaptable. The adaptability allows researchers to generalise from specific cases to broader categories and modify theories as new data emerges. Glaser (1978) emphasised that hypotheses and theories in grounded theory reveal observable patterns. Concepts are patterns that were identified through constant comparison analysis (section 4.6.1) and theoretical sampling (section 4.3.2) (Glaser 2002). The method continuously corrects for biases through comparison and abstraction, refining underlying patterns (Glaser 2002; Glaser 2007). Modifiability ensures the theory remains rigorous and open to new evidence, avoiding rigid adherence to initial hypotheses (Glaser 1978).

Elliott and Lazenbatt (2005) assert that while criteria are important, the research methods themselves are essential for maintaining quality in grounded theory research. The rigour and credibility of the research study is contributed to by the meticulous application of classic grounded theory techniques involving constant comparative analysis, theoretical sampling, field notes, and theoretical memoing. These methods, grounded in the seminal work of Glaser and Strauss (1967) and further refined in Glaser's subsequent publications (Glaser 1978; Glaser 1992; Glaser 1998), highlights the robustness and dependability of the methodology. In contrast to broader qualitative research approaches that utilise member validation, the iterative and progressive nature of this grounded theory study ensured validation through ongoing data comparison and the involvement of new participants. As a result, member validation was not utilised in this study.

4.12.2 Reflexivity

Reflexivity is a vital aspect of quality in qualitative research, the general objective to increase transparency and trustworthiness of the research report through the work that is produced, decisions made in the research process and guidance for future actions (Birks and Mills 2015; Engward and Davis 2015; Finlay 2002). Reflexivity allows for the essential recognition and acknowledgement of limitations related to theoretical contextualisation, data gathering and analysis, and the

construction of new knowledge. Awareness of these factors helps to provide a clear understanding of the research's scope and potential constraints (Finlay 2002).

Reflexivity, with its multiple definitions and widespread use, has become an expected component of qualitative research (Gentles et al. 2015). Contemporary grounded theorists like Charmaz emphasise reflexivity, ingrained in symbolic interactionism, highlighting researchers' awareness of their influence on the research process (Charmaz 2006; Neill 2006). Although '*reflexivity*' is not explicitly mentioned in seminal CGT texts (Glaser 1978; Glaser and Strauss 1967), related concepts such as theoretical sensitivity (section 4.6.3) and constant comparative analysis (section 4.6.1) emphasise the importance of researcher engagement with data. These elements were integral to the HV antenatal research study, enabling recognition and connection of important data, continuous comparison, and development of grounded concepts and categories (Glaser 1978; Glaser and Strauss 1967).

I recognised that my current role in HV practice along with my clinical background and experience could potentially influence the research process. My work locality and wider team were excluded from the study to avoid any conflicts of interest. My background in HV practice and reasons for the choice of study are transparent (section 1.3 and section 1.4). My philosophical viewpoint and impact on the decision to use CGT is documented (section 3.6).

Opting for a non-committal literature review demonstrated the strong implementation of CGT methods. Additionally, my professional experience plays a key role in enhancing theoretical sensitivity, as highlighted by Glaser (1978).

The initial sampling of data was partially informed by my professional expertise regarding the HV antenatal visit, as well as the expectation that HVs and expectant parents could contribute rich and diverse data. This approach aligns with the reflexivity described by Burns et al. (2010) in their midwifery study. I recognised insider knowledge and how that impacted on the research from acknowledging how HV teams work compared to midwifery teams, and the potential impact upon

recruitment of expectant parents. Recruitment issues were encountered during the study, necessitating a substantial amendment to address and mitigate these challenges (section 4.1.6).

Maintaining a research journal throughout the study provided documentation of my personal journey with the research process. It provided a space for reflection about the methodology, own biases, assumptions and decision making as well as supervisor reactions and suggestions (Silverman 2005).

The research process and decisions made during data collection and analysis were documented through field notes, memos, NVIVO coding, and the maintenance of a research journal. This comprehensive approach created a written, auditable trail of evidence. An illustrative memo showcasing reflexivity during the research process is provided in Table 4.16.

Rigour in the use of observational and interview data was ensured by emphasising their depth and detail (Coker et al.2013). Utilising an observational schedule and topic guide for interviews (Appendix 16,17,18), digitally audio recording the observations and interviews and transcribing them, as well as documenting field notes and memos about the observations and interviews helped achieve rigour (section 4.5.4 and 4.6.4).

Regular sessions with academic research supervisors were pivotal in evaluating the progress of the research and the implementation of its methods. The meetings served as an open platform for addressing challenges, raising inquiries, and resolving concerns encountered during the process. Consistent supervision played a vital role in ensuring methodological rigour and upholding grounded theory principles. Having a single research supervisor throughout the study provided continuity and support, reflecting Glaser's assertion on the significance of researcher engagement and ongoing feedback in preserving the quality and integrity of grounded theory research (Glaser 1978).

Table 4.16 Memo demonstrating reflexivity

<u>Memo 15/11/21 20.20. Understanding Code.</u>
Revisiting understanding sub codes. Found reference to expect which was recoded to understanding sub code and then added to the description of expect sub code. It is right what Glaser (1998) describes about coding. If they are coded wrongly they get sorted to where they belong by constant comparison and I now see where that happens. Describing the codes helps me to do that. I am surprised at how the majority of the content of the codes appear to be familiar to the code and appropriate. It gives me confidence in my ability to code as I doubted my ability in doing so as some of the initial open coding seemed to be more descriptive than related to social processes. Understanding sub code links to building relationships, assessment and information sharing codes relating to how HVs and parents understand each other when they relationship build, understanding information to form part of their assessments and information sharing linking them all together.

4.13 The Use of Literature

The use of literature in CGT is different to other methodologies as to when and how it is used. Delaying of the literature review is recommended to avoid the literature providing preconceptions if carried out before data analysis occurs. Literature becomes part of data to be analysed and compared once the theory develops and is then used to contextualise and validate the theory within knowledge from existing literature (Glaser 1978; Glaser 1998; Glaser and Strauss 1967; Urquhart 2013). Each aspect is considered in more detail and how it applied to the research study.

Chapter 2 highlights the importance of avoiding preconceptions by conducting a non-committal literature review, rather than postponing the review until after data analysis began (Glaser 1992). While the literature review was necessary to meet course requirements, it also aligned with Glaser's recommendation that CGT researchers engage in preliminary reading to contextualise the proposed study

(Glaser 1998). The application of theoretical sensitivity (section 4.6.3) and reflexivity (section 4.12.2) was instrumental in minimising the influence of existing literature on the research process. By maintaining a focused engagement with the study data, the emerging theory was able to determine the relevance of the literature Glaser 1992; Glaser and Strauss 1967).

Initial data collection and open coding were conducted without referencing existing literature. Once the core categories emerged from the data, existing literature was incorporated as supplementary material to compare with the developing theory, supporting, challenging, or refining it during the constant comparative process (section 4.6.1). Theoretical coding was applied to build and refine the substantive theory (see section 4.7). Analysing the theory and its theoretical codes in relation to existing literature deepened its scope and abstraction, emphasising connections between concepts with explanatory and predictive significance (Glaser and Strauss 1967). By employing constant comparison, the study illustrated how the theory aligned with or diverged from established knowledge.(Chapter 6: Discussion). To validate the findings, the new substantive theory was positioned within the context of current academic literature, reinforcing its unique contribution to the field of HV practice (Chapter 6: Discussion) (Glaser 1992; Glaser and Strauss 1967).

4.14 Chapter 4 Summary of Research Methods

This chapter described the research methods utilised in the study, which were grounded in a qualitative design and informed by the classic grounded theory methodology. In order to examine the research question these methods were implemented focusing on the perspectives and experiences of expectant parents regarding the HV universal antenatal home visit process. Initial sampling involved eligible HVs and expectant parents. Data collection and analysis were conducted simultaneously through three observations and 18 interviews, continuing until theoretical saturation was reached.

A structured analysis process followed consisting of coding involving three stages utilising open, selective and theoretical types of coding. Categories were identified and linked using the constant comparative method. Additional theoretical sampling supported the targeted data collection during interviews and observations, aiding the development of emerging categories. Field notes and theoretical memos were instrumental in uncovering concepts and defining relationships between categories. Theoretical coding played a pivotal role in constructing the emerging theory. The adaptability of these methods allowed for a transition from uncertainty to clarity, culminating in the creation of a new substantive theory. A summary of the methods used for data collection and analysis was also provided in this chapter, while addressing aspects of research quality, reflexivity, and the integration of literature.

The following chapter provides an analysis of the findings related to the perceptions and experiences of expectant parents and HVs in the universal antenatal home visit process. The first section examines the core category, highlighting how expectant parents and HVs adapt to prioritise the wellbeing of the unborn baby during the antenatal visit. The chapter then goes on to explore the themes of relationship building, assessment, and management, which contribute to the core category and inform the development of the new substantive theory.

Chapter 5: Findings

This chapter presents an overview of the research findings aimed at exploring the social interactions between HVs and expectant parents during the antenatal home visit. The inclusion of participants' words, phrases, and quotations throughout the text demonstrates how the grounded theory approach secures the findings in the data. Additionally, diagrams placed at key points provide visual representations to convey deeper meanings effectively.

5.1 Overview of Findings

The substantive area in which the data collection took place was the HV antenatal visit with the purpose to learn more about the social processes between parents and HVs during the visit. Concepts were identified iteratively from the data. They related to the social processes where data coding and constant comparative analysis occurred consistent with CGT. It included asking the key question:

“What is the data a study of?” (Glaser 1978, p.57).

The core category *parents and HVs adjusting to support the wellbeing of the unborn baby* is the substantive theory of CGT that addresses the main concern of the wellbeing of babies and will be further explained. From the core category three main categories arose: *therapeutic and supportive relationship building*, *assessing the wellbeing of the unborn baby*, and *managing in the antenatal visit*.

Parents and HVs became familiar with each other through *therapeutic and supportive relationship building* which was seen as the gateway for HVs assessing parental situations and the impact upon their unborn baby's wellbeing. Through *managing in the antenatal visit* HVs and parents *adjusted to support the wellbeing of the unborn baby*. The three main categories were observed concurrently during the HV visit. They link to the subcategories 'supporting and guiding', 'tailoring' and 'information sharing' which are key elements of the main categories.

A diagrammatical representation of the main concern, core, main and subcategories is demonstrated in Figure 5.1 where an onion image helps illustrate the main concern at the centre of the diagram. As in an onion, layers can be peeled back to reach and see the core. In this instance, the core category is represented in the layer wrapped around the main concern as it addresses the main concern. The next layer represents the three main categories that describe the core category, with the subcategories or features of the main categories in the subsequent layer. The final layer consists of characteristics familiar to all the categories, subcategories, and the core category.

The core category, *parents and HVs adjusting to support the wellbeing of the unborn baby* is the substantive theory derived from CGT that addresses the main concern being the wellbeing of the unborn baby. Through *therapeutic and supportive relationship building* HVs adjusted their conversations to promote trust in the HV so parents would use them for support and advice. Expectant parents adjusted their conversations and what information they shared with the HV depending on the trust they had in the HV and whether they wanted to use them for advice and support. HVs adjusted their *assessment of the wellbeing of the unborn baby* to the topics of conversation with expectant parents and the information shared about the family. *Managing in the antenatal visit* was through establishing the visit and adjusting support and guidance according to parental need. Parental past experiences impacted on whether they chose to use the HV for support and advice and HV past experiences impacted upon what information was shared with expectant parents.

The main concern identified by participants was the wellbeing of the unborn baby. Wellbeing was considered in a variety of ways such as the impact of the pregnancy and maternal health on the unborn baby, partners health, parental relationships and lifestyles and experiences of previous children's health or wellbeing issues during pregnancy, birth or postnatally.

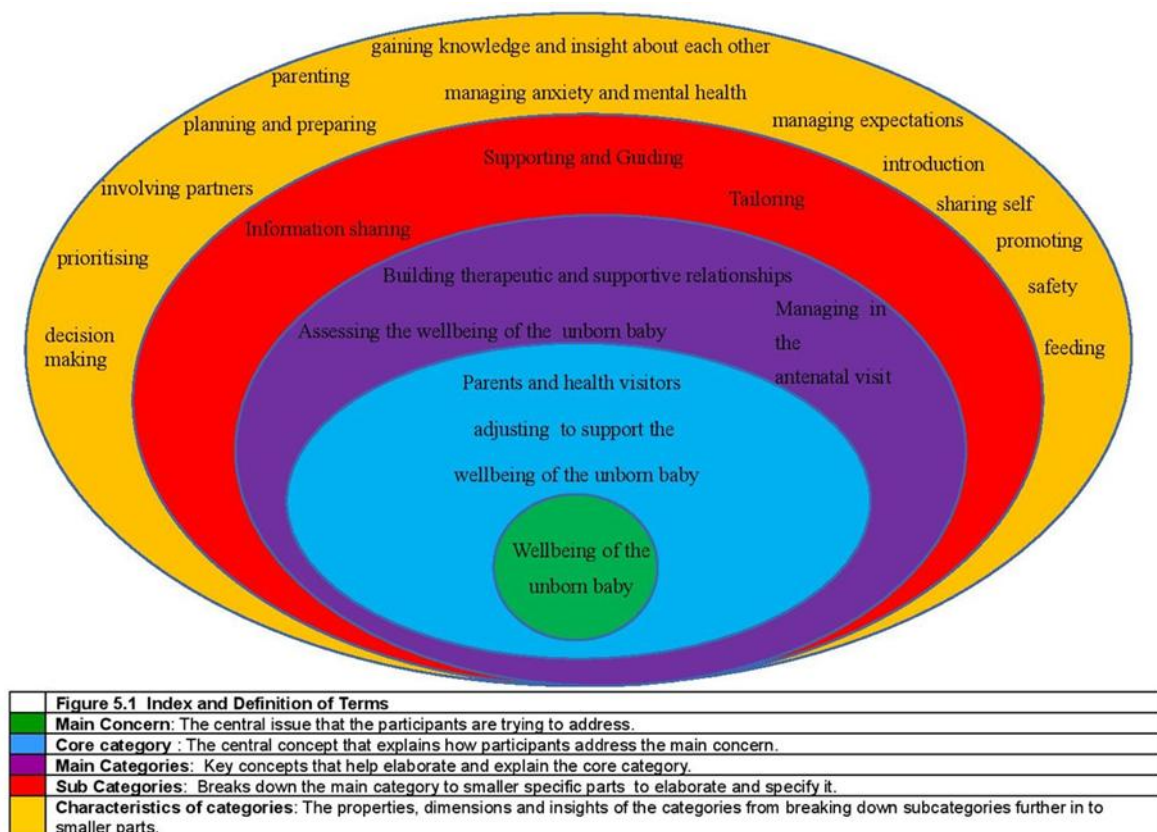


Figure 5.1 Core category, main and subcategories and their characteristics

5.2 Sample Characteristics.

The study involved six parents and 13 HVs with the HV participants recruited from six different HV teams within a single NHS Health Board in Scotland.

There were challenges to recruiting. Despite visiting recruitment sites and communicating and providing information to recruiters, the strategies did not increase recruitment rates as also recognised by Preston et al. (2016) in their recruitment efforts with health care professional researchers. Prior to the COVID-19 pandemic, three HVs and four expectant parents had been recruited. However, the pandemic interrupted the study (section 4.4.1). After implementing amendments and conducting an additional recruitment drive within the research area, two more parents and 10 additional HVs joined the study.

Parent participants were selected from the caseloads of five of the recruited HV caseloads. Three HV antenatal visits were observed involving three HVs and four expectant parents. All were also interviewed apart from one parent who withdrew from the study after the observation. A further two expectant parents and 10 HVs participated in interviews. One father was recruited to the study. His information has not been added to the sample characteristics in order to maintain anonymity. His data has been included in responses from expectant parents. Two of the parents were interviewed after their babies had been born due to the restrictions COVID-19 posed on HV visits post pandemic and researchers being unable to observe HV antenatal visits. Table 5.1 provides an overview of the participant details.

All parents recruited to the study were either receiving routine midwifery services or universal health visiting services with no identified additional needs. The age range of parents varied. Mothers ranged from 25 to 30 year age group to 35 to 40 year age group. The mean age was 32 years. None of the study participants disclosed their sexual orientation and it was not asked of them as part of the research. Terminology relating to heterosexual relationships such as ‘father’ and ‘mother’ were referred to by participants and are therefore used within the text. The discussion chapter (Chapter 6: Discussion) considers the findings of this study for all parents whatever their sexual orientation.

The participants were also asked their ethnicity to reflect the diversity of the culture and conditions of the study area. The ethnicity of the sample population shows a predominance of white Scottish participants, followed by UK country of origin. When comparing the study demographics with the 2011 Scottish Census for the geographical region (Scottish Government 2023) it reflects a similar predominance of white Scottish people, known as geographic homogeneity. However, the small number of participants, and specific participants identified in the inclusion criteria limited the ability to represent all ethnic groups, ages, and genders in the study area.

The study revealed a range of employment types among expectant parents with caring roles featuring more for expectant mothers. The sample size for employment data was relatively small. Consequently, while the findings reflect some variety,

employment status did not appear to significantly influence the outcomes of the study. Although employment was not a determining factor in the results, the inclusion of participants with varying employment backgrounds contributes to the robustness and inclusivity of the dataset.

The NHS Health Board area that participants were recruited from was a predominantly rural geographical area with 39% of the population living in remote rural areas. The urban rural classification distinguishes urban areas as settlements of more than 10,000 population (Scottish Government 2022d). Only one participant was in an urban area, the remaining participants identified as being in rural areas.

The updated 2016, 6-fold urban rural classification (Scottish Government 2018) was therefore utilised to give more details about the kind of rural areas participants came from. It distinguished settlement sizes and accessibility by travelling distance. Using the urban rural classification reclassified participants to within small towns, rural areas or other urban areas.

Data collection comprised of:

- 3 observations of the antenatal visit being undertaken- total time taken 90 minutes. Field notes of the observations x 3.
- 13 individual interviews with 13 HVs- total time taken 473 minutes
- 4 interviews with 5 expectant parents - total time taken 93 minutes

Further details on data collection is referred to in section 4.5.

The next section describes the results from coding of the data and constant comparative analysis within CGT (Glaser 1978) that identified the main concern of participants as being the wellbeing of babies. Further analysis identified the substantive theory that resolved the main concern from development of the core category: *parents and HVs adjusting to support the wellbeing of the unborn baby*.

Table 5.1 Participant characteristics

Table 5.1 Participant characteristics							
Participant Interview (I) Observation (O)							
Participant	I or O	Health Visitors					
		Gender	Location	Area	Years Qualified	Ethnicity	Age range
1	I	Female	Small Town	7	6 to 10	UK	35 to 40
2	I + O	Female	Rural	5	21 to 25	UK	50 to 55
3	I	Female	Other Urban	1	0 to 1	UK	30 to 35
4	I	Female	Small Town	1	2 to 5	UK	45 to 50
5	I	Female	Rural	3	26 to 30	UK	50 to 55
6	I	Female	Small Town	4	6 to 10	UK	50 to 55
7	I	Female	Rural	6	2 to 5	UK	50 to 55
8	I	Female	Rural	6	0 to 1	UK	25 to 30
9	I	Female	Small Town	6	6 to 10	UK	40 to 45
10	I	Female	Rural	6	11 to 15	UK	40 to 45
11	I + O	Female	Small Town	7	6 to 10	UK	35 to 40
12	I + O	Female	Other Urban	5	11 to 15	UK	45 to 50
13	I	Female	Small Town and Rural	7	0 to 1	UK	25 to 30
		Parents					
Participant	I or O	Gender	Location	Area	Employment	Ethnicity	Age range
1	I	Female	Other Urban	1	project coordinator	UK	30 to 35
2	I	Female	Other Urban	1	self employed	UK	30 to 35
3	I + O	Female	Rural	5	carer	UK	25 to 30
4	O	Female	Other Urban	5	shop worker	UK	30 to 35
5	I + O	Female	Small Town	7	carer	Eastern European	35 to 40

Their adjustments took place through three main concepts known as main categories: *therapeutic and supportive relationship building*, *assessing the wellbeing of the unborn baby*, and *managing in the antenatal visit*. The main categories provide insight into how parents and HVs adjusted to support the main concern of the study, the wellbeing of the unborn baby.

5.3 Main concern-The Wellbeing of the Unborn Baby.

The wellbeing of the unborn baby was the main concern ascertained from participants. Expectant parents focussed on the wellbeing of their unborn baby through asking questions about safe sleeping or feeding the baby, the baby's birth, their own health affecting the pregnancy or previous birth or postnatal experiences. One parent captured the main concern in their summary of HV and parent roles:

"Your primary care is around making sure that we are safe; the baby is safe, and the mum is safe... I've come to that conclusion myself as a mother, you are basically keeping your child safe" (A101 parent).

Evolution of the main concern developed as evidenced by memos in Table 4.15. The unborn baby's wellbeing was evaluated by HVs through assessments of home conditions, family health and wellbeing, and various factors such as sleep and feeding safety, family relationships, and support networks. Parents contributed information about the progress of the pregnancy, their physical and mental health, home and work circumstances, relationships, support systems, and readiness for the baby's arrival all which influenced the wellbeing of their unborn baby. One parent talked extensively about being on medication for their own blood pressure and risks to the unborn baby:

"Really worried about being on one blood pressure medication and asked consultant to take off it and up another blood pressure medication. Benefits to me outweigh risks to the baby. Yes that is the scary thing" (A501 parent).

Another parent talked to their HV of their own and their partners mental health and impact of a previous stillbirth and coping with the current pregnancy:

“I think it was with the one that we lost that he just thinks deep down it is going to happen....it definitely hit him harder than it hit me. He didn’t see it coming at all whereas I had a bit of warning on the scan as I could tell on the screen that there was nothing there”... I think he is still quite nervousand when I stop work he will chill out a bit” (A502 parent).

Through finding out about parents and their situations HVs were able to explore the impact of the parental situation on the wellbeing of babies. Advice, support, and guidance HVs offered to parents appeared to link to the wellbeing of babies. One example of HV advice linked to aspects of the baby’s development, promotion of communication and the baby’s emotional wellbeing:

“Will talk to them about baby’s brain developmentand about the importance of chatting to their bump and singing to the bump and introducing the bump to all sorts of situations and telling the bump all about it and, and how beneficial that is, and also the benefit of safety and cuddles and close proximity and how it, it soothes and at the same time develops the baby’s brain development” (A301HV).

Further detail on the main concern is revealed as the core category is discussed and how the main concern was resolved.

5.4 Core Category: Parents and HVs Adjusting to Support Wellbeing Needs of the Unborn Baby at the HV Antenatal Visit.

The core category and its associated variables illustrated how the participants sought to address the main concern identified during the antenatal visit (Glaser 2001). The main concern was identified as being the wellbeing of the unborn baby which was addressed by *expectant parents and HVs adjusting to support the wellbeing of the unborn baby at the antenatal visit*. For example, a mother discussed her baby’s wellbeing and the lack of support she received in a previous area. She was initially apprehensive about receiving support from a new HV in her current area. However, as their relationship developed, she adjusted her view and shared the positive support she received for her baby as depicted in field notes from the interview in Table 5.2.

Table 5.2 Field Notes Area A101

24/10/2020 Field notes area A101
HV makes link between relationship building and preparing parents for parenthood. Relationship building and supporting was key for the mother. The interview enabled her to voice her disappointment with HV relationship in another area compared to current HV in supporting her manage tongue tie and feeding issues. In contrast her experiences were positive with current HV who she immediately built a rapport with. The HV was described as knowledgeable, "a Wikipedia", and was able to support subsequent baby with tongue tie. A change in decision about using support of HV based on the quality of HV communication skills and knowledge base.

HVs talked about adjusting the support they provide to expectant parents as being individual to the needs of families as the following support memo describes in Table 5.3.

Table 5.3 Support memo

12/06/2021 13:10: Memo: Support
A604 HV describes support as coming from someone you know linking to familiarity and relationship building. She gave a good description of support: <i>"And you'll get that person and that you just support them, really support them, to let them go in a way over time" (A604HV).</i> The HV describes dependence to independence and is an empowering statement that is paced over a period of time. Almost comparable to the HV parenting the parent. She then goes on to discuss the more familiar the more they ask you, possibly linked to seeking support from a trusted source.

Adjusting to support the wellbeing of the baby binds the main categories together. Within *therapeutic and supportive relationship building* HVs want parents to engage with the service to gain appropriate support with their wellbeing needs. HVs seek ways to relationship build effectively by tailoring conversations to what parents want

to talk about. The field notes and memo examples above highlight the relationship building qualities of HVs in enabling that to happen.

Therapeutic and supportive relationship building is the gateway to *assessing the wellbeing of the unborn baby*. Through the conversations during relationship building information is shared with the HV who *assesses the wellbeing of the unborn baby* through observing the home situation and topics of conversation. The HV adjusts the assessment to what they observe and what information the expectant parents share with them. The assessment information helps the HV to provide appropriate support and guidance to address parental need which is part of *managing in the antenatal visit* main category.

Figure 5.1 (section 5.1) demonstrates how the main concern and main categories link together. The main categories *therapeutic and supportive relationships building*, *assessing the wellbeing of the unborn baby* and *managing in the antenatal visit* are closely interlinked as they are social processes that occur simultaneously during the antenatal visit.

Each main category and their variables are described in turn whilst illuminating the core category and the links to the other categories. Participants develop therapeutic and supportive relationships. The relationship building is seen as a gateway for HVs to assess the ability of parents to meet the wellbeing needs of their unborn baby. Through information sharing and supporting and guiding each other, parents and HVs manage in the antenatal visit by adjusting to support the wellbeing of the unborn baby.

5.5 Main Category-Therapeutic and Supportive Relationship Building

The section begins with an overview of the key aspects of the category, followed by exploration of each point individually.

5.6 Summary of Main Category-Therapeutic and Supportive Relationship Building

One of the three main categories *therapeutic and supportive relationship building* was the starting point of the social process of the antenatal visit whereby parents and HVs became familiar with each other through the conversations they undertook in the parental home. *Therapeutic and supportive relationship building* was a social process that underpinned HVs carrying out their HV role and was seen as the gateway for the assessment of the wellbeing of the unborn baby. HVs wanted parents to engage with them so they could assess the wellbeing needs of the unborn baby. Through promoting their role and tailoring their responses to parent led conversations, HVs built trust and approachability with parents. Parents also adjusted conversations and information they shared with HVs depending upon the relationship they had or wanted to have with the HV. If parents established the HV was approachable they would engage with the HV, share information and seek advice and support from the HV about the wellbeing needs of their unborn baby.

Information sharing included participants sharing of personal information or 'sharing self' when confidentiality could be maintained and where HVs upheld their professional image. Partners of expectant mothers were rarely seen at the HV visit, trying to get them involved in the visit was not easy for HVs to achieve. HVs wanted to build relationships with both parents and at the same time get a clear picture of parental lifestyles and how they impact on the unborn baby through their assessment of the wellbeing of the unborn baby which interconnects with relationship building. *Therapeutic and supportive relationship building* is therefore seen as the gateway for *assessing the wellbeing of the unborn baby*.

Firstly, building trust and approachability is discussed followed by tailoring conversations to individual families and what parents want to talk about. Information sharing follows and how it developed the HV/parental relationship concluding with engaging with partners of expectant mothers.

5.6.1 Building trust and approachability

Therapeutic and supportive relationships building was a social process at the heart of the HV role and where trust and approachability was built so parents were likely to utilise the HV service for help and support:

“The biggest thing from an antenatal visit is that forming of relationships, because that is the foundation to everything we do. Without having fostered that relationship everything is pointless because communication breaks down, there isn't that trust there isn't that continuity, everything else gets weak if there is no proper relationships...build up that trust and that relationship so that they find us approachable so that they are happy and confident approaching us when things do happen in their home environment and their lives” (A101HV).

“I feel like the main purpose of the visit is to get that therapeutic relationship when you know, mums can put a face to the name” (A702HV).

Most HV participants reported therapeutic and supportive relationship building was about the social process of building trust and approachability by making good impressions with parents by meeting face to face, promoting their role, and familiarising themselves with parents and their situations:

“For first face to face contact, letting the mum know you are approachable, that they can contact you...and introduce yourself as the salesperson's let them know about the HV service” (A101HV).

“Identifying what my role is and sharing what I will be responsible for” (A102HV).

HVs recognised that first time parents may have limited knowledge of the HV role and therefore promoted the HV role and the HV service during the therapeutic and supportive relationship building process:

“Primips (women in their first pregnancy) most of them haven't a clue what a HV is or does... they're not necessarily aware that our service was there” (A301HV).

“A lot of them don’t really know what a HV does so it is very much kind of a blank canvas for them” (A401HV).

In person contact at the parental home was seen by HVs and parents as an ideal environment for promoting therapeutic and supportive relationship building and building trust in the HV. A familiar environment for parents supported the process as parents and HVs identified:

“With the whole situation with us things will be much easier discussed here (parental home) I just think it is more relaxed in your own home” (A701 parent).

“ I need to build up relationship in her environment, especially in a rural area so she can begin to trust me because if you lose the trust you will not be able to provide the optimum service to that family and that can be seen by them not being available, cancelling visits” (A501HV).

Parents highlighted the impact of meeting their HV antenatally gave them a good feeling about the HV, affirming HVs were demonstrating their approachability:

“It was nice definitely to have met her before that...and just obviously like really personable and just somebody that you could speak to” (A102 parent).

Building trust and approachability at the antenatal visit is seen by some HVs as demonstrating to parents that they are there to support them:

“Because I want this lady or mum to feel supported by me. And I think the only way to do that is to have the therapeutic working relationship...“I think if they feel like you are a support and they can trust you as such with that then it helps the therapeutic relationship”.....“if I hadn’t ...done an antenatal visit, then that opportunity might not have arisen you know, for us to provide that help and support” (A703 HV).

The example above highlights how many HVs felt about the antenatal visit being a timely visit for building therapeutic and supportive relationships where the building trust and approachability promotes the opportunity for expectant parents to be provided with support by the HV if required.

When parents had raised issues about a poor experience with a previous HV where they had felt unsupported, approachability and trust was a major factor in deciding whether they built another relationship with a HV or considered using them for advice and support, as one parent commented:

“I think it was relief. I liked her, she was warm and friendly and really approachable and I think definitely felt a huge sense of relief that would be somebody that you liked coming in to your house to talk to you about your baby... and just obviously reassured at the way that she had answered the questions that I had asked... just felt like she was someone that was going to be supportive...there was no judgement there... so I think that just helped me feel a lot better...she was somebody that I got a good feeling from” (A101 parent).

The building of trust and approachability occurred by HVs promoting their role, making good impressions in conversations with parents in their own homes, and offering to provide help and support if required. The building of trust and approachability took place through conversations that were tailored to individual family circumstances which will now be considered.

5.6.2 Tailoring conversations to individual families

The conversations that took place between HVs and parents at the antenatal visit promoted relationship building. They commenced with greetings between HV and parents and then moved on to HVs asking parents about their health and how the pregnancy was progressing. HVs were either relationship building with first time parents or rekindling relationships with parents with second or subsequent pregnancies. The conversations were seen as informal and fluid by some HVs with parents leading the direction of the conversation:

“I let the women take me off at tangents and try for her to be as informative as she wants me to be” (A604HV).

“Just kind of be a wee bit led by their responses” (A601HV).

Other aspects of conversations mentioned by some HVs included listening and some elements of humour during conversations balanced alongside factual information as one HV highlighted:

“I find humour ...as the biggest ice breaker” “a little bit tongue in cheek but also being able to be very factual” (A102HV).

Following initial introductions a variety of topics were discussed (section 5.8.2). Many conversations involved HVs tailoring their conversations to what the parents led with or requested advice about. In one observation of an antenatal visit (A701) the first time parent was concerned about managing the baby’s temperature after birth and asked the HV, whom they had only just met, to observe the baby’s sleeping area and bedding attire and give advice about how appropriate it was for managing the baby’s temperature at night. The HV tailored their advice to what they observed and what they were asked. Following a trip together to the bedroom, the parent was more relaxed, turned to face the HV, and eye contact with the HV had improved. As the conversation progressed the HV finished some of the parent’s sentences, and they were laughing together.

Field notes from the observation (Table 5.3) captured the conversation and noticeable changes to a more relaxed social interaction between the HV and parent from their conversation. A building of trust in the HV by the parent was evident through the conversations and the interactions that took place during the visit.

With families that some HVs had existing relationships with, they were able to use information already known to them to promote discussion and offer appropriate support to parents. In the example below the HV asked the parent about the use of a baby sling which they owned but had not used:

Parent- *“Yeah those slings they scare the hell out of me.... I was so frightened of them with (name of child) because I didn’t use them with (name of child). What if I made a mistake and didn’t tie it tight enough and they fell?”*

HV – “ *If you want, when you have had the baby I can show you how to use it, I will bring a doll and we can practice with a doll then that would make you more confident. It is really good especially when you are busy and you have got two little ones*” (Observation A502).

Table 5.4 Field notes from observation A701

Table 5.3 Field Notes Observation A701 06/12/2019
Parent states first time experience as a parent and how they have read about room temperatures for baby to sleep in. They are worried about their heating system and if it would be too cold at night/time of year. Shares knowledge of what room temperatures should be. More relaxed stance by parent after showing HV the bedroom. They sit back down and are facing HV more directly. Advice giving by HV about needing new cot mattress, opens up for parent to ask more questions of HV, appear to trust and respect her advice giving. Further advice given regarding temperature control for baby and in the room. Being on the same wave length- at one point HV finished parent's sentences.is able to pre-empt what parent is saying, understanding what they are talking about, and they are acknowledging the conversation together. Synchronisation of speech. Parent and HV use hand gestures used to explain what they are talking about.

As well as building trust and approachability and tailoring conversations, information sharing between HVs and parents was also seen as a way of *therapeutic and supportive relationship building*. The promotion of familiarity between HVs and parents about their roles through information sharing was the way the relationship was built which is explored further.

5.6.3 Information sharing in relationship building

Information sharing played a pivotal role in *therapeutic and supportive relationship building*. Through information sharing HVs and parents gained knowledge about each other and their roles. A large part of information sharing was about what and how much was shared between HVs and expectant parents to build the relationship and encourage parents to access the HV service postnatally. The information that HVs shared about promoting the HV role and the service helped build trust and approachability (section 5.6.1). Many of the examples HVs and parents revealed

were about sharing information about themselves which has been termed *sharing self*, which is now focused upon.

5.6.3.1 Sharing self

Sharing self explains how HVs and parents shared personal information about themselves to help build trust and approachability and develop the *therapeutic and supportive relationship*. Finding common ground to talk about helped relationships develop. An example was described by a HV on an initial encounter with a first time parent:

“There were a few pictures on the wall of Canada, and I lived in Canada before and was into mountain biking so I said, ‘is that so and so I have been there, do you like mountain biking?’...so then mum relaxed and opened up to me a bit more. I think she felt we had a joint interest that we could talk about” (A502HV).

Another HV wanted to find a balance in what information they shared so the emphasis remained on the parent rather than shifting to them:

“I do think people ask a lot about my own experiences. I do give a wee bit of myself but I don’t want it to be about me, the visit is not about me” (A602HV).

Parents who had well established relationships with their HV from previous pregnancies were observed to share personal information about their feelings, relationships, mental health and past experiences. One parent who was observed to have a relaxed and comfortable relationship with their HV stated:

“I am just really glad that (name of HV) is there for support...I am totally open to speak to (name of HV) about anything in regard to this pregnancy and the previous pregnancy. More than happy to discuss anything with her” (A501parent).

A first time parent shared a lot of information about their personal life to a HV they had only just met. One of the most noticeable aspects of sharing self for first time parents was building trust and approachability were necessary for the sharing to occur (Observation A701, Table 5.3).

Due to recruitment difficulties of first time parents, further elaboration on sharing self was predominantly from parents who had previously had other babies.

As well as consideration of the stage of *therapeutic and supportive relationship building* between parents and HVs, the personality of the parent involved and their intentions about engaging with the HV were also factors that were considered by participants, as one parent describes:

"I am the kind of person that always shares all of the time. I'm not somebody who ever holds anything back. (Name of husband)'s not like that. He'll put a face on, so he wouldn't say how he was feeling" (A102 parent).

A picture of openness and honesty was described by the parent, but for their partner the masking of how they were feeling was linked to a decision not to engage fully with the HV service from an experience with their first baby:

"He'd just smile and wave. Just, just, "yeah, that's fine. That's fine. Aha." Just agree with everything that is being said to kind of get them out the door" (A102 parent).

Another HV highlighted that although previous experiences could impact on whether parents engaged with HVs, that the approachability of the HV was central to the therapeutic and supportive relationship building:

"For me, it's that key for that visit because it's their first impression of me...I had a mum who it was a bit like getting blood out of a stone to begin with. She was very closed off she wouldn't, she was very guarded. She wouldn't really open up and she was a second time mum.my perception was that this was going to be an easy antenatal. She was new to our area so did not know any of us....but unfortunately she'd had a bad experience the first time round...she already had it in her mindset that this wasn't going to go well. So we just spoke about the older child and how they were feeling about becoming a big brother. By the end of visit she had said, you've restored my faith in health visiting. That was a key visit because I thought do you know, if you can change somebody's mind in 45 minutes to an hour, I've done my job." (A702HV).

However some HVs also recognised that despite their best efforts at relationship building the personality of parents and differing levels of engagement affected the relationship building process as one HV summed up:

“Some people can be very open and some are quite engaging and others can be quite difficult and that can continue through your HV involvement with that family. I think some people again are just naturally more open and chatty than others and some families you don’t feel you really get a good relationship with them” (A401HV).

When sharing information there were dilemmas identified by parents and HVs about the confidentiality of information they shared with each other, and for HVs how it affected them being seen in a professional capacity by parents. Confidentiality is discussed prior to staying professional when sharing information.

5.6.3.2 Maintaining confidentiality

Some HVs acknowledged that parents might be worried about the security of sharing information with the HV who also sees other parents they may know. Reiteration of confidentiality of personal information was provided to help allay parental fears:

“Everybody knows you and they are afraid that information will leak out”... I stress about confidentiality and reassurance that sharing of information is important and secure” (A501HV).

Some HVs were also concerned about any personal information they might share with parents being shared in their community by the parent. It was highlighted more by rural HVs who lived in the same community that they worked in:

“Personal information for me is a very, very riskyyou’ve really got to watch what you share becauseyou don’t want them to know too much about you, especially when you work and live in the same place” (A702HV).

5.6.4 Balancing staying professional with sharing self

Part of information sharing in *building therapeutic and supportive relationships* is about both HVs and parents sharing information in the antenatal visit to understand each other's roles. HVs expressed varied perspectives on whether sharing information should strictly pertain to their professional role or include aspects of their personal lives as part of the relationship building process, as illustrated by the following examples:

"I would discuss myself in a professional way to what my role was and how I can support families, but I wouldn't discuss anything about my life with a family at the antenatal visit" (A601HV).

"It kind of humanises you a wee bit. When you are talking about realistic expectations and babies crying and I'll say "and there won't be much worse than my daughter when she" I can fully sympathise. Some families it wouldn't be appropriate to share much at all" (A301HV).

For some HVs it is seen as a fine balancing act being seen to be empathetic but also maintain a professional persona:

"I try not to share personal information because I do think it then muddies the water of that professional boundary, but it's about me being human as well" (A702HV).

However for some HVs sharing personal experiences was seen as a way of empathising with and understanding parental experiences:

"Parents will say to you "do you have children, or have you experienced it?". You can reassure them by saying "in my experience this has happened" and that lets them know that you are not there to judge them, you are there as the supportYou are human as well. It is an equal partnership" (A501HV).

The findings suggest a balance is made by parents and HVs on what information they share, dependent upon where they are in the process of building therapeutic and supportive relationships, what they understand about each other's roles, how professionally involved they are with the family and the support they are providing, and where they live and work.

Finally *therapeutic and supportive relationship building* is seen by most HVs as the gateway to assessment as one HV sums up:

“Want to try and get to know a little bit about the parents and to be able to offer them the opportunity to get to know you a bit as well and hopefully build up a level of rapport where there's trust.... and you're basically asking them about how they plan may be to raise a child, perhaps parenting techniques they may have.and that gives you scope then to be able to offer additional support and information” (A601HV).

Therapeutic and supportive relationship building takes place in the parental home where parents feel relaxed and HVs can observe the environment they live in. Conversations are mostly led by parental agendas and the information that is shared as the relationship develops helps inform the HV assessment of parents. Therapeutic and supportive relationship building appears to be the gateway to *assessment of the wellbeing of the unborn baby* which is the next main category of discussion.

5.7 Main Category Assessing the Wellbeing of the Baby

This part of the section opens with a concise outline of the main elements of the category followed by an in depth exploration of each aspect.

5.8 Summary of Main Category- Assessing the Wellbeing of the Unborn Baby

The second main category was the social process of assessing the wellbeing of the unborn baby at the HV antenatal visit through the HVs identifying how expectant parents adjusted to support the wellbeing needs of their unborn baby. The HV assessment painted a picture of the wellbeing needs of the unborn baby and how they were being addressed by parents. The assessment involved identifying physical and mental health of parents, observation of the home environment and living conditions, parental lifestyles, and information sharing through conversations with parents and midwives. Parents also demonstrated to HVs how planned and prepared they were for the baby's birth during the visit.

The wellbeing needs of the unborn baby were the main concern of participants with a significant focus on safety during the assessment process. Aspects of safety included a safe home environment, wanting a safe birth, safe sleeping and feeding practices, safe and supportive parental lifestyles free of any risks to their health and wellbeing such as domestic violence or mental health issues. The assessment prepared the HV for offering advice and support that parents needed at the antenatal visit and after the birth of the baby.

Firstly painting a picture of the wellbeing of the unborn baby is addressed by identifying the health needs of the parents. A focus on safety follows and finally how the HV assessment prepared for the HV to provide support and advice both antenatally and after the birth of the baby.

5.8.1 Painting a picture of wellbeing needs of the unborn baby.

Through HV assessment a picture was painted of the wellbeing needs of the unborn baby:

“Painting a picture of what they’re like” (A102HV)

Rather than being a clinical assessment that is designed to diagnose and treat health issues, the HV assessment, a core component of HV practice, offered a holistic assessment that considered the physical, emotional and environmental impacts upon the parents and unborn baby (Scottish Government 2015a). The health needs of expectant parents were recognised by HVs as part of their assessment of expectant parents with an emphasis on maternal mental health. Expectant parents demonstrated to the HV how planned and prepared they were for the baby’s arrival. Discussion with the HV about various topics during their conversations gave the HV more insight in to their transition to parenthood and how they were adjusting to meet the wellbeing needs of their unborn baby. The safety of the unborn baby was a particular focus for participants. Each of the aspects of the assessment are covered in turn.

5.8.2 Identifying health needs

Finding out about health issues for parents was part of the HV assessment, how they were managed and whether or how they impacted upon the pregnancy and the health or wellbeing of the unborn baby. One HV summarised the health assessment as identifying health needs:

“If (parent) needs help with anything.. It’s sort of identifying health needs as such” (A 703HV).

The HV clarifies the meaning of identifying health needs:

“Ask how mum's feeling how she's doing in pregnancy? If there's anything recorded on the maternity documents I would want to talk about that. Whether it's a physical health need or mental health need,and just make sure that she is getting the right treatment or care for that if necessary to make sure that she's doing all that she can and obviously for care of baby as well...making sure that they had immunisations, they're getting vitamin D, and that they're going to appointments” (A703HV).

The identifying of health needs was referred to by some HV participants in relation to a domain of HV practice identified by the NMC “searching for health needs” (NMC 2004). The HV domains of practice have recently been updated by the NMC to six spheres of practice (NMC 2022), aspects of which are in the discussion chapter (Chapter 6: Discussion).

Topics of conversation between HVs and expectant parents helped provide information to the HV for their assessment of parents during the simultaneous processes of *therapeutic and supportive relationship building* and *assessing the wellbeing of the unborn baby*. Some topics were led by parents and others are asked by the HV. Topics included:

- home situation
- finances and employment
- parental physical and mental health
- parental support including the role of partners/fathers
- parental knowledge about parenting

- parental preparation for the baby's arrival
- babies emotional and brain development and emotional attachment
- feeding the baby
- safety
- immunisations
- HV service and role of HV

There was an emphasis on parental mental health rather than physical health when HV participants identified health needs which is expanded upon in the next section. Of the discussed topics safety was the most significant aspect which follows in being addressed after parental mental health.

5.8.3 Assessing parental mental health

HVs and parents were aware of the impact parental anxiety and mental health can have on their ability to parent their baby. HV participants ask parents about their mental health and how it affects them:

“Especially first time mums I would actually ask them about their mental health, experience of depression, anxiety, been on medication in the past” (A501HV).

If partners of expectant mothers were present at the visits, it was an opportunity for HVs to ask how they were feeling too:

“If it's his first baby how he's feeling about it too? (referring to fathers) Because it can be pretty anxious for him as well” (A101 HV).

The identification of physical or mental health issues enabled the HV to gauge what advice and support might be needed by the expectant parents to help manage their health issues and the care of their baby. Providing appropriate advice and support is discussed further in managing in the antenatal visit (section 5.15).

5.8.4 Focussing on safety of the unborn baby

The main concern of participants was the wellbeing of the baby with an emphasis on HVs gathering information about safety and providing appropriate advice and support to keep the unborn baby safe. Different aspects of safety were highlighted by participants including safe home environments, safe birth, safe sleeping, safe feeding, and safe and supportive parental relationships, which are discussed in turn.

5.8.4.1 Safe home and living conditions

HV participants identified the antenatal visit was an effective way of observing whether the parental home was an environment appropriate for a baby to live in:

“I think that's a good opportunity to see the home because the living conditions are part of our assessment. Particularly when baby comes, we need to know that they are in a safe and warm and comfortable environment” (A101HV).

“The home look safe to you and does mum have any concerns about safety?” (A602HV).

Some HVs recalled the purpose for observing home environment and identifying issues with living conditions and lifestyles was about trying to help give children the best start in life and for them not to be disadvantaged at birth:

“If somebody is living in cramped poor conditions with limited facilities or drug misuse so whatever around them, the likelihood of that child still having the same opportunities as a child who's living in a different area with the security in the home is already out of balance” (A102HV).

In addition to observation of the home environment HV assessment included discussions with parents about their living conditions and housing.

Some of the topics covered were:

“Different things..... smoking and about fire alarms and helping people maybe if they had issues with their housing, like damp” (A601HV).

Some parents commented that it was a necessary role for HVs to assess their home and lifestyle, but was still invasive:

“To have somebody come into your home and review what's going on feels like quite interventionist, but I'm like, don't get me wrong, in terms of health visiting, I think it's only you have to do it. It's not something I think that shouldn't happen. I definitely think it should happen... So coming into a home and being able to tell very quickly what the setup is..... they seem to be very respectful as to what was going on in the home” (A102 parent).

The HV coming in to observe their home environment was seen by some parents as more of an inspection type role:

“I would have thought and had it in my mind that she would have had an inspection of the property for any hazards” (A701parent).

However, HV participants did not identify with or want parents to feel like they were inspectors when they visited:

“Some people still have these strange ideas that like, you're going to like check in the house and cupboards and things like that. So for them to realise that's not the case” (A603HV).

There was an acknowledgment by some parents that HVs had skills and techniques in assessing quite quickly if their home is an appropriate place for the baby to be brought up in:

“Probably with HVs coming into people's homes from their experience they probably know the minute they walk in from people whether they are ready prepared, or whether they are struggling” (A701 parent).

Many HVs identified that a visit taking place at the parental home is an effective way of observing the various aspects of safety that are focussed on including parental living conditions and where the baby will sleep.

5.8.4.2 Safe birth

Some expectant parents who had health conditions that may affect the unborn baby, or health issues with a previous birth such as a stillbirth or caesarean section spoke of ensuring the baby's wellbeing and wanting safe births:

“ They are not keen at all for me to be sectioned because there is too much of a history of damage above my bladder because I have had so much surgery in between..... I will be telling them I will be having a section....there is no point in risking an emergency then the damage is going to be done” (A502 parent).

Conversations about the health conditions or previous birth experiences with expectant parents provided HVs with a clearer picture about the birth plans and what support or advice might help during the delivery of the baby:

“Aware of the anxiety she had experienced in her last birth and experience postnatally so I felt it was important to meet her today and see if there was any more help I needed to give her to make it a less stressful experience. I wanted to discuss feeding as I was aware she wanted to breastfeed the last time and she wasn't able to” (A501HV).

The assessment information helped the HV adjust their advice and support so it was tailored to the needs of the expectant parent and the wellbeing of the unborn baby.

5.8.4.3 Safe sleeping

HVs established with parents where the baby was going to sleep in order to assess if the baby was going to have a safe sleeping space after birth:

“Do they have a Moses basket or crib (brand name) or what their preparations are around about sleeping?” (A401HV).

The rationale for asking about how and where babies were going to sleep is summed up by one HV:

“I think I always talk about safe sleep messages, making sure they are sleeping in the parent’s room in a Moses basket or baby box, feet to foot those kind of safe sleep messages making sure you reduce the risk of SIDS (Sudden Infant Death Syndrome)” (A502HV).

Outdated sleep practices such as using cot bumpers or previously used mattresses were identified by some HVs who then updated parents on the most up to date research advice to prevent the risk of sudden infant death syndrome in babies.

5.8.4.4 Safe feeding

HVs explored parental thoughts about feeding their baby, including previous experiences of feeding. For those parents who had chosen to formula feed, experiences of bottle sterilisation and feed preparation were discussed to support safe bottle preparation and feeding practices for the baby. The following example emphasised how a HV discussion with an experienced parent highlighted outdated feeding practices, some way the HV used to help address the issues by sharing their own experiences (section 5.6.3.1) and updating advice in the hope of persuading the parent to reconsider their practice:

Expectant parent - “I fell out with the health visitor with (name of child) with that one because I just did the bottles in the morning for the day. Just take it out of the fridge and heat it up when you need it (Name of older child) survived to live another day”

HV – “So did I. That is how we did it when I had mine, but you know what the current advice is?”

Expectant Parent - “I will be doing it again with the bottles in the fridge. Take them out when I need them.”

HV – “Well we do advise to just make them up as you need them but, there is a leaflet here when I give you all your bumf about formula feeding just to remind you”

Expectant Parent - “So, it was never like they were ever kept for more than like a day and they were always in the fridge. It is just easier having them ready to grab.”

HV – “How did you heat them up? Did you just put them in some hot water like a cup?”

Parent – “No I put them in the microwave. My health visitor hated me.”

HV – “we do recommend putting it in some hot water but if you use a microwave just really shake it so there are no hot spots because you can get little hot spots if you put it in the microwave” (A502 observation).

In the above example the HV adjusts the discussion and tailors the advice to the parent responses.

5.8.4.5 Safety of babies through parental lifestyles

Safety of babies relates to lifestyles, parental relationships and domestic violence. HV participants gain some insight into the parental lifestyle from midwives and then gain a fuller picture by observing the home environment and talking to parents:

“See families in their homes for you to get an understanding of what life is like for them... trying to gauge what their understanding is before you start plugging the gaps in their knowledge” (A101HV).

“Trying to get a gist of how they are going to cope with this little baby that is going to cause stress in their life and a whole change of life for them” (A701 HV).

“Being able to understand what the issues are for them and how and why it's problematic for them” (A601HV).

HV participants describe “life” consisting of home environment, finances, employment, parental health, parental relationships and supports, social situation, and any parental experiences of being around babies:

“I think that’s really good to get a feel of their kind of background when they are about to have a baby, is there any immediate concern” (A602HV).

One HV described gaining a sense of what parental relationships were like by seeing both parents at the visit:

“Sometimes you get a bit of a feel of what the relationship is like between them whether it seems quite supportive or whether there is a bit of friction there or not” (A401HV).

The safety of the unborn baby and parent is considered by HV participants from what they find out about the parental relationship and support networks. Also whether there is any risk of harm to either of them from domestic violence:

“So, I also touch upon if it's just the mum that's present, I'll touch upon domestic violence. And I just make her aware that regularly as part of the pathway that it is something that we will ask repeatedly throughout kind of our visits. And the reason why, and, and different types of domestic violence so emotional, physical things like has she got access to her own money? Is she able to go out and about with her friends freely, does she have access to the car, that kind of thing” (A101HV).

Some HVs had dilemmas about partners being present as they wanted to discuss experiences of domestic violence with expectant mothers. The issue is discussed further in managing in the antenatal visit (section 5.16).

5.8.5 Demonstrating preparation for baby's arrival

Expectant parents demonstrated to HVs how planned and prepared they were for the baby's arrival by showing their preparations as well as discussing their birth plans (section 5.8.4.2). Some HVs also explored support networks, parental expectations of what life would be like with the practicalities of caring for a baby and socialising with their baby postnatally as the following examples illustrate:

“What they have got planned for their birth and kind of their perceptions of how they expect things to be? Thoughts and feelings on play dates, baby groups, how they're going to kind of communicate and, and interact with people after the baby comes?” (A101HV).

HVs found out about how the family were going to adapt to the baby's arrival:

"How are the other children feeling about being prepared for a baby as well? In terms of they going to have to share a room eventually, how are they feeling about that?" (A501HV).

Having information about parental plans gave a point of reference for continuing conversations postnatally:

"It reassured me knowing that they were kind of organised and then I think it maybe gives you a topic of discussion when you go again. You can say how did it go? Did the plan work out ok when your mum came to look after the wee one? how's it been with your partner being off? Makes them feel important as you are remembering what they have told you" (A502HV).

Parental demonstrations and discussions, along with identifying health needs, assessing parental health and focussing on the safety of the unborn baby all provided information for the HV assessment as to how prepared parents were for their baby's arrival. The assessment also helped the HV to plan and prepare any advice and support parents might want at the visit or at future contacts. The main category managing in the antenatal visit provided further insight to the support provided and how parents and HVs adjust to support the wellbeing needs of the unborn baby at the visit.

5.9 Main Category Managing in the Antenatal Visit

This section starts by summarising the key themes of the category, then examines each of them in turn.

5.10 Summary of main category managing in the antenatal visit

Managing in the antenatal visit was the third main category that helped describe the core category of how *parents and HVs adjusted to support the wellbeing of the unborn baby* at the HV visit. Managing included establishing an antenatal visit with expectant parents to promote the HV role and HV service and the advice and

support they can offer to them. Attempts to establish the visit highlighted the flexibility and adaptability of the HVs as well as the barriers they encountered.

Barriers included the unpredictability of births, fitting in with parental schedules, engaging with partners of expectant parents, the impact of work pressures, expectant parent past experiences impacting upon decisions to engage with the HV and the impact of the Covid-19 pandemic on visiting families antenatally. Once a visit was organised participants prepared for managing the visit by gathering information and using aide memoires. Past experiences featured in managing what information was asked for and shared. For HV participants their experiences led to focussing on certain topics in conversations with parents, whilst for parent participants past experiences played a part in the decisions they made to engage with the HV or access help and support from them.

Parental support was the final area of *managing in the antenatal visit* identified by participants. HVs provided advice and support related to topics of conversation raised in *therapeutic and supportive relationship building* and information from *assessing the wellbeing of the unborn baby* relating to parental need. Examples included breastfeeding advice and support and signposting to postnatal breastfeeding support, community support groups and local resources. The physical and emotional development of the baby after birth were addressed which included promoting communication skills and emotional attachment to the unborn baby. The focus for some participants was on promoting safe parenting practices such as safe sleeping and infant feeding, as well as addressing domestic violence and the challenges they faced, and managing parental mental health.

5.11 Establishing an Antenatal Visit

HV participants wanted to meet up with parents for the antenatal visit around 32 to 36 weeks of the expectant parent's pregnancy but experienced difficulty in arranging the visit:

“They’re sort of planned between ...32 and 36 weeks... it can be quite difficult to actually arrange a time that is suitable for them and also for yourself” (A601HV).

HV participant invites varied from phone calls to standard invite letters to expectant parents. Appointments made by invite letters were often less suitable for expectant mothers as one HV commented:

“It is a letter it goes out the same to everyone and is addressed to mum and dad, they are both invited to it, and then most mums then make contact with you because the date or the time, whatever you’ve put on that it’s useless” (A603HV).

The difficulties in establishing a visit were due to various barriers which are now discussed.

5.12 Barriers to establishing the antenatal visit

Barriers to establishing the antenatal visit identified by some HV participants included fitting in with parental schedules and progression of the pregnancy, engaging with partner of expectant parents, the impact of work pressures, and the impact of the COVID-19 pandemic on visiting families antenatally. Each aspect is addressed in turn.

5.12.1 Fitting with parental schedules and pregnancy progression

Arranging the visit included fitting around working mothers and the unpredictability of the baby’s birth:

“You’re starting to miss them because they’re delivering before you’ve got a chance to get to them, ...women are working, they’re working full time and it’s trying to find time that is convenient for them” (A101HV).

HV participants described being flexible and adaptable, moving the date of the visit to work in with the availability of working parents or progression of the pregnancy:

“So we just tend to work it in with the mums sometimes it's mostly towards the end of the day, I fit in an antenatal visit then because obviously they are working, maybe can get an hour off their work” (A604HV).

“35, 36 week mark... if we know that they're scheduled visits and a mum is going to be induced early, then we'll make it earlier” (A602HV).

The findings emphasised the flexibility required by HVs to provide appointments that meet the needs of the *wellbeing of the unborn baby* by fitting in the progress of the pregnancy and parental availability.

5.12.2 Engaging with partners of expectant mothers

There were a mix of HV participant views about the antenatal visit and who should be present. Some HVs discussed focussing their visits only on the expectant mother, whilst other HVs recognised some partners being more involved in the care of the baby and therefore were actively trying to engage with them to take part in the visit:

“Gone are the days where dad escapes from the room when the HV comes round. I feel that dads are more present and more involved which I think is a positive” (A101HV).

“If the partner is there you can find out whether they are quite excited about the baby arriving and are they wanting to sort of be hands on and get involved with baby care ...or whether they have done their bit and its hand over to their partner or wife to do the rest” (A401HV).

Some expectant mothers were under the impression their antenatal visit did not include their partners:

“I don't think there was an invitation for him to be there and it was just a case of (name of HV) coming to meet myself, but my husband would have been at work anyway. So he wouldn't have been there. My impression was that it was just sort of between ourselves” (A101 parent).

The above example highlighted that partners work patterns not fitting in with the scheduled antenatal visit dates was a similar issue that some expectant mothers also faced. It was unclear whether partners were part of the antenatal visit invitation suggesting HVs consider ways of prompting inclusion in the visit for partners.

HV participants shared mixed experiences regarding partners' involvement in antenatal visits. Some partners were eager to participate and learn more about the process:

“Once or twice that there has been a partner present when I have done the antenatal visit and I think that is not necessarily because they have arranged to be there when I am there just that they haven't been working and they have been happy to stay and find out what it is all about as well for them.” (A104HV).

Whilst other partners showed little interest and left the visit:

“Even though you've invited them and dads are there they'll sometimes excuse themselves” (A301HV).

Involving partners in the visit was seen by some HVs as a way of assessing parental relationships and how they were transitioning to parenthood together:

“I think it gives you a bit of a feel for their family, the way they operate, the way they communicate, you know. You can tell a lot from even just an atmosphere between, between a mum and a dad and also what dad's expectations are” (A101HV).

If HVs rarely see partners of expectant mothers, then they may have difficulty finding out their parenting styles and experiences which helps form their assessment of parenting ability as part of *assessing the wellbeing needs of the unborn baby*.

The challenges some HV participants experienced with trying to engage partners of expectant parents to be part of the antenatal visit were mirrored in difficulties sourcing partners to this study where only one partner was successfully recruited. Including partners in the invitation to the antenatal visit varied amongst HV participants but even when invited their uptake was low. Some HVs talked of promoting their role but the findings did not elaborate on how they promoted the importance of the role for partners of expectant parents suggesting further exploration in this area.

5.12.3 Impact of work pressures

Staff shortages were identified by some HV participants as a barrier to undertaking the HV antenatal visit in person with parents:

“In many teams where the numbers are so high that is unfortunately one of the first things to go the antenatal contact.. it changes to telephone contact which is still a contact but not the same as face to face contact. You don’t get the beginnings of the real rapport” (A701HV).

The impact of not carrying out the antenatal visit for some HVs meant they had not established a relationship with parents and had not been able to paint a picture of the family situation for themselves, leaving them feeling unprepared and anxious about the birth visit, also referred to as the primary visit, scheduled to occur approximately 10 to 14 days following the baby's birth (Scottish Government 2015a).

When the antenatal visit had not taken place it made the birth visit longer to undertake:

“You are starting off on the back foot a bit, you are kind of having to rewind a bit about what’s happened.. the visit takes a bit longer as you are trying to establish that relationship between you both and trying to find out a bit more” (A502HV).

For parents who had not received an antenatal visit they juggled managing a new born baby whilst trying to build *therapeutic and supportive relationships* with a HV they had never met:

“Just feel that there’s so much information at the primary visit that is quite overwhelming for a family that have got a new baby, they are sleep deprived.. not retaining the information and a lot of it is in leaflets... just makes it easier for myself and for the family to have that AN contact because it is breaking it up” (A101HV).

Omitting the antenatal visit makes the birth visit longer and more challenging for participants to deal with as they try to relationship build whilst the HV attempts to assess *the wellbeing needs of parents and the baby* and provide the most appropriate support to the family.

5.12.4 Parental past experiences

For some parents their past experiences were about health issues with their first born babies and how they were supported by previous HVs in managing the issues. The issues influenced choices about whether they planned to engage with the HV service and use the HV going forward for advice and support with the current pregnancy.

One parent who had a traumatic experience of their first baby being hospitalised for weight gain issues shared that at their second pregnancy HV antenatal visit the HV referred to a checklist which brought back all the memories for them about their experience:

“Oh, here we go. I'm part of a part of a system again, where I have to meet a certain standard. That's what I felt likebut that was just my internalisation of my feelings and my association with it...it was a massively stressful situation the first time round and just very emotive... so all of those feelings kind of come back with the association of health visiting... I wouldn't have felt like that the first time round... I think there was just that sort of feeling of, is this going to be somebody that you can speak to or is it just someone that's just like, like a tick box exercise” (A102 parent).

The expectant parent recounting their experience demonstrated how traumatised they had been from it. The actions of the HV using the checklist was a turning point in deciding whether to build a relationship with the HV or use them for support at the HV antenatal visit:

“It was nice to meet (name of HV) and she was absolutely lovely. It kind of felt like just something that we had to go through more than something that we needed any help with” (A102 parent).

Previous issues were about feeding the baby which they struggled with at the time and reflecting back required further support with. With the second pregnancy there were no issues with their baby's feeding so they made the decision to engage with the HV on a superficial level, seeing the HV but not using them for advice and support:

“I have now had that experience of having a child that wasn't jaundiced and wasn't sleepyso I didn't have that experience, I didn't know at that time, how often, (name of older child) needed to be fed” (A102 parent).

Another parent described their first baby having tongue tie which affected feeding, and the lack of HV support they received in their previous area. Although the parent was nervous about a subsequent antenatal visit with a new HV it was the qualities

and attributes of the HV that gained the parent's trust and they went on to use the HV for support:

"I was quite nervous...and she sort of put me at ease straight away..."it was just quite a nice personal touch that (name of HV) had reached out to me to meet me before the baby arrived.... I feel much more secure and just, yeah, you feel like you've got somebody there to properly support you.... definitely felt a huge sense of relief" (A101 parent).

The qualities and attributes of the HV helped persuade the parent to decide to engage with the HV and utilise their help and support with their subsequent baby who also experienced tongue tie. There were feeding issues but the parent felt fully supported by the HV during the process.

For parents it was either the actual experience that affected their decision or the behaviour and disposition of the HV that had a part to play in the decision to use the HV for advice and support at the antenatal visit.

Some of the HV participants were aware of the impact of first time experiences for parents with subsequent pregnancies, and recognised the need for exploring their experiences:

"How was their first experience, how did it go for them? A lot of mums have had real significant trauma and are very anxious about being in labour again or being a mum or how that's going to look.... it's what you can get a gauge for, how she wants it to be this time round" (A102HV).

The findings highlighted the value of HVs exploring past experiences of birth and labour with expectant mothers so that they can provide the right support with the current pregnancy. HVs should be aware of their own communication skills when meeting parents for the first time how their presentation impacts upon parental decisions to engage with the HV service and use the HV for advice and support.

5.12.5 Impact of COVID-19 pandemic on antenatal visiting

During the COVID-19 pandemic antenatal visits were halted. Some HVs highlighted that postnatally they were seeing more mental health issues postnatally that required mental health service intervention, and that families were isolated. Expectant parents were unable to meet HVs antenatally and build therapeutic and supportive relationship with them which some HVs emphasised as being a pressure for helping build relationships with parents and support them appropriately:

“COVID-19 there's been a lot of mums that I'm just going out to the primary visit having never met them and all I've got is the discharge form or the maternity documents,... It is not the same as meeting somebody face to face” (A703HV).

Even during the post COVID-19 pandemic period when data collection for the study was underway some HVs were phoning expectant parents rather than visiting them which impacted upon the quality of the therapeutic and supportive relationship building process:

“It had been getting done in the home but since Covid I haven't been doing antenatal visits it's been a phone call.....you can't read people's expressions” (A603HV).

The findings suggested *therapeutic and supportive relationship building* (section 5.5) and early identification of need from *assessing the wellbeing of the unborn baby* (section 5.7) were beneficial for engaging expectant parents with the HV service at the antenatal visit. The antenatal visit provided early intervention so that families obtained the most appropriate advice and support to meet theirs and their unborn baby's health and wellbeing needs. The findings suggest the HV antenatal visit should be considered as a priority visit within the Universal Health Visiting Pathway when workloads are under pressure. Additionally, it is vital to consider how the HV antenatal visit can be delivered effectively in the event of future pandemics so that expectant parents receive early intervention they may require.

5.13 Preparation for the antenatal visit

Preparation for the antenatal visit consisted of information sharing between other professionals and HVs about the pregnancy or family situation. Some participants used some kind of reminder or checklist to help them carry out the antenatal visit.

5.13.1 Information sharing with other professionals

Some HV participants commented that information from other professionals such as GPs and midwives would help them prepare them for undertaking the antenatal visit:

“We do have an antenatal meeting once every six weeks where we'll sit down and chat through all the women that are due and are pregnant and that allows us a safeguard as well in case anybody has had a miscarriage or there's an issue with the baby, had to have a termination or actually if mums are just not coping as well as maybe they were in the early stages...it means we can keep regular updates on how, women are getting on. I think it's critical for us to be able to ...have a little bit of knowledge about what women we've got coming up a little bit of background on them, are they in a couple or they have they got supports?” (A702HV)

Regular information sharing from midwives meant HVs were prepared for the antenatal visit:

“You are not going in blind because you have got information from the midwife” (A701HV).

The COVID-19 Pandemic hindered information sharing for some HV participants and midwives as their in person meetings diminished due to the restrictions on individuals meeting. However some HVs adapted to the situation, proactively setting up video meetings to ensure the information sharing continued:

“It's been a little bit more difficult since COVID because for the midwives, we sit in the offices next to each other ...And because we're not being encouraged to go in more than we need to. I think we've kind of been a little

bit out of sight out of mind. But we've now set up some meetings every few weeks with them, VC (Video Conference) meetings to be able to keep up to speed and up to date with antenatals" (A301HV).

Gaining information about expectant parents from other professionals was a valuable way of preparing some HVs for undertaking the antenatal visit.

5.13.2 Compiling reminder checklists

In addition to HVs gathering information from midwives and other professionals to prepare for the antenatal visit, some participants also prepared by creating mental reminders or written checklists of topics they intended to discuss:

"I was hoping to try it again (breastfeeding)...I was like, I had written down a couple of questions. I remember one of them was definitely the pram" (A101parent).

Most HVs referred to the guidance from the HV implementation plan (Scottish Government 2015a) that reinforced the key areas of the visit and acted as a reminder of the essential topics they focussed on at the antenatal visit:

"I remind myself what the recommendations are from Scottish Government on the pathway for the antenatal visit... looking at finances, feeding, any previous mental health problems and ..immunisation status, introducing that a little bit. Talking about preparation for parenthood and parenting kind of things as well.. I give myself a little aid memoire ...write a few things down on my antenatal sheet before I go to remind myself to talk about those things" (A502HV).

Some other HVs did not have a written list but utilised their memories to remember what to discuss:

"I always tried to get through those topics that I feel like is my mental checklist. I feel as I am going through that kind of feel as though I've covered most of my SHANARRI bits" (A301HV).

SHANARRI is an acronym of eight wellbeing indicators that captures the essence of wellbeing in babies and children identified within the GIRFEC national assessment framework. The acronym SHANARRI represents: Safe, Healthy, Active, Nurtured, Achieving, Respected, Responsible, and Included (Scottish Government 2022a). The wellbeing indicators are part of the assessment of the wellbeing of the unborn baby embedded within the HV documentation for the antenatal visit and all other Universal Health Visiting Pathway visits (Scottish Government 2015a) after the birth of the baby.

The implementation plan guidance (Scottish Government 2015a) and the national assessment framework (Scottish Government 2022a) provided a rationale for some of the HVs to carry out the antenatal visit:

“Sort of had a script in my head about things that needed to go over...about whether it's the pathway, any health issues going on, that searching for health needs, if they need support with anything at all” (A703HV).

The term HV *pathway* refers to the Universal Health Visiting Pathway in Scotland which provides the list of 11 HV home visits provided for children and families pre-birth to school age (Scottish Government 2015a). Some of the HV participants in the study commented they were relatively new to antenatal visits, in some cases work pressures delaying their implementation. Those HVs talked of referring to the Universal Health Visiting Pathway as a reminder of their role before undertaking the visit more than HVs who were more experienced at delivering the antenatal visit.

Checklists were predominantly not obviously displayed at the antenatal visit, they were kept close to the HV who glanced at them occasionally as observed at one HV visit (A701HV observation). The rationale for the checklist use was to make sure they had covered everything required of them at the visit:

“The sheet of paper I keep to the side and I'll just, you know, occasionally look to make sure I've covered everything that we need to get” (A604HV).

Checklists were useful tools for many participants. For HVs they were used to help support their *assessment of the wellbeing of the unborn baby* and for parents to address issues they wanted to discuss with the HV antenatally.

Some parent and HV participants reflected on their past experiences and how they managed the antenatal visit. Parental past experiences influenced decisions to engage with the HV and use them for advice and support. HV past experiences influenced how they managed discussing certain topics with parents at the visit. Firstly parental past experiences are considered followed by HV experiences.

5.14 HV Past Experiences

Some HV participants past experiences affected how they *managed in the antenatal visit*. One HV asked a parent a lot of questions and gave a lot of information about every aspect of safety for a baby including safe sleeping, formula feeding safely, safety around other children and pets at the visit. (A502 Observation). When asked why they had focussed on safety their response related to previous experiences of sudden infant death syndrome and shaken baby syndrome in their professional role:

“I have years ago, not one of my cases, a baby died of sudden infant death, so I think I have always remembered that, and it was horrific... I am always anxious about talking about that trauma... on the children’s ward we had a couple of cases of shaken baby syndrome so that is another... when something like that happens to you, you remember it... sometimes that is why it makes you focus on things when you go and do a visit, you are always a bit more paranoid about it” (A502HV).

Another HV talked explicitly about experiences of complex families involving domestic violence and the impact that it had on them as a HV. Their experiences appeared to be reflected in their keenness to prevent situations escalating and frustration at colleagues who in their view were not asking parents about domestic violence:

“If there is a need identified I’ll not let it drift... I’d rather work that way upfront than wait for the crisis or the unending drama to come or the blood under the door. I think all those things, I’ve worked in a (describes a domestic violence situation). I’ve seen more in real life than I wanted to admit, but I think the trauma becomes the trauma of the practitioner..... I am trained to live in that child’s world for a bit... we get so caught up in all of the minutiae of the adults sometimes... it all loses sight of the child. If you have got one HV who doesn’t want to break the barriers down with a relationship... I am the HV that asks because that’s what I am trained to deliver in my pathway. But I’m not saying their way is right or my way is right. It’s about the child. You still need to know if that child’s living in coercive control irrelevant of what perceptions are that people have about it” (A102HV).

The HV examples provided an emphasis on the safety of the child, the focus being on *assessing the wellbeing of the unborn baby and managing in the visit* by providing appropriate parental support and advice to address the safety issues.

What examples from participants suggests is that past experiences impact upon the way participants respond within the HV visit either in what they discuss, what information they share or how they relationship build. The findings highlight the importance of HVs understanding parental past experiences, as these can influence relationship building and the support provided during HV visits. Additionally, the findings emphasise the need for HVs to address their own experiences that may impact upon the care they deliver.

5.15 Parental Support Relating to Parental Need.

Parental support focused on managing the support and guidance offered by HVs to expectant parents during antenatal visits, tailored to their specific needs. The support provided was linked to the *therapeutic and supportive relationship building* where trust developed with HVs so that parents would open up about their issues with the HV. Some HVs saw support being about working in partnership with expectant parents and what they required rather than telling them what to do:

“We’re not there as a service to tell them how to parent their child” (A601HV).

"I am not wanting to raise their children for them, that's their journey" (A102HV).

The support expectant parents wanted depended upon factors such as previous experiences of parenting and what support they received, as one expectant parent commented upon:

"Didn't feel like maybe because the two of us are there and we've done everything on our own with the first baby...So, we get pretty much for each other support the whole way through...we've kind of got this covered" (A102 parent).

Advice and information sharing was part of the support and advice HVs provided to expectant parents in their transition to parenthood in preparation for caring for the baby after birth. Signposting to community groups and resources was part of the process. Support and advice was provided in relation to breastfeeding, promoting baby development and emotional attachment to the unborn baby. The main concern was about the wellbeing of the unborn baby in relation to safety and so the focus was on safe parenting practices.

5.15.1 Supporting breastfeeding

Some HVs provided information about breastfeeding to expectant parents at the antenatal visit and shared information about the support available to help with feeding postnatally:

"I don't like to put pressure on people, and if they're unsure, like I just give them all the facts about breastfeeding and facts about formula. And if they are a bit nervous, about breastfeeding, I just reassure them that there's so much support and that we're all trained baby friendly standards and that there's lots of us to help support them. And it just kind of, yeah, just want them to know that, you know, it can be tough. It can be so rewarding as well though, and that they will be supported" (A602HV).

One expectant mother living in a rural area valued the advice from the HV about breastfeeding during the antenatal visit as well as the support on offer postnatally to help her feed from the HV team and other community professionals and groups:

“I had already made the decision by then to bottle feed (talking about first pregnancy). This time I am in two minds and don’t know which way I want to go yet... (Name of HV) had mentioned like there is a breastfeeding support (named location) that can come out and for them to come out to the house is great because we can’t just nip out to centres or anywhere that we have got a long travel. So having rural community support from the likes of health visitors or the breastfeeding support or the baby massage that comes after and yeah its brilliant” (A501parent).

The provision of postnatal information gave clear messages from HVs to parents that they would be supported with feeding after the baby’s birth if required.

5.15.2 Promoting baby development and parental emotional attachment.

Most HV participants talked of promoting the baby’s development including communication skills in babies and parental emotional attachment to the unborn baby. Some HVs provided resources to parents from the Universal Health Visiting Pathway such as *the play at home book* comprising of age appropriate activities to promote physical activity and development in babies from birth (Scottish Government 2015b):

“I’ll bring out the play at home baby book at that point.... it’s a really good time for them to forward plan, like what to expect with a baby, especially if it’s first babies. Some people are really fortunate they have been around babies but there are so many people that have never had anything to do with a baby. So it gives them a really good idea of what they could be doing to promote the baby’s development, like brain development” (A602HV).

Other HVs talked about promoting communication and emotional attachment by parents to the unborn baby antenatally and in to the postnatal period:

“I also discuss things like I mention play at home book and baby massage these things, I then link to bonding and attachment and skin to skin because

that can all be really important and particularly communication. So we do a bit about words up as well, and really about the importance of that face to face, eye contact singing stories, chatting” (A502HV).

Words up is a literary resource (Highland Council 2020) that includes key messages to aid communication and emotionally connect with the unborn baby by talking and singing to the unborn baby *bump* with key messages continuing after the birth of the baby as one HV highlighted:

“Introducing the bump to all sorts of situations and telling the bump all about it and how beneficial that is, and also the benefit of safety and cuddles and close proximity and how it, it soothes and at the same time develops the baby's brain development” (A301HV).

The key messages HVs provided in relation to communication skills and emotional attachment were supported by utilising visual aids such as information leaflets and signposting to community resources such as baby massage and social groups for parents and babies.

5.15.3 Promoting safe parenting practices

The main concern of participants was the wellbeing of the unborn baby with a focus on safety. In *managing in the antenatal visit* HV participants advised and supported expectant parents with promoting safe parenting practices in areas such as safe sleep and safe feeding practices. as well as how they manage broaching the topic of domestic violence with parents.

HV participants described distributing information to parents at the HV antenatal visit relating to the promoting safe sleep for babies:

“So, I like to give out.....protect their head space and talk about that.. I give out the Scottish cot death trust leaflet” (A602HV).

Information about promoting safe sleep was also covered in section 5.8.4.3. Some HVs rationalised the importance of sharing safe sleep messages at the antenatal visit in order to promote safe parenting practices from the baby's birth:

"It could be much more beneficial and educating the family about these things before they actually start using them (referring to sleep products) .. by the time we go in they are like "Oh well, I've used them up until now, they are absolutely fine and actually my baby loves sleeping in it" (A101HV).

HVs provided information about infant feeding and promoted safe feeding practices (section 5.8.4.4) as part of *assessing the wellbeing of the unborn baby* addressing safe feeding when unsafe feeding practices were identified. Managing the promotion of safe parenting practices was therefore closely linked to the assessment process.

When HVs engaged with expectant parents during the antenatal period and promoted safe parenting practices, they were able to prevent the establishment of unsafe habits. This proactive approach addressed issues that some HVs had previously observed during postnatal visits with parents who had not received antenatal support as captured in the following quote:

"All those things that you want to make sure they are established first of all, so there are not bad habits before you have had a chance to see them" (A502HV).

The findings suggest early identification of safety issues at the antenatal visit by HVs and raising awareness on how to address the issues helps promote safe parenting practices.

5.16 Broaching Domestic Violence

Some HV participants wanted to support pregnant women who may have been experiencing domestic violence at the antenatal visit but broaching the subject could

be difficult when they had only just met the expectant mother or if partners were present at the visit.

Pregnancy was seen as a time associated with an increased risk of domestic violence with the antenatal visit being an ideal opportunity to ask about domestic violence and signposting to support services if disclosed:

“Women are higher risk when pregnant of domestic abuse and you know if they don't have financial control themselves, that's a sign that there could be domestic abuse there.we want to try and support women to get support from women's aid for that” (A702HV).

Routine sensitive enquiry to domestic violence was referred to (NHS Highland and Highland Council 2021) by some HV participants about their role in being required to speak to expectant mothers on their own about domestic violence at HV assessments. If expectant mothers were on their own at the antenatal visit HVs would discuss domestic violence with them:

“If it's just the mum that's present I'll touch upon domestic violence. I just make her aware that regularly as part of the pathway that it is something that we will ask repeatedly throughout our visits, the reason why and different types of domestic violence so emotional, physical, things like has she got access to her own money? Is she able to go out and about with her friends freely, does she have access to the car” (A501HV).

Some HV participants talked about difficulties in broaching the subject of domestic violence, picking the right time in the visit, asking the right questions when HVs have only just met the expectant mother and *the building of the therapeutic and supportive relationship building* has only just commenced:

“It is always tricky to approach about domestic abuse. I do try and approach it. I don't always succeed I have to be honest, it is all about knowing how to go about, how to approach it, how to ask.... things get kind of side-tracked and we are on to a different kind of conversation... that first meeting with the mum to be as well. It is not always easy to approach it” (A401HV).

When expectant parents and their partners were present together at the antenatal visit some HVs raised the subject of domestic violence with them both which promoted talk about relationships:

“Just raising it (domestic violence) as a subject say something that we look for and ask about, and we’re here for support. I had one mum who did say that she’s the one whose more likely to hit the dad” (A601HV).

Some HVs viewed normalising discussions about domestic violence and addressing the issue regularly as an effective way to reduce its stigma, creating opportunities for women experiencing it to feel more comfortable opening up to their HV:

“Discussing all the different areas of domestic violence that then kind of normalises it and it makes it a lot easier then to approach that subject further down the line” (A101HV).

Although discussing the issue of domestic violence was challenging, HVs demonstrated flexibility in providing opportunities for parents experiencing it to open up about their experiences by normalising their conversations about the subject.

Another topic where stigma was recognised by HVs was mental health where normalising talking about it was promoted, as discussed further in the next section.

5.17 Managing Mental Health

Mental health was seen as an important role for HV participants in early identification and intervention that included HV support. This study was undertaken pre and post COVID-19 pandemic where some HVs had noticed an increase in mental health issues post pandemic:

“I think given COVID, I find every visit has a different element of mental health attached to it because of the pressures that we’re under (A102HV).

“Mental health, because we've seen it more in COVID times, but I just think there's a huge risk for mums out there for, you know, depression after baby and I don't think that there's enough support out there. So I think if we can identify it early and support, and you know do some early intervention, then that is the best way forward” (A703HV).

Mental health was considered by some HVs as being stigmatised. Getting the topic out in the open by normalising conversations about mental health with expectant parents helped promote expectant parents seeking advice and support in the future as one HV recounted:

“I have got a mum at the minute who I have been supporting around anxiety and when I met her antenatally we kind of talked a bit about, that it is not uncommon for you to feel more anxious after you have had a new baby but it is important that you talk about it to somebody. In that being more open and honest about it, we are not going to think worse of you if you do feel more anxious it is about getting the right level of support. So from around the first 4 week mark she was more open and honest, she said, “you said I would be more anxious and you said to talk about it well it has been getting worse” and she was able to talk about it and we were able to put some self-help methods in place and I have been seeing her every couple of weeks to just give support around that” (A502HV).

Although the above example is about supporting a mother postnatally the conversation that the HV had with the expectant mother about anxiety at the antenatal visit was key for the expectant mother to recognise they needed to seek further advice and support. Some HV participants tried to paint a picture for expectant parents about what the transition to parenting looked like for them to prepare them emotionally:

“The first few weeks or months in particular are really difficult and lack of sleep in itself can make people feel quite low sometimes and really just acknowledging that” (A401HV).

As well as normalising discussions about mental health, some HVs recognised that some expectant parents may have past or current mental health issues so finding out more about their experiences and support mechanisms as part of *assessing the wellbeing of the unborn baby* helped inform the HV of what support the expectant parent might require:

“Just because you're having a baby, it's okay that you've had anxiety, depression that you may still have these challenges, but how we can support that and how can we help you through that and how you gain support.....what help do you access when that happens to you? ...understanding as well their own awareness of their mental health if they have suffered from mental health problems in the past . So if their mood is dipping, are they aware of it, or is there other people around them that become aware of it so that they know to seek help”(A101HV).

Normalising conversations about what happens if mental health becomes an issue for expectant parents and how HVs assess and support was captured by one HV:

“If they're to have breakdowns over little things, but it's continuing and it's not going away and it's not getting better and it's not kind of passing, then I'll discuss the postnatal depression scale. And how we do mood assessments when we do them and I just explain a little bit, about the tool we use, not in much depth, but just so that when it does come around, it's normalised for them” (A101HV).

Managing mental health at the antenatal visit was not only about early identification and support but also reducing the stigma associated with it by normalising mental health so that expectant parents would reach out for support. HVs having conversations about what mental health might be like after having a baby, providing realistic insights in to the transition to parenthood and sharing the process if it became an issue.

5.18 Chapter 5 Summary of Findings.

This chapter presents the findings of the study consisting of analysis of the data that explores the social processes of the HV antenatal home visit and what occurs between parents and HVs at the visit.

Overall, the findings uncovered the main concern of both parents and HVs at the HV antenatal visit was the wellbeing of the unborn baby. Through conversations parents and HVs familiarised themselves with each other which led to therapeutic and supportive relationship building. The relationship building was a gateway for

HVs to assess parental situations and the impact on the wellbeing of the unborn baby by parents demonstrating preparation for the baby's birth, and participants focussing on the safety of the unborn baby. Managing in the visit looked at how the antenatal visit was established and factors that affected relationship building and assessment. It gave insight in to how HVs provided advice and support on the transition to parenthood with a focus on promoting safe parenting practices.

All three social processes *therapeutic and supportive relationship building*, *assessing the wellbeing of the unborn baby* and *managing in the antenatal visit* occurred simultaneously during the visit and emerged as main categories that addressed the wellbeing needs of the unborn baby. The core category that linked the main categories together was the social process of *parents and HVs adjusting to support the wellbeing of the unborn baby* which addressed the main concern of the wellbeing of the unborn baby.

Chapter 6: Discussion

6.1 Introduction

This chapter presents a newly developed substantive theory regarding the HV antenatal visit. It revisits the study's research question, which served as the basis for developing the theory. The proposed theory suggests that the wellbeing of the baby is the primary concern for both parents and HVs during the visit. Through relationship building, assessment, and management, parents and HVs *adjust to support the wellbeing needs of the unborn baby during the antenatal visit.*

The substantive theory formulated through theoretical coding is introduced in this chapter. The theory is then evaluated by examining its alignment with existing literature. Additionally, the chapter addresses the study's strengths and limitations, examines its relevance to clinical practice and investigates possible avenues for future research.

6.2 Substantive Theory

The research question that led to an exploration of the HV antenatal visit using CGT method was:

What are the perceptions and experiences of expectant parents and HVs about the process of the HV antenatal home visit?

Through observations of the visit and interviews with parents and HVs who have experienced a HV antenatal home visit the following substantive theory emerged:

Expectant parents and HVs adjusting to support the wellbeing needs of the unborn baby at the HV antenatal home visit.

The substantive theory developed using CGT techniques (Chapter 4: Research Methods). Theoretical coding generated the substantive theory by identifying three main categories that shaped the substantive theory and conceptualised how the categories related to each other: *therapeutic and supportive relationship building*; *assessing the wellbeing of the unborn baby*; and *managing in the HV antenatal visit*.

Therapeutic and supportive relationship building was seen as the starting point of the HV antenatal visit where parents and HVs learnt about each other through conversation and information sharing. HVs adjusted their conversations to promote parental trust so parents would use them for advice and support. Parents adjusted their conversations with the HV dependent upon their trust in the HV and whether they wanted or needed their support and advice. Therapeutic and supportive relationship building was the gateway for *HV assessment of the wellbeing of the unborn baby* which occurred simultaneously with the relationship building process. The HV assessment was adjusted to include observations of the home and lifestyle and information parents shared and demonstrated about their transition to parenthood. Following assessment, *managing in the antenatal visit* demonstrated how HVs planned and carried out the visit, providing support and guidance adjusted to parental need and the consideration of past parental and HV experiences.

Adopting a CGT approach, the substantive theory was articulated through the conceptual integration of the main categories. The new substantive theory holds importance for clinical practice, as it provides insight into the experiences of both parents and HVs during the antenatal visit. For parents relationship building familiarises them with the HV, and during assessment they demonstrate how they are transitioning to parenthood antenatally. They also consider whether they wish to utilise the HV service for advice and support antenatally and in the postnatal period. For HVs the new substantive theory provides insight in to how their role develops during the antenatal visit to support the wellbeing of the unborn baby through relationship building, assessment and providing guidance and support to parents. Incorporating the study's findings into practice guidance with an emphasis on the importance of building strong relationships with parents and providing empathetic, non-judgmental support will raise awareness for HV development.

Additionally, directing HVs to Solihull modules can further develop their relationship-building skills.

6.3 The Theory and Current Literature

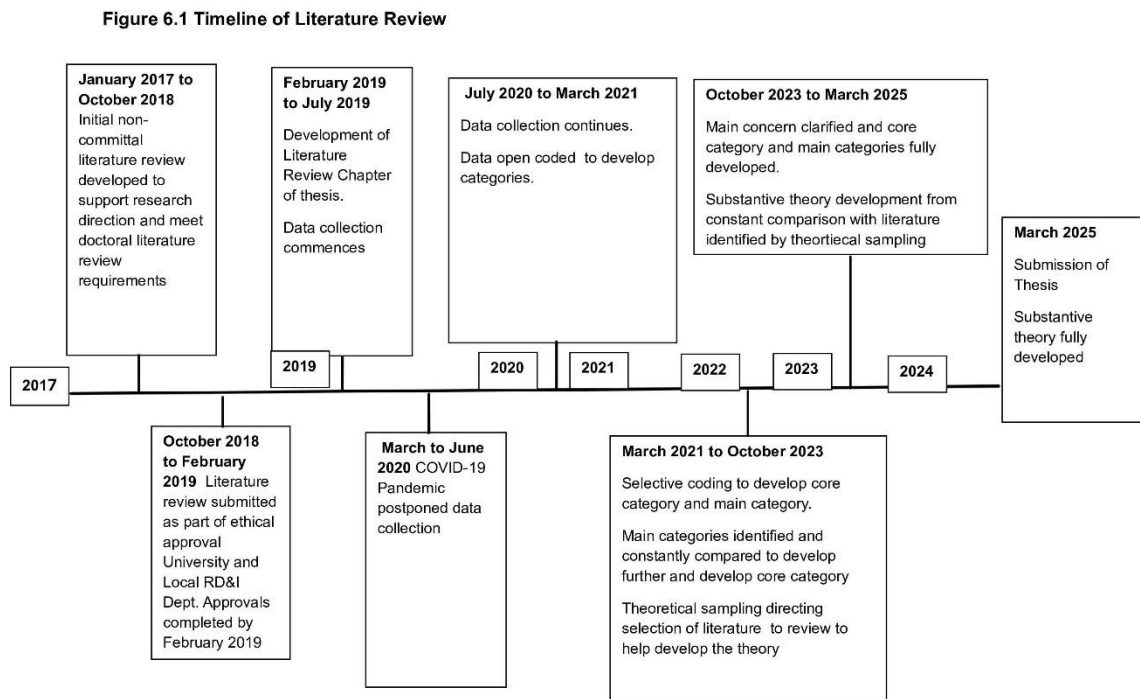
This section begins by discussing the second stage of the literature review process, which is a more targeted approach, that selects appropriate existing theories to support the development of the substantive theory (Glaser 1998; Urquhart 2013). The subsequent sections in this Chapter address the theory that developed from the HV antenatal home visit study, in relation to the existing literature and the study's contribution to knowledge. Firstly the wellbeing of the unborn baby is addressed, the main concern identified as the focus of the HV study. It then examines the core category, which involves expectant parents and HVs adjusting to support the wellbeing needs of the unborn baby. Finally, it explores the three key categories: therapeutic and supportive relationship building, assessment, and managing within the context of the HV antenatal visit.

As recognised in Chapter 2 Literature Review, in classic grounded theory the idea is to delay the literature review to allow conceptual categories to develop from the study data, enabling an avoidance of the distortion that can occur when applying externally imposed theoretical constructs from existing literature (Dey 2007; Glaser 1978; Glaser 1998). The resulting first stage literature review was therefore non-committal to identify gaps in the research topic, to meet requirements of doctoral study and help develop the research question (Hallberg 2010; Urquhart 2013). The second stage of the literature was carried out once the study data developed the conceptual categories that developed the study's theory (Glaser 1978; Glaser 1998).

In order to develop the substantive theory from the core category and main categories once identified, existing literature was sought and compared to recognise similarities with the study or to find new knowledge about HV antenatal home visiting (Glaser 1998). A visual representation of the literature review process within the study is shown in Figure 6.1 which demonstrates the literature review interwoven

with the constant comparative analysis process of the data as described fully in section 4.6.1.

Figure 6.1 Timeline of Literature Review



Once the main concern, core category, and main categories were identified, literature was searched to find relevance to HV antenatal visiting. Although some of the first literature review evidence was of significance to the developed theory, there was a need to carry out a more focussed search that included from the concepts identified from the categories in the study (Glaser 1978; Glaser 1998). Search terms included wellbeing, relationship building, trust, information sharing, experiences, assessment, identifying need, preparing, support, managing, mental health, domestic violence were included in the second literature review utilising the same search bases utilised in the first literature review. One example of the literature search being more focussed was that the study identified the concept of managing the antenatal visit in the area of parental mental health which was not an area that was identified in the initial literature review. Searching literature in the newly identified area gave comparisons with existing HV practice in relation to

managing mental health, how the HV antenatal study complemented current HV practice, and provided new knowledge (see section 6.9.4).

A re-run of the first literature review was also carried out September 2023 and again November 2024 to capture any new research papers that may have been of relevance. No new papers were found. Literature relevant to the substantive theory is referenced in the remaining sections of this chapter which now follow.

6.4 The Main Concern- Wellbeing of the Unborn Baby

Findings of the HV antenatal study indicated the wellbeing of the unborn baby was the main concern of parent and HV participants. The findings are consistent with HV literature supporting health and wellbeing of babies as being a core HV specialism (Stephen and Nettleton 2022) and that the care of the baby is what expectant parents seek to learn more about as they navigate the journey into parenthood (Deave et al. 2008; Olander et al. 2019). The findings are also supported by the national risk framework for assessment of children, GIRFEC (section 1.3) used by midwives and HVs to identify any health and wellbeing issues for the unborn baby (Scottish Government 2022c). The eight national SHANARRI wellbeing indicators, within the national framework were referred to in varying degrees, mainly by HVs (Scottish Government 2022c) (section 5.13.2). The findings highlighted aspects of health, nurturing, and safety, aligning with the literature on the Universal Health Visiting Pathway, which emphasises promoting, supporting, and safeguarding children's wellbeing, as well as preventing unintentional injuries through the encouragement of safe parenting practices (Scottish Government 2015a; Scottish Government 2022c).

Evidence regarding the wellbeing of unborn babies in the context of HV practice during antenatal visits is limited. Guidance from antenatal midwifery care (NICE (National Institute for Health Care and Clinical Excellence 2021a) highlights foetal wellbeing as measured by foetal growth monitoring involving clinical examination of the mother and assessing her general health and wellbeing. In addition risk factors

that might affect the health and wellbeing of the unborn baby are assessed such as maternal health issues, previous traumatic births, infections, medical and family history and screening for foetal abnormalities. Family and home and social situations are also assessed to identify issues significant to affect the health and wellbeing of the unborn baby such as parental mental health, smoking, alcohol use, and domestic violence.

The HV antenatal study offers significant insights into the factors influencing the health and wellbeing of unborn children within families identified by midwives as having no additional health or wellbeing concerns. Utilising the national practice model in conjunction with the SHANARRI wellbeing indicators, HVs systematically evaluated the wellbeing of unborn babies during antenatal visits (Scottish Government 2022a; Scottish Government 2022c). This methodology aligns closely with the framework applied by midwives in their professional practice (Highland Council and NHS Highland 2015). Additionally, both HVs and midwives conduct comparable assessments of family health that include family health, lifestyles and social situations (Highland Council and NHS Highland 2015; NICE 2021a).

Safety was a feature of wellbeing giving insight in to expectant parents concentrating on the health of the baby, a safe birth and reducing the risk of cot death. In addition HVs focussed upon assessing the safety of the baby and promoting safe parenting practices to prevent unintentional injuries or safeguarding issues (Scottish Government 2015a; Scottish Government 2022a).

Sharing the findings of the study with HVs would raise awareness of aspects of wellbeing that parents and HVs focus on so future delivery of the contact is cognisant of parental and HV concern about the wellbeing of the baby. Also that HV assessment and advice considers promoting safe parenting practices that respond to parental situations, parental concerns and promotes the safety of the unborn baby.

6.5 Core Category- HVs and Parents Adjusting to Support the Wellbeing Needs of the Unborn Baby at the HV Antenatal Visit

The findings revealed a core category centred on the experiences of both parents and HVs: *expectant parents and HVs adjusting to support the wellbeing needs of the unborn baby* (section 5.4). HVs built trust with parents adjusting their relationship building skills to promote expectant parents sharing information about their health, wellbeing and lifestyles. Expectant parents adjusted information they shared based upon the relationship that formed and what support they wanted, as recognised in the evidence about relationship building between HVs and expectant parents (Cowley et al. 2013; Cowley et al. 2015) and covered further in section 6.7.

HV flexibility in assessing the wellbeing of the unborn baby through parental health, wellbeing and lifestyles is evidenced in literature about parent's readiness to receive the information and HVs wanting to maintain access to families (Appleton and Cowley 2008) and more recently partnership working, using strength based approaches and aligning to family agendas (Astbury et al. 2016; Day and Harris 2013).

The HV antenatal study findings provided new evidence about expectant parents demonstrating and discussing adjustments to their lives during their transition to parenthood. The transition to parenthood is recognised as a major adjustment period for families expecting a baby (Cowan and Cowan 1995; Deave et al. 2008) yet little is known about it from a parental perspective at the antenatal visit. The findings provided new understanding about how expectant parent's saw the baby's arrival affecting them and the changes and support mechanisms that they might require postnatally. Parents sought advice and support from the HV regarding their transition to parenthood. The findings align with previous research, which suggests that parents appreciate such guidance from health professionals during the antenatal period (Deave et al. 2008; Olander et al. 2019).

The adaptable and flexible approach employed by HVs during antenatal visits highlights the multifaceted nature of their role, encompassing relationship building,

home visits, and the assessment of needs (Cowley et al. 2013). In addition the utilisation of a non-directive partnership promotes parental confidence (Donetto et al. 2013) and is adaptive to the needs of individuals and families (Stansfield and Gilroy 2022). The findings provided evidence about the principles of universal HV practice in the antenatal period for core families, supporting evidence about orientation to practice from HV postnatal practice (Cowley et al. 2013; Elkan et al. 2000), influences of FNP practice (Kemp et al. 2006) and standards of proficiency for specialist community public health roles (NMC 2022).

Sharing the findings of this study with HV teams about parental transitions to parenthood would help HVs reflect on their practice and adapt their approach to relationship building, assessment, and providing advice and support during antenatal home visits.

6.6 Main categories

This section discusses the three main categories that inform the core category: *therapeutic and supportive relationship building*, assessment of the wellbeing of the *unborn baby* and *managing in the HV antenatal visit*.

6.7 Therapeutic and Supportive Relationship Building

This section looks at how relationships build between HVs and expectant parents within the study, compared with the current literature about relationship building in order to expose the developments this new knowledge can bring to. Areas covered include characteristics of relationship building, partnership working and the home environment. Each are addressed in turn.

This study identified the HV antenatal home visit as the starting point of the social process of therapeutic relationship building between HVs and expectant parents. It is where HVs built trust and approachability by promoting themselves and their roles

so parents would engage with the HV services for advice and support. The findings echo reviews of postnatal relationship building and HV practice guidance where HVs need to engage confidently and effectively to promote family health and wellbeing, provide early intervention and safeguard children in the process (Cowley et al. 2013; Cowley et al. 2015; Scottish Government 2015a, Scottish Government 2022a).

Parents in the study talked of HVs being friendly and approachable, making good impressions by listening to what parents talked about and where the HV was helpful, supportive, and non-judgemental. The findings aligned with some postnatal studies that found parents appreciated characteristics in HVs that helped build strong relationships between them, and where the HV listened and responded sensitively to parental circumstances, without making them feel judged (Bidmead et al. 2016; Donetto et al. 2013). Their findings also noted parents valued traits such as empathy, approachability, respect, genuineness, calmness, caring nature, and friendliness. Empathy, in particular, is perceived as understanding and helps parents feel acknowledged, facilitating their ability to express their thoughts and emotions during assessments which is part of a strengths based approach to relationship building within FNP programmes (Bidmead et al. 2016; Day and Harris 2013). When HVs show interest in the family's well-being and offer praise, it fosters respect, confidence, and trust in the parents' own judgments (Bidmead et al. 2016).

The HV antenatal study provided detail from within an antenatal setting of some of the characteristics Bidmead et al. 2016 and Day and Harris 2013 found. It provided detail about the conversations and discussions HVs and expectant parents had and where HVs demonstrated understanding, acknowledged parental viewpoints, and offered support or advice to help parents make their own decisions about aspects of the care of their unborn baby.

The HV antenatal study provides valuable insight in to how the therapeutic relationship develops at the antenatal home visit through the HV promoting their role and provision of advice. It was where mutuality and partnership working developed to meet parents' needs, considered as a core skill of HV practice in early years studies (Bidmead and Cowley 2005; Cowley et al. 2013; Cowley et al. 2015; Sturley

et al. 2022) and where parents recognised they required help when adjusting to new or current experiences through taking the lead (Cowley 2013) and shared decision making with HVs (Astbury et al. 2016).

Aspects of the relationship building process demonstrated within the HV antenatal study included HVs being tuned in to the parent, valuing their input, listening to them, following verbal and non-verbal cues, adjusting their responses and mirroring parental communication. They are recognised as successful moments of relationship building (Koloroutis and Trout 2013) and are a way of respecting others and keeping them in mind, an orientation to HV practice known as 'human valuing' (Cowley et al. 2013).

The study found that parents demonstrated qualities such as trust in their HV, openness in sharing personal experiences, and responsiveness to advice and support. These qualities are considered essential for building therapeutic relationships (Bidmead et al. 2016).

The relationship building attributes of some HVs in the antenatal study demonstrated authenticity in the HV parent relationship (Sturley et al 2022) and had similarities to aspects of the Solihull approach used in HV practice to support parental management of various aspects of children's behaviour, such as reciprocity (Douglas 2010; Moore et al 2013).

The Solihull approach developed in the late 1990s is a model that integrates psychoanalytic theory (containment) with child development research (reciprocity) and learning theory (behaviour management). Its goal is to enhance the emotional health and wellbeing of both children and parents by highlighting the connections between behaviour and emotions. It focuses on regulating emotions for both parents and children, strengthening the relationship between them, as well as the relationship between practitioners and parents (Douglas and Johnson 2019).

HV relationships require mutual exchange with parents otherwise known as reciprocity as defined within the Solihull approach:

“the dance of interaction between two individuals when they are tuned in to each other’s emotions and needs and respond to these in a sensitive way” (NHS Education Scotland.p.5.).

When initiation of communication, regulation and ending of communication goes well between parents or carers and their children, both the children and parent feel connected, listened to and understood, which is similar to HV relationship building with parents in the HV antenatal home visit. Trust developed by the appropriate commencement, regulation and termination of communication which also served as a way for the HV to model behaviour (Douglas 2010). The parents experienced an element of control which led to the trust developing (Day and Harris 2013). The HV antenatal study provides insight to how reciprocity developed in an antenatal visit with parents taking the lead in conversations, HVs being flexible, adaptable, and fluid, tailoring their conversations to what parents said as well as what HVs observed.

More recently the Solihull approach has developed antenatal parenting programmes and online parenting courses (NHS Education Scotland 2020) based on evidence about early brain development, the significance of early experience from conception, and how formative relationships and lived experiences shape this process (Black et al. 2019; Center on the Developing Child 2019a; Center on the Developing Child 2019b). The emphasis is on attuned and connected parental relationships with their babies which is a topic of conversation within the HV antenatal study. In the study research area, Solihull two day training is considered essential for development of the HV role and a suite of online learning to support HV continual professional development is provided (NHS Education Scotland 2020). From 2020 free online parenting courses became available for parents to access in the research area (Education Scotland 2020). The study did not explore if any of the parents or HV participants had training or experience of the Solihull approach. It was therefore uncertain if the approach influenced their relationship building skills.

The HV antenatal study added to the literature on home visiting providing information on the factors that are important for parents and HVs at the start of the relationship building process. Familiar objects in the home environment such as photos or pictures also provided topics of conversation that HVs could use to help build relationships with parents. The study found that expectant parents and HVs valued the contact between them taking place in the parental home. For parents they liked the familiarity of the home that provided a relaxed atmosphere. For HVs a home environment was more conducive for building relationships with parents where they may openly inform the HV about their lives (Cowley et al. 2015).

Some of the HV parent relationships in the HV antenatal study were well established from previous pregnancies through a named HV, a well-known and consistent reliable HV contact as identified by Bidmead et al. (2016). Named HVs are allocated to families to provide consistency of care within universal HV service provision, partnership working with them, responding to their changing needs, and ultimately promoting and safeguarding their health and wellbeing (Scottish Government 2015a). Cowley et al (2015) highlight that therapeutic relationship building develops over time and there is a need for a long term approach to its development (Cowley et al 2015). The HV antenatal study provided examples where information known about the family or previously discussed with parents were revisited during conversations, the information sharing helping with relationship building between them over time.

The longevity and consistency of some of the rekindled relationships in the HV antenatal study mirror those found within FNP and Flying Start programmes across the UK (Department of Health 2010; HSC Public Health Agency 2025; Scottish Government 2014; Scottish Government 2015a; Welsh Government 2009) which supports the long term approach to relationship building that Cowley et al (2015) advocate. The family nurses in the targeted programmes visit much earlier in pregnancy than HVs do within the universal HV pathway, commencing before 28 weeks of pregnancy, with more frequent visits longer in duration within the antenatal period. The home visit in the HV antenatal study occurs between 28 to 34 weeks of pregnancy and is only one visit in the antenatal period for families receiving the

universal HV pathway. The study findings relate to only one visit giving valuable insight into the early stages of the therapeutic relationship between HVs and expectant parents.

The HV antenatal study discovered some HVs share information about themselves to help build therapeutic relationships with parents whilst others chose not to, facing a dilemma about crossing professional boundaries when doing so. The HV governing body expects nurses to foster therapeutic relationships that promote confidence and trust (NMC 2018). Antonytheva et al. (2020) suggests therapeutic intimacy involves the development of closeness, trust, reciprocity, and self-disclosure. The degree of self-disclosure is based on the nurse's judgment of the degree of disclosure to maintain professional boundaries. Professionals that have concerns about remaining professional by not self-disclosing may avoid achieving therapeutic intimacy (Antonytheva et al. 2020).

The sharing of genuine self encourages deep relationships and builds trust where vulnerability is presented as a strength promoting both personal and professional growth (Jourard 1971). The HV antenatal study identified the challenges for HVs in enacting professional intimacy in their roles. However, with a paucity of guidance relating to intimate relationships between nurses and service users (NMC 2018, NMC 2022) the dilemma continues. The recommendation from the findings support work from Antonytheva et al. (2020) to identify and assess professional intimacy to ensure safety and appropriateness in practice can be ensured.

Home visiting as well as being beneficial for relationship building was recognised as being the gateway for assessment of need and early intervention by providing support tailored to need as also found in postnatal studies (Cowley et al. 2013). Three fundamental aspects of HV practice: building therapeutic relationships, conducting home visits, and assessing health needs were identified within the study, recognised as HV core principles of practice (Cowley et al. 2013). Yet instead of occurring simultaneously during the visit as Cowley et al (2013) suggests, the findings of the HV antenatal study noted that relationship building required and

element of establishment before assessment of parental situations could occur within an antenatal setting.

In summary, new evidence from the HV antenatal study provided insight into aspects of therapeutic relationship building with newly formed relationships as well established relationships, including parental trust in the HV and confidence in approaching them for advice and support. The relationship building process demonstrated aspects of partnership working including empathy and mutual respect as recognised in targeted programmes such as the FNP programme and Solihull approach. Building of positive therapeutic and supportive relationships provided a mechanism for HV assessment of parental strengths and risks (Day and Harris 2013; Sturley et al. 2022).

The next main category *assessment of the wellbeing of the unborn baby* will now be discussed.

6.8 Assessment of the Wellbeing of the Unborn Baby.

The antenatal visit was an opportunity for HVs to utilise the social processes of observing and assessing family health, lifestyles, relationships, and support networks as recognised in an evaluation of the Universal Health Visiting Pathway in Scotland (Doi et al. 2021; Scottish Government 2021) and as supported by government policy and statutory regulation of HV practice (Scottish Government 2015a; NMC 2022). HVs mentioned ‘wellbeing indicators’ (section 5.13.2) as well as ‘My World Triangle’, both GIRFEC ecological and holistic child assessment tools underpinned by Bronfenbrenner and Ceci’s (1994) bioecological model of child development theory (Aldgate and Rose 2008; Coles et al. 2016). As assessment tools they have little focus on assessing wellbeing outcomes specifically for unborn babies (Scottish Government 2022c). The HV antenatal study findings provide insight into what happens during the assessment process and how information is gathered for the assessment through conversations with parents and observing their home environment. The findings highlight the significance of home visiting as a HV

core practice gaining pictures of parental lifestyles in their own situation, known as health ecology and how they impact on the wellbeing of their children (Cowley et al. 2013), although with an emphasis on the wellbeing of the unborn baby.

Assessment tools in the HV antenatal study provided a framework for HV conversations with parents (Astbury et al. 2016). Topics raised covered many core public health priorities identified in the Universal Health Visiting pathway (Scottish Government 2015a). However, the findings highlighted both parents and HVs focussed on the safety aspect of wellbeing of the baby. Topics included safe sleeping and feeding, and parental lifestyles and their impact on the unborn baby. The findings support evidence that the early intervention role of the HV in the antenatal visit has an element of addressing the emotional and physical safety of children, safeguarding and protecting them from harm as also recognised within postnatal visiting (Cowley et al. 2013).

In their transition to parenthood, parents want a healthy baby (Heinonen 2021) but there was no specific literature found about the safety of the baby. Findings of the HV antenatal study would suggest the safety aspect of the unborn baby's wellbeing is new evidence from a parental perspective. As well as parents demonstrating aspects of home safety, they discuss their parenting role and ways they plan to keep their babies safe. Further exploration of the unborn baby's safety needs from a parental perspective would help HVs provide the most appropriate advice and support.

Findings of the HV antenatal study highlight the HV role at the antenatal visit in identifying parental mental health issues as antenatal depression and anxiety are substantial risk factors for postnatal depression (Norhayati et al. 2015). Previous literature suggests a potential link between parental antenatal anxiety and implications on the emotional health and wellbeing of their children from a longitudinal study (O'Connor et al. 2002). In the HV study mental health issues were identified through conversation (NMC 2022).

Partners of expectant mothers rarely engaged with HVs in the antenatal study, a challenge also reflected by other HV studies (Vipham 2023; Monaghan and Owen 2012) and was a barrier for HVs to assess and support the needs of the whole family. However, on the rare occasions that HVs met partners, the findings provided evidence that HVs gained a clearer picture of their transition to parenthood as well as a brief insight into parental relationships. Further discussion about engaging partners is covered in section 6.9.1.

The third main category will now be discussed *managing in the HV antenatal visit*.

6.9 Managing in the Antenatal Visit

Managing in the antenatal visit was a social process that developed as a main category in how expectant parents were supported relating to their individual needs. Firstly the findings provided valuable insight in to how the antenatal visit was established to utilise the social process of promoting the HV role and that of the HV service. Findings highlighted how flexible and adaptable HVs were in preparing for and managing the visit, juggling workload pressures, poor uptake and the demands of the COVID-19 pandemic visit.

Engagement between health visitors (HV) and expectant parents can be challenging, as parents' past experiences significantly influence the interaction. The study highlighted that parents' understanding of the HV role, their previous encounters with HVs, and their preparation for the visit collectively shaped the quality of the engagement. Similarly, HVs' own past experiences influenced their practice and the way they shared information with expectant parents. These factors, along with the importance of aligning parental support with specific needs, are explored further in the following section.

6.9.1 Preparing for and conducting the antenatal visit

The HV antenatal study findings highlighted information sharing from midwives was essential for HVs to gain information to help inform their assessment of the family and to provide timely contact with expectant parents. Some HVs experienced regular contact with midwives which was positive for updating on the pregnancy and family situation, whereas others encountered issues communicating regularly with them. Evidence suggests there is a need for improvement in pregnancy notifications from midwives to HVs, emphasising the importance of enhanced collaboration between the two professions (Aquino et al. 2018; Monaghan and Owen 2012). The HV antenatal findings support the promotion of improved relationships between HVs and midwives.

Using guidance on the HV assessment (Scottish Government 2015a) enabled HVs to plan and carry out the HV antenatal visit, using it as a checklist or reminder of what to talk about. A parent commented that the checklist made the visit impersonal and procedural as echoed by the findings of the Institute of Health Visiting (2019) where 22% of parents felt the same. The findings suggest HVs consider how they promote themselves in visits and how they can provide a personalised and meaningful experience for expectant parents.

Undertaking the HV antenatal visit was positive in terms of the social process of relationship building and providing continuity of care (Olander et al. 2019), as well as shortening the time required to undertake the birth visit postnatally (Doi et al. 2021; Institute of Health Visiting 2025). However, if there were HV workload pressures, the antenatal visit was withdrawn from the HV universal pathway, as observed in other areas of Scotland and nationally (Doi et al. 2021; Institute of Health Visiting 2025). The findings of the HV antenatal study recommend prioritisation of the HV antenatal visit even when work pressures exist on HV caseloads. The benefits in relation to therapeutic relationship building and early identification of need for the HV outweighing those of not undertaking it as also highlighted by Doi et al. (2021).

Uptake of HV antenatal visits by parents was also low, a familiar picture recognised nationally, where and how parents were invited was cited as a factor impacting on the uptake (Doi et al. 2021). Olander et al. (2019) identified parents wanted the visit in the third trimester of pregnancy and flexible to parental circumstances, for example earlier if it was a twin pregnancy. Pregnant employees are entitled to take time off from their paid work to attend antenatal appointments, with their employer covering the cost at their usual rate of pay (GOV.UK n.d. a). Partners, including a spouse, civil partner, long term partner, the baby's father, or the intended parent in cases of surrogacy, are entitled to unpaid leave for up to two antenatal appointments. Each appointment may last up to six and a half hours or longer, subject to the employer's discretion. (GOV.UK n.d. b). HV flexibility in trying to fit in with stage of pregnancy and expectant mother and partner work schedules is therefore recommended, whilst acknowledging potential financial detriment to partners if they do attend. If HVs liaise closely with midwives to obtain the most up to date relevant antenatal information, it would be more likely contact could be made at a more acceptable time to the parents.

Very few HVs invited partners to the HV visit, being more orientated to the expectant mothers as evidence suggests is an issue (Bateson et al. 2017; Vipham 2023). Yet literature suggests partners want more guidance and support about preparing for parenthood and relationship changes in their partners (Baldwin et al. 2017; Deave et al. 2008, NICE 2021b). Recommendations from the HV antenatal study findings would be for HVs to look at effective ways to relationship build with partners and provide the guidance and support they are wanting. In doing so HVs should address any potential barriers to engaging with partners that the literature has previously identified, such as professional attitudes and stereotypes of partners, and a paucity of information resources tailored for them (Bateson et al. 2017, Vipham 2023).

Managing the HV antenatal visit during the COVID-19 pandemic was highlighted by HVs in the antenatal study as significant as antenatal visits were unable to be delivered in the traditional face to face home based contact so other forms of communication were utilised such as phone calls, texts or digital video technology, as noted by Burrows et al. (2022).

During the COVID-19 pandemic, HVs observed a rise in women's mental health challenges postnatally that included anxiety, stress, and depression, exacerbated by social isolation. There was a notable increase of parents on HV caseloads requiring NHS acute mental health services. The findings were similar to online UK survey during the first COVID-19 lockdown of 3097 adults across the UK (Jia et al. 2020) and Canadian findings of pregnant and postpartum parents (Harville et al. 2023, Morden et al. 2023).

HVs during COVID-19 lockdown were directed to change the antenatal contact to a phone call which hindered the relationship building in the HV antenatal study as experienced when HV antenatal visits are not carried out (Doi et al. 2021). Disjointed care perinatally was a factor for Canadian women along with anxiety about how COVID-19 would impact on their babies and their own health (Harville et al. 2023). Antenatal depression has been strongly linked to a heightened risk of emotional and behavioural issues in children (Leis et al. 2014).

The COVID-19 lockdown imposed restrictions on HVs in the antenatal study, limiting their ability to fulfil their crucial role during the perinatal period which included early detection of parental mental health issues, promoting mental wellbeing, and facilitating access to appropriate support (NMC 2022, p.17). Some parents that gave birth during lockdown felt they did not have enough information to help them with their transition to parenthood antenatally and after the birth (Best Beginnings et al. 2020). The study recommends preserving HV practices during future pandemics, ensuring they address the associated risks while continuing to support parents effectively. This includes providing essential information to aid the transition to parenthood and emphasising the identification and support of mental health challenges and issues related to social isolation.

Some HV participants mentioned in the study that when the HV antenatal visit is being conducted occasionally there can be difficulty engaging with parents, whilst some parents recounted difficult encounters with previous HVs at their antenatal visits. Both issues have been previously recognised postnatally by Donetto et al. (2013) and antenatally by Olander et al. (2019). Parents recalled uncomfortable or

unpleasant parental experiences where they felt judged or undermined, lacked trust in HV knowledge or were not listened to, and where HV advice was not attuned or personalised to their situation. These experiences jeopardised further HV service engagement (Donetto et al. 2013). The HV antenatal study findings provides new evidence on how parents with previous experiences managed the relationship with the HV and the results. There was an overall emphasis from HVs in the HV antenatal study that it was a HV responsibility to get parents to like, trust and approach them for advice and support. The new evidence supports HVs to acknowledge the parent and their situation by exploring and understanding previous parental experiences in order to engage successfully with them and gain their trust.

The HV study revealed that first time parents often lacked understanding of the HV role, while second time parents sought clarity on the transition from midwifery to health visiting services (McLeish et al. 2020).

Olander et al. (2019) and McLeish et al. (2020) similarly discovered that parents across England emphasised the importance of receiving clear information regarding the role of HVs. This need was expressed irrespective of whether they had attended an antenatal visit. Parents also highlighted the necessity for detailed and accessible information about the timing, purpose and content of postnatal care, available at any stage of pregnancy (McLeish et al. 2020).

Findings of the HV antenatal study suggest that HVs prior experiences, whether from professional practice scenarios or personal experiences of pregnancy and the postnatal period, seemed to influence their approach to practice. Examples included hypervigilance in discussing the safety of the baby with parents or HVs self-reporting their focus on the need to assess domestic violence thoroughly with families. It has been recognised how emotionally demanding the HV role can be dealing with parents whose mental health is vulnerable during pregnancy and the first year of life, alongside interventions to vulnerable families on their caseloads (Stephen and Nettleton 2022).

The impact of the HV antenatal findings recognise the need for HVs to consider their own wellbeing as part of their professional practice. Suggestions include utilising effective clinical supervision, such as restorative supervision, which helps HVs think about their own feelings and needs, promotes professional resilience and aids finding practical solutions to challenges they face in practice (Wallbank and Woods 2012; NHS Education for Scotland 2022; Stephen and Nettleton 2022).

The next section discusses HVs providing parental support relating to parental need.

6.9.2 Parental support relating to parental need

Parental support was provided, in consultation with parents, related to individual need. Areas such as breastfeeding support, promoting safe parenting practices, addressing domestic violence and managing mental health were covered. The findings from these areas are discussed relating to the literature.

The HV antenatal study offers empirical evidence of how HVs deliver antenatal care by supporting parents in understanding their responsibilities and promoting an emotional connection with their baby. This aligns with Heinonen's (2021) synthesis of studies examining how midwives, public health nurses, and nurses perceive the role of care in antenatal settings. Additionally, the HV antenatal study provides deeper insights into how care is modified to meet the specific needs of individual parents and families.

The findings highlighted key public health priority areas where HVs are mandated at a national level to offer guidance and support (Public Health Scotland 2022; Scottish Government 2015a). These priorities aim to ensure children have the best possible start in life, maintain healthy nutrition and lifestyles, and receive mental health support. Priorities involve supporting breastfeeding as the main source of infant nutrition during the first six months, fostering responsive parenting to strengthen bonding and secure attachment, and creating a safe environment to minimise risks such as sudden infant death syndrome.

Broaching domestic violence and managing parental health were two areas of focus within the HV antenatal study which are addressed after consideration of the key public health priorities that now follow.

Breastfeeding is a highly cost effective public health intervention that reduces the prevalence of various health conditions, such as digestive disorders, obesity in childhood, type 2 diabetes, and certain types of breast cancer in mothers (Victora et al.2016). Additionally, breastfeeding promotes infants' physical growth, cognitive development, and emotional bonding with their mothers (UNICEF 2018). Despite some improvement in breastfeeding rates in Scotland between 2001 and 2018, the figures remain relatively low, with significant drop off rates and disparities among women in deprived areas, contributing to health inequalities (Scottish Government 2019b). HV teams in the study area, having completed dedicated training and accreditation programmes, provide expectant parents with support and guidance on feeding and nurturing their babies. This aligns with Scotland's drive in becoming a breastfeeding supportive nation protecting, promoting, and supporting it through these specialised efforts (Scottish Government 2019; UNICEF (United Nations Children's Fund) 2018; WHO (World Health Organisation) 2017).

Expectant mothers want information on feeding at the antenatal visit (McLeish et al. 2020, Olander et al.2019). Findings from the HV antenatal study provide new insight as to how HVs address feeding with expectant parents at the HV antenatal home visit. Through partnership working they provide non-judgemental guidance and support to expectant parents tailored to their needs, signposting to midwifery, HV and community resources that parents could utilise antenatally and after the birth of the baby.

HVs promoted aspects of baby development with expectant parents in the study including communication with the unborn baby, and nurturing parental relationships that promote bonding and attachment responses in babies. Infant mental health and wellbeing is well documented in evidence about conception up to the end of the first two years of a baby's life being crucial for forming a strong foundation for cognitive, emotional, and social abilities (Center on the Developing Child 2025;

Cowley et al. 2013). Over the past decade, the mental health of children and young people in Scotland has seen a decline, making infant mental health a key national focus (Marini 2022). The HV role in facilitating health enhancing activities (Cowley and Frost 2006; Horne and Owen 2022; NMC 2022) and the promotion of communication and parental bonding helps support babies brain development. This involves reducing negative factors, such as toxic stress, and enhancing positive influences like nurturing relationships, fostering lifelong health and wellbeing (Center on the Developing Child (2025).

6.9.3 Broaching domestic violence

The HV antenatal study identified a dilemma for some HVs who hoped to meet the partner of the expectant mother but also wanted time alone with the expectant mother to be able to talk openly about their relationship with their partner to help identify risks of domestic violence or intimate partner abuse. Evidence suggests in the perinatal period there is an increase in domestic violence or intimate partner abuse rates, the risks increasing when substance misuse and mental health problems exist (Howard et al. 2013). HVs are in a unique position in visiting the home and being able to observe signs of violence or abuse in the home situation (Bacchus et al. 2003).

An evaluation of the Universal Health Visiting Pathway (Scottish Government 2015a) identified it facilitated discussion of gender based violence and early identification of strengths and concerns (Doi et al. 2021). Recent evidence from HV service users in Scotland who experienced domestic violence revealed factors such as a lack of trusting relationships between parents and HVs, and HV practices that did not address parental experiences of abuse or support needs (McFeely 2016). These issues prevented parents from disclosing abuse to HVs, as similarly recognised in previous research (Peckover 2003). Recommendations from the HV antenatal study are for HVs to consider how they engage with partners of expectant mothers so they can get a whole picture of the family situation. In addition for HVs

to reflect on how they build trusting relationships with expectant parents so those experiencing domestic violence might confide in them (section 6.7).

6.9.4 Managing parental mental health

HVs talked about mental health to normalise it so that parents felt able to recognise and discuss any issues they might have during their transition. Extensive research highlights perinatal mental health disorders, with anxiety and depression being the most prevalent, impacting both mothers and fathers during the prenatal period (Burrows et al. 2022). HVs are aware that stigma associated with talking about mental health has existed for many years (Stephen and Nettleton 2022). New evidence in the findings show ways that HVs work in partnership with parents to help them recognise their mental health needs. The normalisation of mental health conversations involves fostering therapeutic and supportive relationships, creating a foundation for open and honest discussions (Bambridge et al. 2017). This study highlights how some HVs effectively apply these skills in practice (Cowley et al. 2015).

6.10 Limitations of the Study

Participants were purposively recruited to the study but there was difficulty finding parents compared to HV participants. The resulting sample size of parents was small, with only six parents recruited that included one partner. Age differences and gender could not be explored further as anonymity of participants details needed to be prioritised, being known only by the main researcher (Scott 2005). This was due to the small number of partner participants and the potential for recognition within the research study setting. Recommendations are made in section 6.13 regarding consideration of recruiting parents in further research studies relating to the HV antenatal home visit.

A proposed sample size of 12 is considered adequate for a homogeneous group when exploring individual experiences (Guest et al 2006), and this study exceeded that with 13 HVs recruited. Despite the smaller number of parent participants compared to HVs, being six in total, the sample size aligned with the principles of the CGT methodology and adequately addressed the research question (Glaser 1978). Comprehensive and varied data were collected from the two groups of participants using multiple approaches, such as observations and interviews (Glaser and Strauss 1967). From thorough comparison and analysis a core category and main categories emerged that reflected both the richness and variability of the data, and the reaching of theoretical saturation demonstrated the concept of the HV antenatal visit had been fully and deeply explored (Glaser 1978; Glaser 1998).

Views were mostly from UK born parents in the study who conversed in English and over the age of 18 years as reflected in the geographical homogeneity of the research area (Scottish Government 2023). The study findings reflected the characteristics of the people within the study population rather than broader populations and was therefore unable to generalise to other populations (Lewis et al. 2013). Participant responses from the HV antenatal study may differ from other ethnic groups, differing ages and differing genders of parents. Recruitment to the study was related to adult expectant mothers of childbearing age whilst their partners could potentially be of a wider age range. Inclusion to a broader more heterogenous sample may lead to further development and widening of the themes identified within this study.

The substantive theory derived from the CGT approach is specifically relevant to the area of study, namely HV practice, and does not assert broader applicability to other fields (Glaser 1998). However, this is not a limitation of the study, as its primary objective was to focus exclusively on HV practice, a goal that was successfully accomplished.

During data analysis, a lack of confidence and skill in using NVIVO software meant it was not utilised to its full potential. A cumbersome remote accessing process along with internet connection challenges compounded usage, especially when

recording memos. Ultimately, the data were distributed between a research journal and NVIVO. If all the data had been stored within NVIVO, it could have streamlined processes such as comparing memos during theoretical coding, saving time that was otherwise spent on manual tasks.

A potential limitation of grounded theory is the risk of researcher bias arising from their professional experience and pre-existing knowledge of the research field. To mitigate this, their workplace and immediate team were excluded from the study. Attempts to limit researcher bias was sought through reflexivity (section 4.12.2) and theoretical sensitivity (section 4.6.3) documenting thoughts and decisions in memos and within the research journal. Glaser (1978) advocates that through theoretical sensitivity the researcher can recognise more significant data as well as understanding of their meanings. Additionally research supervisors closely monitored the process, reviewed interview transcripts, and provided guidance on data collection to further minimise bias.

Professional experience helps make researchers theoretically sensitive (Holloway and Wheeler 2010) and could also be seen as a strength in developing the grounded theory method.

6.11 Strengths of the Study

One of the study's key strengths lies in its contribution to clinical practice by generating new knowledge about the HV antenatal visit. Historically, the social dynamics during these visits were largely unexamined and not well understood. This research provided a fresh perspective on the processes involved in therapeutic relationship building, assessment, and the management of antenatal visits within the context of the HV antenatal home visit. The study highlighted that the wellbeing of the unborn baby was the central focus for participants, with both HVs and parents adapting to prioritise wellbeing. The findings offer valuable insights with significant relevance to clinical practice (Section 6.12) and suggest important avenues for future research (Section 6.13).

Adopting a CGT methodological approach provided valuable understanding and fresh insights into the social dynamics of the HV antenatal visit, as perceived by participants (Glaser 1998), which was a notable strength of the study. Existing evidence offered limited depth or meaningful perspectives on the experiences of HVs and parents during the HV antenatal home visit, owing to the scarcity of qualitative studies in this area.

By employing a qualitative methodological approach, the study enabled a thorough exploration of the diverse experiences of individual participants. When integrated with the views of others, these insights enriched the findings and introduced new evidence to the field of practice. Utilising a CGT approach allowed for the uncovering of fresh perspectives on the social processes present during the HV antenatal visit, ultimately leading to the recognition of the core category and the development of a new substantive theory.

A broad sample of participants gained from the initial and theoretical sampling was a strength of the study. It included first time parents, second time parents, expectant mothers, their partners, and HVs. The expectant mothers represented a diverse range of ages and experiences with both pregnancy and HV antenatal home visits. Similarly, the HV participants varied in their years of qualification and antenatal home visiting experience. Participants were drawn from a mix of urban and rural locations, further enhancing the study's diversity.

As an exploratory study, participants entered without any preconceived notions about the social processes of the HV antenatal home visit prior to being observed. Using the constant comparative analysis approach inherent in CGT, the iterative process of theoretical sampling allowed for deeper exploration of emerging concepts from the data. Incorporating multiple data sources, such as observations and interviews, facilitated the expression of various dimensions of participants' concerns or challenges in the research context (Gibson and Hartman, 2014). This wealth of rich data significantly contributed to the development of the substantive theory, as described by Simmons (2010).

6.12 Implications for Clinical Practice

The new contribution of this study to the field of health visiting practice during the antenatal period is examined in this section. The primary advantage for clinical practice lies in the enhanced understanding of the social processes involved in the HV antenatal home visit. The study highlights the critical role of HVs in recognising the factors that affect the health and wellbeing of the unborn baby. It also emphasises how both parents and HV use the social process of adjusting to meet these needs during the transition to parenthood. This focus reinforces the essential practice of home visiting within HV services. The study affirms the need for HVs to prioritise the antenatal home visit even when under considerable workload pressures (Morton 2024).

Therapeutic relationships are the cornerstone for assessing families and without building them HVs may have difficulty providing appropriate antenatal support for parents. It also highlights the need for HVs to consider how they portray themselves and their role and develop the social process of gaining parental trust during the relationship building process. Relationship building that includes developing approachability and trust is likened to reciprocity in the Solihull approach. Exploration of the study results with the Solihull approach and its application to the HV antenatal home visit requires further consideration. Scoping the HV workforce to identify use of the Solihull approach within the workforce would help determine if it is an area of skill development that requires further development. Promotion of the use of available online resources including the Solihull programme and HV clinical supervision could provide ways to support competence in using the approach in antenatal relationship building.

The study recognises a need for HVs to acknowledge the parent and their situation, exploring and understanding previous parental experiences of pregnancy and involvement with the HV service. Ultimately these actions will help promote parental engagement with the HV service and provide situations where parents are more likely to disclose their health and wellbeing needs.

National guidance identifies opportunities in the antenatal and preschool period for HVs to meaningfully engage with parents and care givers (Scottish Government 2015a). Referencing this study in the guidance would help highlight the importance of HV relationship building for both first time parents and parents that have engaged with HV services in the past.

The study revealed limited engagement from expectant mothers in accepting an antenatal visit by a HV and even less involvement from their partners. Providing detailed and understandable information about the HV role and that of the HV service in the antenatal period along with the postnatal care they provide in accessible formats for expectant parents and their partners at any time during pregnancy would support the process.

HVs are encouraged to offer antenatal home visit appointments to both parents that suit their availability, whilst being at an appropriate stage of pregnancy. Close liaison with midwives to gain information about the pregnancy progression would assist the process. Tailoring the antenatal visit for partners might help them engage with the HV service. Exploring partners needs in relation to transition to parenthood and what they want from the HV service may provide a starting point for the tailoring to occur.

While pandemics are uncommon, the study acknowledged the significant impact of the COVID-19 pandemic on rising maternal health challenges among parents and increased social isolation for families. HVs were unable to conduct in person antenatal visits during this time. For future practice, it may be beneficial to explore safe alternatives that enable HVs to establish therapeutic relationships with parents during the antenatal period when face to face contact is not feasible. Such approaches should also support HVs in identifying and promoting parental mental health.

The study recognised that HVs have a varied role and can experience complex situations that can impact on them emotionally and may impact on how they practice. It highlighted the need for HVs to utilise effective clinical supervision to

promote their wellbeing and find solutions to challenges in practice, referring to local supervision policies to support the supervision process.

Finally, following completion of the Doctorate study the dissemination of the study's findings aims to advance knowledge in health visitor practice and enhance outcomes for antenatal visits by providing evidence based insights about the social processes involved. Sharing the findings will foster collaboration among researchers, practitioners, and policymakers, encouraging further research and refinement of the theory developed.

Efforts to disseminate the results include sharing publication information directly with participants, providing a summary report to the local Health Board, and presenting the findings to health visiting teams within the Health Board area of the study. Dissemination will also involve utilising online platforms such as the Stirling Online Research Repository (STORRE) to ensure the thesis has greater visibility in the health visitor and other fields of practice. The study's results will be published in peer reviewed journals relevant to health visiting practice, qualitative research and grounded theory to expand the academic reach of the findings. See Appendix 19 for a drafted journal article. Awareness will also be raised via social media and other online platforms, broadening the accessibility and impact of the research.

This comprehensive approach to dissemination highlights a commitment to ensuring the study's findings contribute to the academic community, support improvements in health visitor practice, and inspire collaboration for future advancements.

6.13 Future Research

The study highlights several areas where existing evidence regarding the HV antenatal visit is lacking, suggesting potential avenues for future research. There is limited evidence about wellbeing in unborn babies from a HV perspective. Information gathered about parents' health, wellbeing and situations by the HV at the antenatal home visit might help provide evidence for the GIRFEC process of

how and what information is gathered to assess the wellbeing of the unborn baby. Further research in capturing the processes involved and the impact on wellbeing outcomes might be a future consideration.

Therapeutic relationship building in the study demonstrated some similarities with reciprocity within the Solihull approach which is known to help with relationship building between HVs and parents, although has limited evidence related to antenatal home visiting. Exploration of HV use of the Solihull approach during the antenatal home visit would provide evidence of its applicability to support the commencement of relationship building during pregnancy.

In relation to therapeutic relationship building and sharing information, the topic of HV self-disclosure to parents was highlighted as a dilemma. Further research into therapeutic intimacy needs to be considered in HV practice so that safety and appropriateness of HV self-disclosure to parents can be ensured. Exploring different cultures and their expectations of relationship building would be recommended as part of the research.

Engaging with partners of expectant mothers was highlighted as an issue. The uptake of the HV antenatal visit by expectant mothers could also be improved. Further research into what partners need from HV and how to engage more effectively with them would help support HVs in providing antenatal visits tailored to the needs of both parents. Finding out more from expectant mothers about what would help them engage with the HV antenatal visit would facilitate HVs to look at improving the uptake of the visit.

There were challenges of being unable to recruit more parents on to the HV study within the time limit and ethical approvals relating to recruitment. A longitudinal study involving first time parents and partners of expectant parents, spanning a wider age range and diverse cultural and social backgrounds, would significantly enhance the study's depth and richness.

6.14 Summary

This chapter examined the newly developed substantive theory derived from the research study, contributing fresh insights into clinical practice concerning the HV antenatal visit. The theory emerged from an exploration of HV and parent perceptions regarding the social processes involved in the antenatal visit. The chapter began by presenting the substantive theory along with the theoretical codes that influenced its development. This was followed by an analysis of the theory in the context of existing literature. The discussion further examined the study's strengths and limitations and concluded by considering its implications for clinical practice, dissemination of the study results and potential directions for future research.

6.15 Conclusion

The HV antenatal home visit is the first part of a programme of HV universal home visiting to families and children. Little was known about the HV antenatal home visit, what social processes occur during the visit, or what HVs and parents' experiences and perceptions were about the visit. The study examined the perspectives of HVs and parents on the social processes involved in the HV antenatal visit, generating new insights to guide clinical practice in conducting HV antenatal home visits.

The study explored the following research question:

What are the experiences and perceptions of expectant parents and HVs about the social process of the HV antenatal home visit?

The study explained the social processes of the HV antenatal home visit and made sense of parents and HVs perceptions about it. The findings provided a new appreciation that the wellbeing of the unborn baby was the main concern for parents and HV participants. The core category identified through the study findings was:

expectant parents and HVs adjusting to support the wellbeing needs of the unborn baby. Subsequent theoretical analysis resulted in the development of a new substantive theory: *expectant parents and HVs adjusting to support the wellbeing of the unborn baby through therapeutic and supportive relationship building, assessing of the wellbeing of the unborn baby and managing in the antenatal visit.*

The social process of *Therapeutic and supportive relationship building* saw HVs adjusting their conversation and information sharing with expectant parents to promote parental trust with them. *Therapeutic and supportive relationship building* was a gateway for *HVs to assess the wellbeing of the unborn baby* through assessing parental health, wellbeing and lifestyle and the impact they have on the unborn baby. Parents demonstrated their transition to parenthood and how they were using the social process of adjusting to meet the wellbeing needs of the unborn baby through assessment, after building a trusting relationship with the HV. HVs adjusted their assessment to expectant parent situations.

Managing in the antenatal visit was the social process of how HVs adapted to establish the antenatal visit, engaged with parents and provided support appropriate to their needs. It provided insight into how past experiences for parents and HVs impact on their roles and how HVs use the social process of supporting parents with their transition to parenthood. The theory offers a distinct and valuable contribution to HV practice within the context of antenatal visits. Its strong explanatory power enhances its credibility, positioning it as influential for driving changes in HV clinical practice.

The findings hold significance for HV clinical practice, as they provide clarity and understanding of the HV antenatal home visit for both parents and HVs who take part in it. They provide a rationale for HVs to focus on the social process of therapeutic relationship building that promotes trust and approachability. In addition to provide an antenatal visit attuned to parental need that effectively engages with expectant parents. Also, for HVs to consider with expectant parents how their past experiences of pregnancy and previous HV involvement may impact on their current antenatal experiences so they can support them appropriately. Finally, for HVs to

reflect on their own past experiences and how they may affect their own practice through effective clinical supervision.

The thesis has contributed to the advancement of antenatal visiting in health visiting practice by introducing both new knowledge and a unique theory.

Chapter 7: References

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Chapter 8: Appendices

8.1 Appendix 1

HV Participant Information Leaflet



Participant Information Leaflet

An exploration of the process of the health visitor antenatal home visit.



Invitation

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others, if you wish, before making a decision. Please do not hesitate to get in touch if anything is unclear or if you would like more information. We will take 5 to 10 minutes to go through this information leaflet with you and answer any questions you have about the study before you consent. Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

From October 2015, Health Visitors (HVs) routinely offer an antenatal visit to expectant parents at around 32 to 34 weeks of pregnancy, under the Scottish Government's enhanced health visiting programme: The Health Visitor Implementation Plan.

Before this date, most antenatal contacts by HVs were with expectant parents who had additional needs who were receiving extra support from their midwives. Currently all expectant families without additional needs, known as "core" families are offered a HV antenatal visit in addition to additional families. We are seeking HV and "core" expectant women and their partner's views and experiences of the HV antenatal visit to help understand the process and what is important for them about the visit.

This study involves an observation of the visit and an interview with expectant parents and a separate interview with the HV to find out what the HV antenatal visit involves and what is important for expectant parents and HVs. The observation is about the social process of the visit between you and the expectant parents and not your competency as a HV. The research findings will help inform future developments of HV practice in the antenatal period.

Why have I been asked to take part?

You have been asked to take part as you are a HV who carries out antenatal visits. The researcher is aiming to observe up to 15 HV antenatal visits and interview the HVs and expectant women involved in the visits and their partners if present.

You will not be able to take part in this study if you are

- A HV who does not carry out antenatal visits.
- A HV who only deals with expectant parents with additional needs (including family nurse partnership professionals).

Do I have to take part?

No. It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time and without giving a reason. You can change your mind at any time and decide not to participate. You will not be paid any expenses for your involvement in this study. HVs are being approached across Highland to take part in this research study. HV numbers required to undertake the study are small so you may show interest, be recruited but may not be required to undertake the study. If this happens you are thanked for your interest in wanting to be part of the study.

What taking part in the study involves

- If you would like to take part or are interested in hearing more about the study before you make a decision, please sign the reply slip and return to the researcher in the envelope provided, alternatively text or email the researcher.
- Researcher providing information about the study and answering any questions you may have. If you decide to take part, signing a consent form and privacy notice to take part in the study.
- Being observed during the HV antenatal visit that you arranged with expectant parents at their home during their pregnancy. The visit will be audio recorded. It would last approximately one hour.
- At a suitable time for you, within two weeks of the HV antenatal visit, agreeing to an interview to find out your experiences and thoughts about the HV antenatal visit. The interview would be either face to face at a location of your choice or via telephone. It would be audio recorded, lasting approximately 45 minutes.
- Being contacted by telephone if required following the observation or interview to clarify any information the researcher is unclear about. The conversation will be audio recorded, lasting approximately 10 minutes.

- Agreeing to any data gathered from the observations and interviews being analysed which would then result in a report being produced from the information across the observations and interviews.

Information about the observation of the HV antenatal visit, interview and follow up phone call

A researcher will explain what will happen and gain your consent in writing before observation or interview commences. You will be asked to provide some personal details such as your age, ethnicity, qualifications and experience as a health visitor. This information will be used to compare similarities and differences between research participants and will not be used to identify you.

Observation

A researcher will accompany you to undertake the HV antenatal visit in the parents' home. Audio recording equipment will be placed nearby to record the conversation. The conversation between you and the parents will last approximately one hour and will be observed. The researcher will sit as far enough away so they do not interrupt the conversation, taking notes of what they see and hear. The observation focusses on the social process that occurs between you and the expectant parents and not on your competency as a HV. The audio recording of the conversation and notes will be analysed.

As nurse registrants all HVs have a duty to prioritise the interest of people in their care and keep them safe by prioritising them, practising effectively, preserving their safety and promoting professionalism and trust (NMC professional standards of practice and behaviour for nurses, midwives and nursing associates October 2018). In the very unlikely event that practice is witnessed that contravenes the NMC code (e.g. puts patient safety at risk), the researcher as a nurse registrant has a duty to follow the NMC guidance and local working procedures and inform the HV Practice Lead about the concerns without delay (NMC Raising Concerns Dec 2018).

Interview

The interview will take place face to face with the researcher at a venue of your choice or via telephone if you wish, ideally within a few days of the observation. We are keen for you to talk openly about your experiences and thoughts about the HV antenatal home visit so the interview will be unstructured with no fixed questions, lasting approximately one hour. You will be asked to give more information about topics you discuss to understand fully what has been said.

Follow up phone call

You will only get a phone call if there are any issues that need clarifying from what was seen or heard at the observation or interview. The phone call will involve a few

more questions that will be audio recorded and should last no more than 10 minutes taking place within 2 months of the observations and interviews.

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you from being involved in the study. Some people may discuss something which they find upsetting. If you do become upset, you have the option of stopping the observation or interview at any time and/or withdrawing from the study. However, some people find it helpful to discuss their opinions and feelings. We can signpost you to local professional support if you wish. If you disclose you are in imminent danger, we have a duty to seek support to keep you safe which would mean we could not keep your personal details confidential.

What are the possible benefits of taking part?

There will be no immediate direct benefit to you should you participate. We hope that the study will provide benefits to other HVs and expectant parents from what is learnt from the study which will help inform and develop HV practice.

Will the information I provide be kept confidential?

Yes. Recordings will be securely stored on a password protected University computer. Paper records will be kept by the researcher in a locked cabinet in their workplace. Only qualified research staff will have access to your information. Your identification will be removed from any recordings or notes and any information that you do provide will be seen by the researcher only. HVs who have taken part will not be identified in any way in the reports. Even if we use quotes of things you have said, it will not be possible for others to identify who said it.

Legal basis for processing personal data

As part of the project we will be recording personal data relating to you. This will be processed in accordance with the General Data Protection Regulation (GDPR); Article 6 (1)(e). Under GDPR the legal basis for processing your personal data will be the official authority of the University.

The University of Stirling is responsible for looking after your information and using it properly. The researcher will keep any paper personal data locked in a filing cabinet in their workplace until the end of the study when it will be destroyed. Any electronic personal data will be held on the University of Stirling secure server until the end of the study and will be electronically deleted. Any other data collected from the study such as audio recordings and notes will be stored electronically for ten years after the study on the University of Stirling secure server. It will be kept for the purpose of further publications from the data. At the end of the ten years, all data will be securely destroyed.

Your rights

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and

accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum amount of personally-identifiable information possible. You can find out more about how we use your information: <https://www.stir.ac.uk/about/faculties-and-services/policy-and-planning/legal-compliance/data-protectiongdpr/gdpr-policy-and-guidance/>

The University's Data Protection Officer is Joanna Morrow, Deputy Secretary. If you have any questions relating to data protection these can be addressed to data.protection@stir.ac.uk in the first instance.

If you remain unhappy, you have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner's Office (<https://ico.org.uk/concerns/>).

Taking part in this study does not affect your normal legal rights. Whether or not you do take part, you will retain the same legal rights as any staff of the Highland Council.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. In the first instance contact: Tina Barrows, Researcher (Chief Investigator) tina.barrows@stir.ac.uk Tel: 07823 361435. If you remain unhappy and wish to complain formally, you can do this by contacting The Highland Council Complaints Department: by telephoning Customer Services on 01349 886606 or in writing to: Complaints, The Highland Council, Customer Services, PO Box 5773, Inverness, IV1 9EJ

What will happen to the results of the study?

The results will be published in journals so that others can read and learn from the results of the study. If you wish, once the study is completed, we will send you information about the findings.

Who is organising and funding the study?

The research is being carried out by Tina Barrows, Health Visitor and Practice Teacher employed by Highland Council. Tina is a researcher undertaking a clinical doctorate at The University of Stirling, with the aim of completing the study within 3 years. She is supervised by a team of two experienced Health Researchers at the Faculty of Health Sciences and Sport, University of Stirling. The Clinical doctorate programme has been half funded by the University of Stirling and half funded by NHS Highland.

Who has reviewed this study?

- The University of Stirling NHS, invasive or clinical research (NICR) Ethics Committee.
- North of Scotland NHS Research Ethics Committee.
- NHS Highland Research and Development Department.

Further Information

If you require further information or have concerns regarding the study at any stage please contact the research team based at University of Stirling, STIRLING, FK9 4LA.

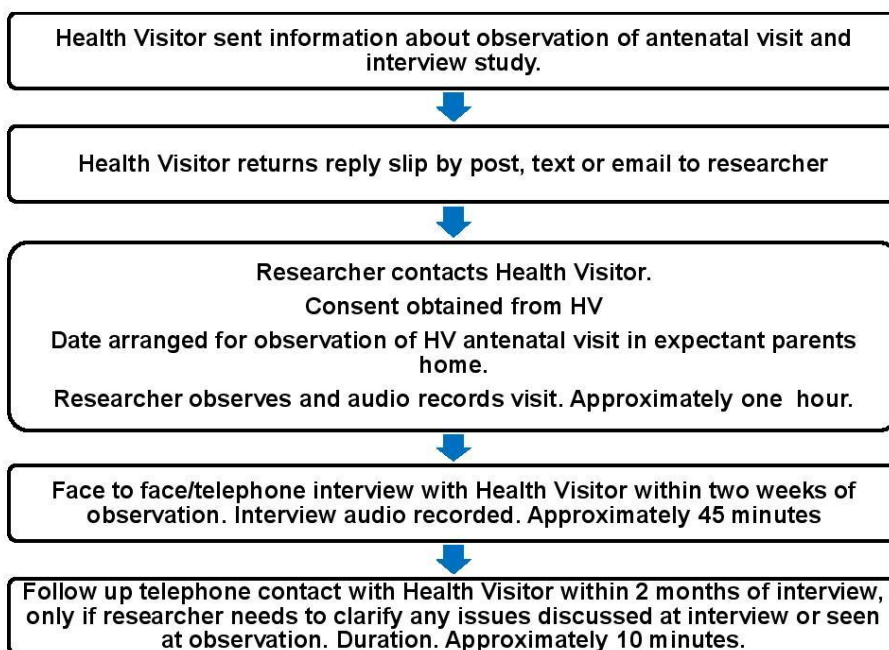
Tina Barrows, Researcher (Chief Investigator) tina.barrows@stir.ac.uk
Tel: 07823 361435.

Carol Bugge (Research Supervisor) carol.bugge@stir.ac.uk. Tel: 01786 466109.

Dawn Cameron (Research Supervisor) dawn.cameron@stir.ac.uk.
Tel: 01786466349

If you would like information about research procedures in general please contact:

Professor Jayne Donaldson, Head of School jayne.donaldson@stir.ac.uk.
Tel: 01786 466 345



Thank you for taking the time to read this and considering taking part in the study.

8.2 Appendix 2 Participant Information Leaflet Expectant Mother



Participant Information Leaflet Expectant Mother December 2018 Version 4 IRAS

242281

Participant Information Leaflet

*An exploration of the process of the
Health Visitor antenatal home visit.*

Invitation



You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others, if you wish, before making a decision. Please do not hesitate to get in touch if anything is unclear or if you would like more information. We will take 5 to 10 minutes to go through this information leaflet with you and answer any questions you have about the study before you consent. Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

From October 2015, Health Visitors (HVs) routinely offer an antenatal visit to expectant parents at around 32 to 34 weeks of pregnancy. The visit is known as the Health Visitor Universal Antenatal Home Visit (which will be referred to as the HV antenatal visit throughout this leaflet). This visit is part of Scottish Government changes to how HVs deliver their care.

Before October 2015, most antenatal contacts by HVs with expectant parents, were with parents who had additional needs who were receiving extra support from their midwives. Currently all expectant parents without additional needs, known as "core" families are routinely offered a HV antenatal visit in addition to those with additional needs. There is very little research about HV antenatal home visiting to core expectant parents, who receive routine care. We are seeking Health Visitor and core expectant parents' views and experiences of the HV antenatal visit. It will help to understand the process of, and what is important for them about the visit.

The study involves an observation of the HV antenatal visit and an interview with the expectant parents and a separate interview with the Health Visitor, to find out what the HV antenatal visit involves and what is important for expectant parents and HVs.

The research findings aim to inform future developments of HV practice in the antenatal period.

Why have I been invited to take part?

You have been asked to take part as you are an expectant parent, over the age of 18 years, receiving routine care from your midwife, and are due to see your Health Visitor for an antenatal visit. The aim is to observe up to 15 HV antenatal visits and interview the HVs and expectant women involved in the visits, and their partners if present.

Do I have to take part?

No. It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time and without giving a reason. You can change your mind at any time and decide not to participate. The standard of care you receive will not be affected in any way if you decide not to take part now or if you withdraw from the study later. You will not be paid any expenses for your involvement in this study.

What taking part in the study involves

- If you would like to take part or are interested in hearing more about the study before you make a decision, please sign the reply slip and return to the researcher in the envelope provided, alternatively text or email the researcher.
- Researcher providing information about the study and answering any questions you may have. If you decide to take part, signing a consent form and privacy notice to take part in the study.
- Being observed during the HV antenatal visit with your health visitor at your home, in the antenatal period. The visit will be audio recorded, lasting approximately 1 hour.
- Within two weeks of the HV antenatal visit, at a suitable time for you, agreeing to being interviewed to find out your experiences and thoughts about the HV antenatal visit. The interview would be either face to face at a location of your choice or via telephone. It would be audio recorded and last approximately 45 minutes.
- Being contacted by telephone if required, following the observation or interview, to clarify any information the researcher is unclear about. The conversation will be audio recorded, lasting approximately 10 minutes.
- Agreeing to any data gathered from the observations and interviews being analysed which would then result in a report being produced from the information across all the interviews and visits.

Information about the observation of the HV antenatal visit, interview and follow up phone call.

A researcher will explain what will happen and gain your consent in writing before observation or interview commences. You will be asked to provide some personal details, such as your age, employment status, ethnicity, pregnancy history, and where you live. This information will be used to compare similarities and differences between research participants and will not be used to identify you.

Observation of the HV antenatal visit

A researcher will accompany the Health Visitor to the antenatal visit in your home. Audio recording equipment will be placed nearby to record the conversation. The conversation between you and your health visitor will last approximately one hour and will be observed. The researcher will sit far enough away so they do not interrupt the conversation, taking notes of what they see and hear. The audio recording and notes of the conversation will be analysed.

Interview about the HV antenatal visit

The interview will take place face to face at a venue of your choice or via telephone if you wish, ideally within a few days of the observation. We are keen for you to talk openly about your experiences and thoughts about the HV antenatal home visit, so the interview will be unstructured with no fixed questions, lasting approximately 45 minutes. You will be asked to give more information about topics you discuss to understand fully what has been said. Any information that you give will not be shared with your HV.

Follow up phone call

You will only get a phone call if there are any issues that need clarifying from what was seen or heard at the observation or interview. The phone call involves a few more questions and will be audio recorded. It should last no more than 10 minutes taking place within two months of the observations and interviews.

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you from being involved in the study. Some people may discuss something about their pregnancy which they find upsetting. If you do become upset, you have the option of stopping the observation or interview at any time and/or withdrawing from the study. However, some people find it helpful to discuss their opinions and feelings. We can signpost you to local health professional support if you wish. If you disclose you are in imminent danger, we have a duty to seek support to keep you safe which would mean we could not keep your personal details confidential.

What are the possible benefits of taking part?

There will be no immediate direct benefit to you should you participate. We hope that the study will provide benefits to other HVs and expectant parents from what is learnt from the study which will help inform and develop the health visiting practice.

Will the information I provide be kept confidential?

Yes. Audio recordings will be securely stored on a password protected University computer. Paper records will be kept in a locked cabinet in the researcher's workplace. Only qualified research staff will have access to your information. Your personal details will be removed from any recordings or notes and any information that you do provide will be seen by the researcher only. Expectant parents who have taken part will not be identified in any way in the reports. Even if we use quotes of things you have said, it will not be possible for others to identify who said it.

Legal basis for processing personal data

As part of the project we will be recording personal data relating to you. This will be processed in accordance with the General Data Protection Regulation (GDPR); Article 6 (1)(e). Under GDPR the legal basis for processing your personal data will be the official authority of the University.

The University of Stirling is responsible for looking after your information and using it properly. The researcher will keep any paper personal data locked in a cabinet in their workplace until the end of the study when it will be destroyed. Any electronic personal data will be held on the University of Stirling secure server until the end of the study and will be electronically deleted. Any other data collected from the study such as audio recordings and notes will be stored electronically for ten years after the study on the University of Stirling secure server. It will be kept for the purpose of further publications from the data. At the end of the ten years, all data will be securely destroyed.

Your rights

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information: <https://www.stir.ac.uk/about/faculties-and-services/policy-and-planning/legal-compliance/data-protectiongdpr/gdpr-policy-and-guidance/>

The University's Data Protection Officer is Joanna Morrow, Deputy Secretary. If you have any questions relating to data protection these can be addressed to data.protection@stir.ac.uk in the first instance.

If you remain unhappy, you have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner's Office (<https://ico.org.uk/concerns/>).

Taking part in this study does not affect your normal legal rights. Whether or not you do take part, you will retain the same legal rights as any client of the Highland Council.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. In the first instance contact: Tina Barrows, Researcher (Chief Investigator) tina.barrows@stir.ac.uk Tel: 07823 361435. If you remain unhappy and wish to complain formally, you can do this by contacting The Highland Council Complaints Department: by telephoning Customer Services on 01349 886606 or in writing to: Complaints, The Highland Council, Customer Services, PO Box 5773, Inverness, IV1 9EJ

What will happen to the results of the study?

The results will be published in journals so that others can learn from the results of the study. If you wish, when the study is complete, we will send you information about the findings.

Who is organising and funding the study?

The research is being carried out by Tina Barrows, Health Visitor and Practice Teacher employed by Highland Council. Tina is a researcher undertaking a clinical doctorate at The University of Stirling with the aim of completing the study within 3 years. She is supervised by a team of two experienced Health Researchers at the Faculty of Health Sciences and Sport, University of Stirling. The Clinical doctorate programme has been half funded by the University of Stirling and half funded by NHS Highland.

Who has reviewed this study?

- The University of Stirling NHS, invasive or clinical research (NICR) Ethics Committee.
- North of Scotland NHS Research Ethics Committee.
- NHS Highland Research and Development Department.

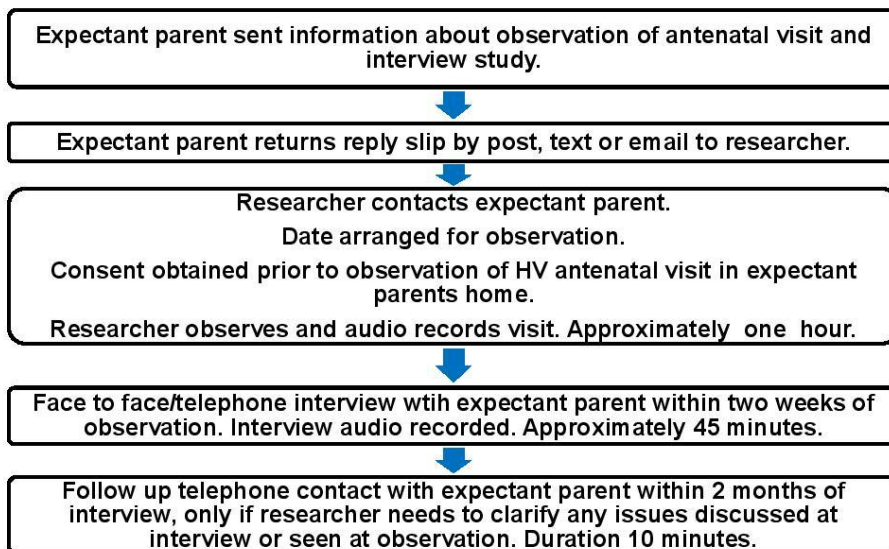
Further Information

If you require further information or have concerns regarding the study at any stage please contact the research team based at The University of Stirling, STIRLING, FK9 4LA.

Tina Barrows, Researcher (Chief Investigator) tina.barrows@stir.ac.uk
Tel 07823 361 435

Dr Carol Bugge (Research Supervisor) carol.bugge@stir.ac.uk. Tel: 01786 466109.
Dr Dawn Cameron (Research Supervisor) dawn.cameron@stir.ac.uk. Tel: 01786466349

If you would like information about research procedures in general, please contact:
Professor Jayne Donaldson, Dean of Faculty jayne.donaldson@stir.ac.uk.
Tel: 01786 466 345



Thank you for taking the time to read this and considering taking part in this study.

8.3 Appendix 3 Participant Information Leaflet Partner of Expectant Mother



Participant Information Leaflet Expectant Parent December 2018 Version 4 IRAS 242281

Participant Information Leaflet

*An exploration of the process of the
Health Visitor antenatal home visit.*

Invitation



You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve.

Please take time to read the following information carefully and discuss it with others, if you wish, before making a decision. Please do not hesitate to get in touch if anything is unclear or if you would like more information. We will take 5 to 10 minutes to go through this information leaflet with you and answer any questions you have about the study before you consent. Take the time you need to decide whether or not you wish to take part.

What is the purpose of the study?

From October 2015, Health Visitors (HVs) routinely offer an antenatal visit to expectant parents at around 32 to 34 weeks of pregnancy. The visit is known as the Health Visitor Universal Antenatal Home Visit (which will be referred to as the HV antenatal visit throughout this leaflet). This visit is part of Scottish Government changes to how HVs deliver their care.

Before October 2015, most antenatal contacts by HVs with expectant parents, were with parents who had additional needs who were receiving extra support from their midwives. Currently all expectant parents without additional needs, known as “core” families are routinely offered a HV antenatal visit in addition to those with additional needs. There is very little research about HV antenatal home visiting to core expectant parents, who receive routine care. We are seeking Health Visitor and core expectant parents’ views and experiences of the HV antenatal visit. It will help to understand the process of, and what is important for them about the visit.

The study involves an observation of the HV antenatal visit and an interview with the expectant parents and a separate interview with the Health Visitor, to find out what the HV antenatal visit involves and what is important for expectant parents and HVs.

The research findings aim to inform future developments of HV practice in the antenatal period.

Why have I been invited to take part?

You have been asked to take part as you are an expectant parent, over the age of 18 years, receiving routine care from your midwife, and are due to see your Health Visitor for an antenatal visit. The aim is to observe up to 15 HV antenatal visits and interview the HVs and expectant women involved in the visits, and their partners if present.

Do I have to take part?

No. It is up to you to decide whether to take part. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a consent form. You are free to withdraw at any time and without giving a reason. You can change your mind at any time and decide not to participate. The standard of care you receive will not be affected in any way if you decide not to take part now or if you withdraw from the study later. You will not be paid any expenses for your involvement in this study.

What taking part in the study involves

- If you would like to take part or are interested in hearing more about the study before you make a decision, please sign the reply slip and return to the researcher in the envelope provided, alternatively text or email the researcher.
- Researcher providing information about the study and answering any questions you may have. If you decide to take part, signing a consent form and privacy notice to take part in the study.
- Being observed during the HV antenatal visit with your health visitor at your home, in the antenatal period. The visit will be audio recorded, lasting approximately 1 hour.
- Within two weeks of the HV antenatal visit, at a suitable time for you, agreeing to being interviewed to find out your experiences and thoughts about the HV antenatal visit. The interview would be either face to face at a location of your choice or via telephone. It would be audio recorded and last approximately 45 minutes.
- Being contacted by telephone if required, following the observation or interview, to clarify any information the researcher is unclear about. The conversation will be audio recorded, lasting approximately 10 minutes.
- Agreeing to any data gathered from the observations and interviews being analysed which would then result in a report being produced from the information across all the interviews and visits.

Information about the observation of the HV antenatal visit, interview and follow up phone call.

A researcher will explain what will happen and gain your consent in writing before observation or interview commences. You will be asked to provide some personal details, such as your age, employment status, ethnicity, pregnancy history, and where you live. This information will be used to compare similarities and differences between research participants and will not be used to identify you.

Observation of the HV antenatal visit

A researcher will accompany the Health Visitor to the antenatal visit in your home. Audio recording equipment will be placed nearby to record the conversation. The conversation between you and your health visitor will last approximately one hour and will be observed. The researcher will sit far enough away so they do not interrupt the conversation, taking notes of what they see and hear. The audio recording and notes of the conversation will be analysed.

Interview about the HV antenatal visit

The interview will take place face to face at a venue of your choice or via telephone if you wish, ideally within a few days of the observation. We are keen for you to talk openly about your experiences and thoughts about the HV antenatal home visit, so the interview will be unstructured with no fixed questions, lasting approximately 45 minutes. You will be asked to give more information about topics you discuss to understand fully what has been said. Any information that you give will not be shared with your HV.

Follow up phone call

You will only get a phone call if there are any issues that need clarifying from what was seen or heard at the observation or interview. The phone call involves a few more questions and will be audio recorded. It should last no more than 10 minutes taking place within two months of the observations and interviews.

What are the possible disadvantages or risks of taking part?

We do not anticipate any risks to you from being involved in the study. Some people may discuss something about their pregnancy which they find upsetting. If you do become upset, you have the option of stopping the observation or interview at any time and/or withdrawing from the study. However, some people find it helpful to discuss their opinions and feelings. We can signpost you to local health professional support if you wish. If you disclose you are in imminent danger, we have a duty to seek support to keep you safe which would mean we could not keep your personal details confidential.

What are the possible benefits of taking part?

There will be no immediate direct benefit to you should you participate. We hope that the study will provide benefits to other HVs and expectant parents from what is learnt from the study which will help inform and develop the health visiting practice.

Will the information I provide be kept confidential?

Yes. Audio recordings will be securely stored on a password protected University computer. Paper records will be kept in a locked cabinet in the researcher's workplace. Only qualified research staff will have access to your information. Your personal details will be removed from any recordings or notes and any information that you do provide will be seen by the researcher only. Expectant parents who have taken part will not be identified in any way in the reports. Even if we use quotes of things you have said, it will not be possible for others to identify who said it.

Legal basis for processing personal data

As part of the project we will be recording personal data relating to you. This will be processed in accordance with the General Data Protection Regulation (GDPR); Article 6 (1)(e). Under GDPR the legal basis for processing your personal data will be the official authority of the University.

The University of Stirling is responsible for looking after your information and using it properly. The researcher will keep any paper personal data locked in a cabinet in their workplace until the end of the study when it will be destroyed. Any electronic personal data will be held on the University of Stirling secure server until the end of the study and will be electronically deleted. Any other data collected from the study such as audio recordings and notes will be stored electronically for ten years after the study on the University of Stirling secure server. It will be kept for the purpose of further publications from the data. At the end of the ten years, all data will be securely destroyed.

Your rights

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how we use your information: <https://www.stir.ac.uk/about/faculties-and-services/policy-and-planning/legal-compliance/data-protection/gdpr/gdpr-policy-and-guidance/>

The University's Data Protection Officer is Joanna Morrow, Deputy Secretary. If you have any questions relating to data protection these can be addressed to data.protection@stir.ac.uk in the first instance.

If you remain unhappy, you have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner's Office (<https://ico.org.uk/concerns/>).

Taking part in this study does not affect your normal legal rights. Whether or not you do take part, you will retain the same legal rights as any client of the Highland Council.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researcher who will do their best to answer your questions. In the first instance contact: Tina Barrows, Researcher (Chief Investigator) tina.barrows@stir.ac.uk Tel: 07823 361435. If you remain unhappy and wish to complain formally, you can do this by contacting The Highland Council Complaints Department: by telephoning Customer Services on 01349 886606 or in writing to: Complaints, The Highland Council, Customer Services, PO Box 5773, Inverness, IV1 9EJ

What will happen to the results of the study?

The results will be published in journals so that others can learn from the results of the study. If you wish, when the study is complete, we will send you information about the findings.

Who is organising and funding the study?

The research is being carried out by Tina Barrows, Health Visitor and Practice Teacher employed by Highland Council. Tina is a researcher undertaking a clinical doctorate at The University of Stirling with the aim of completing the study within 3 years. She is supervised by a team of two experienced Health Researchers at the Faculty of Health Sciences and Sport, University of Stirling. The Clinical doctorate programme has been half funded by the University of Stirling and half funded by NHS Highland.

Who has reviewed this study?

- The University of Stirling NHS, invasive or clinical research (NICR) Ethics Committee.
- North of Scotland NHS Research Ethics Committee.
- NHS Highland Research and Development Department.

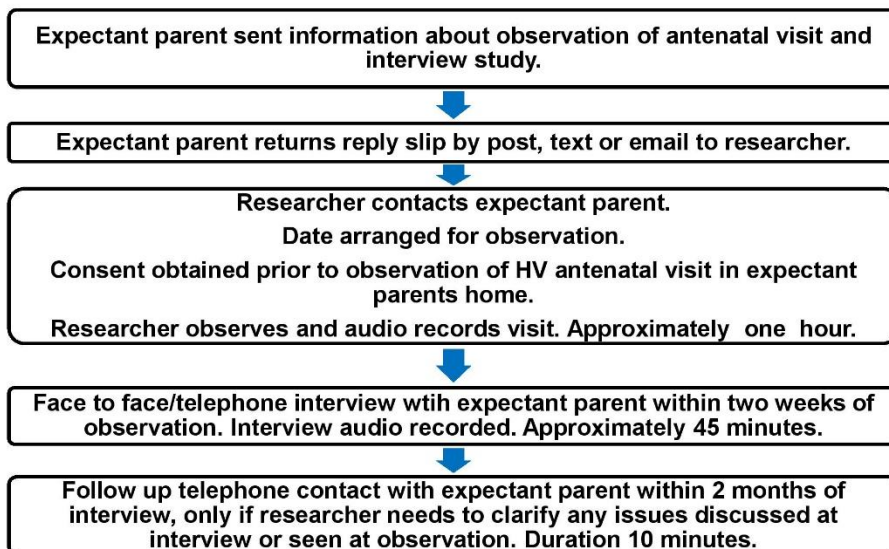
Further Information

If you require further information or have concerns regarding the study at any stage please contact the research team based at The University of Stirling, STIRLING, FK9 4LA.

Tina Barrows, Researcher (Chief Investigator) tina.barrows@stir.ac.uk
Tel 07823 361 435

Dr Carol Bugge (Research Supervisor) carol.bugge@stir.ac.uk. Tel: 01786 466109.
Dr Dawn Cameron (Research Supervisor) dawn.cameron@stir.ac.uk. Tel: 01786466349

If you would like information about research procedures in general, please contact:
Professor Jayne Donaldson, Dean of Faculty jayne.donaldson@stir.ac.uk.
Tel: 01786 466 345



Thank you for taking the time to read this and considering taking part in this study.

8.4 Appendix 4 Privacy Notice



Privacy Notice for An Exploration of the Process of the Health Visitor Antenatal Home Visit Clinical Doctorate Research Study.

Purpose

Your personal information is being gathered for the purpose of the research study: An Exploration of the Process of the Health Visitor antenatal home visit. The research study involves you being observed during the Health Visitor (HV) antenatal visit with your health visitor at your home. Within two weeks of the HV antenatal visit you will be interviewed to find out your experiences and thoughts about the HV antenatal visit. The interview would be either face to face at a location of your choice or via telephone. Both observation and interview will be audio recorded and notes taken about it. The information collected from the audio recordings and notes will be used to analyse the data. The ideas, thoughts and interactions will be compared to find similarities. The similarities will be compared through a process known as coding, that develops one main group called a core category, linking the ideas together. The core category is then further explored and analysed in order to develop new learning about the HV antenatal visit. A written report about the research process and the new learning will be produced at the end of the study.

You will be asked to provide some personal details such as your age, employment status, ethnicity, pregnancy history, and where you live. Although using the information will not benefit you personally it will help the research team to compare similarities and differences between research participants which they may use in the written report of the study. None of the personal information you provide will be used in any way to identify you.

Data will be obtained and recorded of what you said and did at the antenatal visits and interview. Quotes from what research participants said may be used in report of the study to help explain some ideas that emerge from the study. If quotes that you have said are used in the study, it will not be possible for others to identify who said it. The information will not be used for marketing purposes.

Legal Basis

As part of the project we will be recording personal data relating to you. This will be processed in accordance with the General Data Protection Regulation (GDPR); Article 6 (1)(e). Under GDPR the legal basis for processing your personal data will be the official authority of the University.

The University of Stirling is responsible for looking after your information and using it properly. The University of Stirling will keep identifiable information until the end of the study. After that time, all information will be securely destroyed.

Third Parties

The information you provide will not be shared with any individuals or organisations outside of the University of Stirling research team.

**Privacy Notice for An Exploration of the Process of the Health Visitor
Antenatal Home Visit Clinical Doctorate Research Study.**

Security

Audio recordings and electronic records will be securely stored on a password protected University of Stirling computer server, accessible only by the research team. Paper records such as research notes will be kept in a locked filing cabinet in the researcher's workplace. Only qualified research staff will have access to your information. Your information will be anonymised. Audio recordings and notes will be allocated a number that only the research team has access to and can link to your personal data. Once the study is complete, paper records will be stored in a locked filing cabinet in the University of Stirling for 5 years so that the research team can produce further research articles from the data. At the end of 5 years all paper data will be destroyed by cross shredding and electronic data will be digitally erased from the University of Stirling secure computer server. None of the data stored for 5 years will include personal data.

Retention

Your personal data will be destroyed the end of the study.

Your rights

You have the right to request to see a copy of the information we hold about you and to request corrections or deletions of the information that is no longer required.

If you provide consent for us to use your personal data in the ways outlined above, you have the right to subsequently withdraw your consent.

In some circumstances you may have the right to object to the processing of your personal data, to request it is erased where it is no longer required for the stated purposes, or that inaccurate information about you is corrected. For more information about your rights see the University of Stirling Data Protection Policy at <https://www.stir.ac.uk/media/stirling/services/policy-and-planning/gdpr/documents/gdpr-policy.pdf>

To exercise these rights please use the contact details below

Contact details

If you have any questions relating to this form or the way we are planning to use your information please contact: Tina Barrows, Researcher (Chief Investigator), Faculty of Health Sciences and Sport, University of Stirling, Stirling, FK9 4LA. tina.barrows@stir.ac.uk Tel 07823 361 435

You have the right to lodge a complaint against the University regarding data protection issues with the Information Commissioner's Office (<https://ico.org.uk/concerns/>).

**Privacy Notice for An Exploration of the Process of the Health Visitor
Antenatal Home Visit Clinical Doctorate Research Study.**

The University's Data Protection officer is Joanna Morrow, Deputy Secretary. If you have any questions relating to data protection these can be addressed to: data.protection@stir.ac.uk in the first instance.

☐ I consent to the University processing my personal data for the purposes detailed above.

I have read and understand how my personal data will be used.

Signed:

Date:

Time:

Location:

8.5 Appendix 5 University of Stirling Sponsorship Letter



Joy Taylor
Research Development Officer

Research and Innovation Services
University of Stirling
Stirling FK9 4LA
Scotland UK

T : +44 (0) 1786 466443
E : joy.taylor@stir.ac.uk
W : <http://www.stir.ac.uk/>

09 August 2018

To Whom It May Concern

Research Study: An exploratory study of the process of the Health Visitor antenatal visit from the experiences and perspectives of expectant parents and Health Visitors

I am pleased to confirm that the University of Stirling will undertake the role of sponsor as outlined in the Research Governance Framework for Health and Community Care for the project entitled: "An exploratory study of the process of the Health Visitor antenatal visit from the experiences and perspectives of expectant parents and Health Visitors". Chief Investigator: Tina Barrows, Faculty of Health Sciences and Sport, University of Stirling.

Yours sincerely

A handwritten signature in blue ink that reads "J. Taylor".

Joy Taylor
Research Development Officer

8.6 Appendix 6 Ethical Approval North of Scotland Research Ethics Service

North of Scotland Research Ethics Service
Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558458
Facsimile: 01224 558609
Email: nosres@nhs.net



17 January 2019

Ms Tina Barrows
Health Visitor PT, Early Years Team, Care and Learning Services
Fingal Centre
Viewfield Road
PORTREE
Isle of Skye
IV51 9ES

Dear Ms Barrows

Study title:	An exploration of the process of the Health Visitor antenatal home visit from the perspectives and experiences of expectant parents and Health Visitors.
REC reference:	18/NS/0144
IRAS project ID:	242281

Thank you for your letter of 10 January 2019, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The REC favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements. Each NHS organisation must confirm through the signing of agreements and/or other documents that it has given permission for the research to proceed (except where explicitly specified otherwise). Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of management permissions from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publicly accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

<i>Document</i>	<i>Version</i>	<i>Date</i>
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		9 August 2018
Interview schedules or topic guides for participants: Appendix 11 - Topic Guide for Interviews	1	October 2018
IRAS Application Form: IRAS Form 04122018	242281/127 6351/37/99 6	28 November 2018
IRAS Checklist XML: Checklist 15012019		15 January 2019
Letter from Sponsor		9 August 2018
Letters of invitation to participant: Appendix 1 - Health Visitor	1	June 2018
Appendix 5 - Privacy Notice - Health Visitor	1	September 2018
Appendix 7 - Reply Slip - Health Visitor	1	June 2018
Appendix 8 - Reply Slip - Expectant Parents	1	June 2018
Appendix 2 - Invitation Letter - Expectant Parents	1	June 2018
Appendix 6 - Privacy Notice - Expectant Patients	1	September 2018
Dawn Cameron CV		November 2018
Appendix 10 - Expectant Mother	2	December 2018
Appendix 3 - Participant Information Sheet - Health Visitor	4	December 2018
Appendix 12 - Consent Form for Partner of Expectant Mother	1	December 2018
Ethics Response Letter		10 January 2019
Participant Consent Form: Appendix 9 - Health Visitor	1	June 2018
Participant Information Sheet (PIS): Appendix 4 - Expectant Parent	4	December 2018
Research protocol or project proposal: Research Proposal	1	26 November 2018
Summary CV for Chief Investigator (CI): Tina Barrows		26 November 2018
Summary CV for student: CV Chief Investigator		26 November 2018
Summary CV for Supervisor (student research): Carol Bugge		26 July 2018

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: <http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/>

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at <http://www.hra.nhs.uk/hra-training/>

18/NS/0144	Please quote this number on all correspondence
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With the Committee's best wishes for the success of this project.

Yours sincerely



Professor Helen Galley
Chair

Enclosures: "After ethical review – guidance for researchers" SL-AR2

Copy to: Cori Critchlow-Watton
Frances Hines, NHS Highland

8.7 Appendix 7 Local NHS Board RD&I Division Ethical Approval

Professor Angus Watson
Research, Development & Innovation Director
Research, Development & Innovation Division
NHS Highland
Centre for Health Science
Old Perth Road
Inverness
IV2 3JH

Tel: 01483 255822
Fax: 01483 255838
E-mail: angus.watson@nhs.net



1st February 2019

NHS Highland R&D ID: **1468**
NRSPCC ID: **NA**

Tina Barrows
Health Visitor
Fingal Centre
Viewfield Road
Portree
IV51 9ES

Dear Tina Barrows,

Management Approval for Non-Commercial Research

I am pleased to tell you that you now have Management Approval for the research project entitled: 'An exploration of the Health Visitor antenatal visit. (Protocol Version 1 November 2018)'. I acknowledge that:

- The project is sponsored by NHS Highland.
- The project has no external funding .
- Research Ethics approval has been awarded from North of Scotland REC (ref 18/NS/0144)
- The project is Site-Specific Assessment exempt.

The following conditions apply:

- The responsibility for monitoring and auditing this project lies with NHS Highland.
- This study will be subject to ongoing monitoring for Research Governance purposes and may be audited to ensure compliance with the UK Policy Framework for Health and Social Care Research (2018, V3.3 07/11/17), however prior written notice of audit will be given.



Headquarters:
NHS Highland, Assynt House, Beechwood Park, Inverness, IV2 3HG

Chairman: David Alston
Chief Executive: Elaine Mead

- Any researchers coming into NHS Highland for the purposes of carrying out research with patients will require a Letter of Access before starting the study at this site. Please contact Anna McIver (anna.mciver@nhs.net) for further assistance, if this is required.
- You are reminded that all amendments (minor or substantial) to the protocol and associated study documents or to the REC application should be copied to the NHS Highland Research and Development Office to obtain a R&D amendment approval letter. Guidance can be found at <https://www.nhsresearchscotland.org.uk/services/permissions-co-ordinating-centre/permissions>
- The paperwork concerning all incidents, adverse events and serious adverse events, thought to be attributable to participant's involvement in this project should be copied to the NHS Highland R&D Office. Please email documents to Anna McIver, RD&I Facilitator (anna.mciver@nhs.net).
- If applicable, monthly recruitment rates should be notified to the NHS Highland Research and Development Office, detailing date of recruitment and the participant trial ID number. This should be done by e-mail on the first week of the following month, to Debbie McDonald, RD&I Data Manager (debbie.mcdonald@nhs.net).
- Please report any other changes in resources used, or staff involved in the project, to the NHS Highland Research and Development Manager, Frances Hines (01463 255822, frances.hines@nhs.net).

Please quote your RD&I Highland reference number (Highland 1459).

Yours sincerely,

Frances Hines

Frances Hines
RD&I Manager

cc Frances Hines, R&D Manager, NHS Highland Research, Development & Innovation Division, Phase 3, The Centre for Health Science, Old Perth Road, Inverness, IV2 3JH

8.8 Appendix 8 Standard Operating Procedure Midwife Recruitment of Expectant parents



An Exploration of the Process of the Health Visitor Antenatal Home Visit research study by Tina Barrows Health Visitor and Researcher- tina.barrows@stir.ac.uk or telephone 07823 361435

Standard Operating Procedure for Midwives to Recruit Expectant Parents at the 28-week Midwifery Contact for an Observation and Interview Study of the Health Visitor Antenatal Contact around 32 to 34 weeks of pregnancy.

This procedure takes you through the process of recruiting to this study.

1. Identify any expectant mother at the 28-week midwifery contact who meet the following

inclusion criteria:

- Over the age of 18 years
- Lives in Highland area
- On the green midwifery pathway or receiving core midwifery care

and has none of the following **exclusion criteria:**

- Under the age of 18 years
- Has an antenatal plan which means they have additional needs
- Unable to read or speak English or are visually or hearing impaired, or if you have any mental health or any other conditions that impact on your ability to understand and consent to this study.

If the expectant mother meets the inclusion criteria and has none of the exclusion criteria please inform them that there is an observation and interview study being carried out about the Health Visitor antenatal visit at around 32 to 34 weeks of pregnancy and they have been invited to take part.

2. Give the expectant mother a white envelope that contains 2 recruitment packs, one pack is for her (brown envelope) and one for her partner (white envelope). Please let the expectant mother know that if she and her partner wish to take part there is a reply slip in both their information packs for them to contact the researcher. Inform the mother that she can take part if her partner does not wish to.
3. Highlight that if she or her partner are NOT interested in participating in the interview study (before or after reading the information) they do not have to do anything and can dispose of the recruitment pack at any given time and that their care will not be affected.
4. Reiterate that she and her partner can change their mind and not participate in the observation or interview study at any given time without their care being affected.
5. No further action is required from midwifery staff after this point as Tina Barrows Chief Investigator Stirling University will handle everything else.

Thank you for your willingness to support this study.

Any questions, please contact Tina Barrows Health Visitor/ Chief Investigator on tina.barrows@stir.ac.uk or telephone 07823 361435

MW V1 02.03.19

8.9 Appendix 9 Standard Operating Procedure HV Recruitment of Expectant Parents



An Exploration of the Process of the Health Visitor Antenatal Home Visit research study by Tina Barrows Health Visitor and Researcher- tina.barrows@stir.ac.uk or telephone 07823 361435

Standard Operating Procedure for Health Visitors to Recruit Expectant Parents for an Observation and Interview Study of the Health Visitor Antenatal Contact around 32 to 34 weeks of pregnancy, at the point of contacting them to make an appointment for the visit.

This procedure takes you through the process of recruiting to this study.

1. Identify any expectant mother on the HV antenatal caseload that you plan to undertake a HV antenatal home visit with who meet the following **inclusion criteria**:

- Over the age of 18 years
- Lives in Highland area

and has none of the following **exclusion criteria**:

- Under the age of 18 years
- Has an antenatal plan which means they have additional needs
- Unable to read or speak English or are visually or hearing impaired, or if you they have any mental health or any other conditions that impact on their ability to understand and consent to this study.

1a. When you contact the expectant mother BY PHONE to make arrangements for the HV antenatal home visit If they meet the inclusion criteria and have none of the exclusion criteria inform them:

"An observation and interview study is being undertaken in NHS Highland about the HV antenatal visit that I am offering you today. You do not need to take part in the research. Would it be OK if I sent you an information pack about the study? If you and your partner are interested you respond to the researcher directly and not to me. You can take part in the study if your partner does not want to. It is up to you to decide if you want to take part, I will visit you whether you take part or not. "

1b. If the contact for the HV antenatal home visit is made BY LETTER follow instruction 2:

2. Post out a stamped information pack to the mother after completing the address label. It is a white envelope that contains 2 recruitment packs with an invitation letter in each pack. One pack is for her (brown envelope) and one for her partner (white envelope). A reply slip is in both their information packs for them to contact the researcher.

3. Once recruits make contact with the researcher, the researcher will contact you to arrange to accompany you to the HV antenatal home visit appointment with the expectant parents.

Thank you for your willingness to support this study.

Any questions, please contact Tina Barrows Health Visitor/ Chief Investigator on tina.barrows@stir.ac.uk or telephone 07823 361435

HV Version Nov 25 2019

8.10 Appendix 10 Invitation Letter Health Visitor



Study: An Exploration of the Process of the
Health Visitor Antenatal Home Visit

Tina Barrows (Chief Investigator)
Clinical Doctorate Student
School of Health Sciences
University of Stirling
STIRLING
FK9 4LA
07823 361435
tina.barrows@stir.ac.uk

Date:

Dear Possible Participant,

Information about a study you may be interested in being involved with

I have asked your line manager to send you this letter and an information sheet about a study which you may like to take part in.

You have been sent this letter because you are a Health Visitor that undertakes antenatal visits to expectant women and their partners during their pregnancy. This study aims to observe the antenatal visit taking place between Health Visitors and expectant parents and talk with Health Visitors about their experiences and views about it. If you are interested in hearing more about the study, please read the enclosed Participant Information Leaflet for more details.

Taking part in the study would involve being observed during an antenatal visit between you and expectant parents on one occasion and talking with me, the researcher (Tina) on one occasion. There are no right or wrong answers to the questions that are asked, we are simply interested in your thoughts and views.

If you decide you do not wish to take part, you do not need to take any further action. This will not affect you in any way. If, after reading the Information Leaflet, you would like to hear more about the study, please return the reply slip in the stamped addressed envelope or contact me, the researcher (Tina) by text or email. Once your reply slip has been received, or you have made contact, I will call you to discuss the study further.

In the meantime, if you require any further help or information about the study, do please contact me, Tina on 07823 361435 or tina.barrows@stir.ac.uk.

Yours sincerely

A handwritten signature in blue ink, appearing to read "Tina Barrows".

Tina Barrows
Study Chief Investigator
University of Stirling

IRAS ID 242281 HV invitation letter V1 June 2018

8.11 Appendix 11 Invitation Letter Expectant Parent



Study: An Exploration of the Process of the
Health Visitor Antenatal Home Visit

Tina Barrows (Chief Investigator)
Clinical Doctorate Student
School of Health Sciences
University of Stirling
STIRLING
FK9 4LA
Tel no: 07823 361435
tina.barrows@stir.ac.uk

Date:

Dear Possible Participant

Information leaflet about a study you may be interested in being involved with

I have asked your Health Visitor to send you this letter and an information leaflet about a study which you may like to take part in.

You have been sent this letter because you are parents expecting a baby and are due to have an antenatal visit with your Health Visitor. This study aims to observe the antenatal visit taking place between expectant parents and their Health Visitor and talk with expectant women and their partners about their experiences and views about it. If you are interested in hearing more about the study, please read the enclosed Participant Information Leaflet for more details.

Taking part in the study would involve being observed during an antenatal visit between you and your Health Visitor on one occasion and talking with me, the researcher (Tina) on one occasion. There are no right or wrong answers to the questions that I will ask, I am simply interested in your thoughts and views.

If you decide you do not wish to take part, you do not need to take any further action. This will not affect your future care. If, after reading the Participant Information Leaflet, you would like to hear more about the study, please return the reply slip in the stamped addressed envelope or contact me by text or email. Once your reply slip has been received, or you have made contact, I will call you to discuss the study further. In the meantime, if you require any further help or information about the study, do please contact me, Tina on 07823 361435 or tina.barrows@stir.ac.uk.

Yours sincerely

A handwritten signature in blue ink, appearing to read "Tina Barrows".

Tina Barrows Study Chief Investigator University of Stirling
IRAS 242281 EP Version 1 June 2018

8.12 Appendix 12 Substantive Amendment Ethical Approval

North of Scotland Research Ethics Service

Summerfield House
2 Eday Road
Aberdeen
AB15 6RE

Telephone: 01224 558458
Facsimile: 01224 558609
Email: nosres@nhs.net



9 January 2020

Ms Tina Barrows
Health Visitor PT, Early Years Team, Care and Learning Services
Fingal Centre
Viewfield Road
PORTREE
Isle of Skye
IV51 9ES

Dear Ms Barrows

Study title: An exploration of the process of the Health Visitor antenatal home visit from the perspectives and experiences of expectant parents and Health Visitors.
REC reference: 18/NS/0144
Amendment number: Research Proposal v2
Amendment date: 16 December 2019
IRAS project ID: 242281

The above amendment was reviewed by the Sub-Committee in correspondence.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Notice of Substantial Amendment (non-CTIMP)	Research Proposal v2	December 2019
IRAS Form	242281/1393404/37/372	28 November 2018
SOP - Health Visitor	1	25 November 2019
SOP - Midwives	1	2 March 2019
Research protocol or project proposal	2	11 December 2019

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

Working with NHS Care Organisations

Sponsors should ensure that they notify the R&D office for the relevant NHS care organisation of this amendment in line with the terms detailed in the categorisation email issued by the lead nation for the study.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities – see details at: <https://www.hra.nhs.uk/planning-and-improving-research/learning/>

18/NS/0144:	Please quote this number on all correspondence
--------------------	---

Yours sincerely



Mr Craig Cunningham
Vice-Chair

Enclosures: List of names and professions of members who took part in the review

North of Scotland Research Ethics Committee 2

Attendance at Sub-Committee of the REC meeting on 17 January 2020

Committee Members:

Name	Profession	Present	Notes
Mr Craig Cunningham	Inspection Coordinator	Yes	
Dr Detlev Rogahn	Consultant Paediatrician	Yes	

Also In attendance:

Name	Position (or reason for attending)
Mrs Carol Irvine	Senior Ethics Co-ordinator

8.13 Appendix 13 Consent Form Expectant Mother

Expectant Participant Consent Form Version 2 December 2018 IRAS 242281



Expectant Mother Participant Consent Form

IRAS Study Number 242281

Participant Identification number:

Research Project Title: *An Exploration of the process of the Health Visitor Antenatal Visit.*

Name of Researcher: *Ms Tina Barrows*

1.	I confirm that I have read the information sheet dated..... (version.....) for the above study. a. I have had the opportunity to consider the information and ask questions b. I have had any questions answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time during the study without giving a reason, and without any penalty. If I withdraw from the study, the research team will keep the information about me that has been obtained.	
3.	I have read and understood that relevant personal details as stated on the Participant Information Sheet and Privacy notice will be held securely by Ms Tina Barrows (Chief Investigator). They will be held on a University of Stirling secure electronic database during the study, if electronic. Any paper copies of personal data such as consent forms will be kept in a locked cabinet at the researcher's workplace. I understand that these details will be destroyed at the end of the study.	
4.	I understand that my responses will be kept anonymous and I give permission for members of the research team to have access to my anonymised responses.	
5.	I consent to being audio recorded and for the researcher to take notes during observation and interviews.	
6.	I understand that audio recordings and notes will be used for the purposes of this research study in analysis and reports and publications. I am aware that I will not be named in any research and any data will be fully anonymised.	
7.	I have read, understand, and have signed the Privacy notice in relation to obtaining, managing, storing and disposing of my personal data.	
8.	I agree to take part in this study	

Name of Participant

Signature:

Date: [Click here to enter a date](#)

Time:

Location:

Name of Researcher

Signature:

Date: [Click here to enter a date](#)

Time:

Location:

8.14 Appendix 14 Consent Form Partner of Expectant Mother

Participant Consent Form for Partner of Expectant Parent Version 1 December 2 v 2018 IRAS 242281



Participant Consent Form for Partner of Expectant Mother

IRAS Study Number 242281

Participant Identification number:

Research Project Title: *An Exploration of the process of the Health Visitor Antenatal Visit.*

Name of Researcher: *Ms Tina Barrows*

1.	I confirm that I have read the information sheet dated..... (version.....) for the above study. a. I have had the opportunity to consider the information and ask questions b. I have had any questions answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time during the study without giving a reason, and without any penalty. If I withdraw from the study, the research team will keep the information about me that has been obtained.	
3.	I have read and understood that relevant personal details as stated on the Participant Information Sheet and Privacy notice will be held securely by Ms Tina Barrows (Chief Investigator). They will be held on a University of Stirling secure electronic database during the study, if electronic. Any paper copies of personal data such as consent forms will be kept in a locked cabinet at the researcher's workplace. I understand that these details will be destroyed at the end of the study.	
4.	I understand that my responses will be kept anonymous and I give permission for members of the research team to have access to my anonymised responses.	
5.	I consent to being audio recorded and for the researcher to take notes during observation and interviews.	
6.	I understand that audio recordings and notes will be used for the purposes of this research study in analysis and reports and publications. I am aware that I will not be named in any research and any data will be fully anonymised.	
7.	I have read, understand, and have signed the Privacy notice in relation to obtaining, managing, storing and disposing of my personal data.	
8.	I agree to take part in this study	

Name of Participant

Signature:

Date: [Click here to enter a date](#)

Time:

Location:

Name of Researcher

Signature:

Date: [Click here to enter a date](#)

Time:

Location:

8.15 Appendix 15 Consent Form Health Visitor

Appendix 9 HV Participant Consent Form Version 1 June 2018 IRAS 242281



Health Visitor Participant Consent Form

IRAS Study Number 242281

Participant Identification number:

Research Project Title: *An Exploration of the process of the Health Visitor Antenatal Visit.*

Name of Researcher: *Ms Tina Barrows*

Please initial box	
1.	I confirm that I have read the information sheet dated..... (version.....) for the above study. a. I have had the opportunity to consider the information and ask questions b. I have had any questions answered satisfactorily.
2.	I understand that my participation is voluntary and that I am free to withdraw at any time during the study without giving a reason, and without any penalty. If I withdraw from the study, the research team will keep the information about me that has been obtained.
3.	I have read and understood that relevant personal details as stated on the Participant Information Sheet and Privacy notice will be held securely by Ms Tina Barrows (Chief Investigator). They will be held on a University of Stirling secure electronic database during the study, if electronic. Any paper copies of personal data such as consent forms will be kept in a locked cabinet at the researcher's workplace. I understand that these details will be destroyed at the end of the study.
4.	I understand that my responses will be kept anonymous and I give permission for members of the research team to have access to my anonymised responses.
5.	I consent to being audio recorded and for the researcher to take notes during observation and interviews.
6.	I understand that audio recordings and notes will be used for the purposes of this research study in analysis and reports and publications. I am aware that I will not be named in any research and any data will be fully anonymised.
7.	I have read, understand, and have signed the Privacy notice in relation to obtaining, managing, storing and disposing of my personal data.
8.	I agree to take part in this study

Name of Participant

Signature:

Date: [Click here to enter a date](#)

Time:

Location:

Name of Researcher

Signature:

Date: [Click here to enter a date](#)

Time:

Location:

8.16 Appendix 16 Observation Schedule



Observation Schedule

IRAS Study Number 242281

Version 1 June 2018

Date:	Location	ID HV:	ID P:
Time:		✓ Consent:	✓ Consent:
Duration:			
Description of setting: Event- when where why? Atmosphere:			
HV Interaction with P including non verbal: (who does what?) Issues raised: Page 1 of 2		P Interaction with HV including non verbal: (who does what?) Issues raised:	



Descriptive notes including: What occurs? What are the consequences? Why do participants act the way they do?	Reflective notes
When documented- date/time	When documented-date/time
Memo	
When documented: date/time	

8.17 Appendix 17 Topic Guide for Interviews Version 1



Topic Guide for Interviews. October 2018 Version 1

IRAS Study Number 242281

Participant Identification number:

Research Project Title: *An exploration of the process of the health visitor antenatal visit.*

Topic Guide for Interviews

Unstructured interviews. Guide to be used to help probe participants on key areas identified from analysis of observations of the HV antenatal visit and will be added to the list below:

Key areas :

<i>Social interaction</i> • <i>Purpose of the visit and what interactions took place.</i> • <i>Relationships between people in the visit and their significance</i>	<i>Notes</i>
<i>Discussion topics (Listed from the observations) for example:</i> • <i>Public health topics</i>	<i>Notes</i>

• <i>Assessment if any and what it included/importance of it.</i> • <i>Support –types of support and significance</i>	
<i>Outcome of the visit from participant perspective</i>	<i>Notes</i>

8.18 Appendix 18 Updated Topic Guide for Interviews



Topic Guide for Interviews. October 2018 Version 1

IRAS Study Number 242281

Participant Identification number:

Research Project Title: *An exploration of the process of the health visitor antenatal visit.*

Topic Guide for Interviews

Unstructured interviews. Guide to be used to help probe participants on key areas identified from analysis of observations of the HV antenatal visit and will be added to the list below:

Updated key areas in bold

Key areas :

<i>Social interaction</i> <i>Purpose of the visit and what interactions took place.</i> <i>Relationships between people in the visit and their significance</i> Sharing information/sharing self Trust. Fathers/partners involvement How HVs manage the visit	<i>Notes</i>
<i>Discussion topics (Listed from the observations) for example:</i> <i>Public health topics</i> Safety	<i>Notes</i>

Feeding Immunisations Attachment/emotional health of baby • <i>Assessment if any and what it included/importance of it.</i> Parenting Domestic violence Mental health COVID-19 Finances • <i>Support –types of support and significance.</i>	
<i>Outcome of the visit from participant perspective</i>	<i>Notes</i>

8.19 Appendix 19 Draft Article for Publication

The draft publication that follows utilises a journal template. The first three pages are the manuscript details and abstract followed by the 3000 word article commencing with the title Introduction. Plans are for publication and to apply to journals relevant to health visiting such as the Journal of Health Visiting or the Journal of Advanced Nursing, and grounded theory avenues such as Grounded Theory Review.

Title

Exploration of the social processes of the HV antenatal home visit. Classic Grounded Theory Study.

Author

Tina Barrows^{1,2}

Affiliations

¹*Faculty of Health Sciences and Sport, University of Stirling, Stirling, UK.*

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Tina Barrows, Early Years Team, 2nd Floor Tigh na Drochaid, Bridge Road, Isle of Skye IV51 9ER. Email: tina.barrows@highland.gov.uk

Acknowledgments

The author is grateful to the expectant parents and health visitors who gave of their time and shared their experiences and to Professor Carol Bugge, Dr Kate Clarke, Dr Dawn Cameron and Dr Joyce Wilkinson for their expertise support and guidance.

Funding

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Registration: not registered

Keywords

Antenatal Care; Classic Grounded Theory; Expectant Parents; Health Visiting; Home Visiting; Social Process.

What is already known

- Core principles of health visiting practice are likely to occur at the visit
- Family Nurse Partnership programmes give insight in to home visiting.
- Limited evidence on experiences of the health visitor antenatal visit.

What this paper adds

- Relationship building is the gateway to identifying need.
- The needs of the unborn baby are the main concern.
- Identifying needs leads to providing individualised family support

Abstract**Background**

The Health Visitor (HV) antenatal contact, conducted between 32 and 34 weeks of pregnancy, is typically the first meeting between expectant parents and HVs. Government directives and targeted home visiting programmes highlight its importance in early intervention, reducing health inequalities, and fostering family-centred relationships.

Although expectant mothers valued face-to-face contact for learning about the HV role, discussing baby-related topics, and relationship building, limited evidence exists on expectant parent and HV experiences of the antenatal visit. Researching this area is vital to understand how HVs can better support expectant parents, enhance relationship building, and optimise the effectiveness of antenatal visits.

Research question

What are the perceptions and experiences of expectant parents and HVs about the HV antenatal home visit?

Methods

Following a Classic Grounded Theory (CGT) approach, data was collected from three observations of the HV antenatal home visit and unstructured interviews with thirteen HVs and five expectant parents. Participants were recruited from one Scottish health board, and a constant comparative method of analysis was employed.

Findings

Therapeutic and supportive relationship building helped develop parental trust in the HV so parents would use the HV service for advice and support. It was the gateway to assessing the wellbeing of the unborn baby, where parents shared their transition to parenthood, whilst HVs assessed parental need. The wellbeing needs of the unborn baby were the main concern of HVs and parents with a focus on safety. Managing the antenatal visit involved HVs providing appropriate support and advice according to parental need.

Conclusions

The study led to the discovery of the substantive theory: expectant parents and HVs adjusting to support the wellbeing of the unborn baby at the antenatal visit. It established the significance of therapeutic relationship building underpinning early identification of need and provision of individualised HV support to parents.

1. Introduction

Health visitors are healthcare specialists dedicated to promoting health, preventing disease, and addressing physical, emotional, and social wellbeing, particularly for pre-school children and their families (Horne and Owen 2022). Their role aims to tackle deprivation and reduce health inequalities (Cowley and Frost, 2006). In Scotland, the health visitor role has evolved with standardised practices and structured home visits, starting with the antenatal visit (Scottish Government 2015). However, despite its significance, limited research exists on the initial antenatal visit, emphasising the need for further exploration to enhance its effectiveness for expectant parents.

2. Background

Early intervention is integral to health visitor practice, influenced by neurodevelopment and parenting research (National Scientific Council on the Developing Child 2020; Early Intervention Foundation 2020). Frameworks such as UNICEF's Convention on the Rights of the Child (1990) and GIRFEC (Scottish Government 2022) guide health visitors to reduce inequalities and safeguard wellbeing. The universal health visitor pathway introduced antenatal visits for all families, shifting from targeted interventions to universal provision, requiring health visitors to adapt their practice. Supporting and evaluating trainees during this change highlighted the need to explore antenatal visits further to enhance clinical practice.

2.1 Literature

Existing literature primarily focuses on postnatal interventions, leaving gaps in understanding antenatal visits (Elkan et al. 2000; Cowley et al. 2013; 2014). Relationship building was alluded to in the limited literature, with parents preferring individual, face-to-face contact and valuing partner involvement (Curtis and Davidson 2013). First impressions were crucial for parental engagement (Christie 2016), though how supportive relationships developed during antenatal visits remained unexplored (Monaghan and Owen 2012). Research on targeted antenatal interventions in Australia highlighted partnership working but lacked relevance to Scotland's universal service (Kemp et al. 2006).

Researching antenatal visits is vital for understanding how health visitors can strengthen relationship building, better support expectant parents, and improve the effectiveness of early interventions.

3. Study Method

A qualitative methodological approach using classic grounded theory (Glaser 1978; Glaser and Strauss 1967) facilitated an in-depth exploration of how expectant parents and health visitors interpreted antenatal contact within its social context. The research

question asked: What are the perceptions and experiences of expectant parents and health visitors about the social process of the health visitor antenatal home visit?

3.1 Sample and Participants

Conducted within one rural NHS Health Board in Scotland, the study involved 19 participants (n=13 health visitors, n= 6 expectant parents), recruited purposefully over two years, concluding in 2021. One participant withdrew without reason. See Table 1

Table 1 Study Participant characteristics

Table 1 Study participant characteristics							
Participant Interview (I) Observation (O)							
Participant	I or O	Health Visitors			Years Qualified	Ethnicity	Age range
		Gender	Location	Area			
1	I	Female	Small Town	7	6 to 10	UK	35 to 40
2	I + O	Female	Rural	5	21 to 25	UK	50 to 55
3	I	Female	Other Urban	1	0 to 1	UK	30 to 35
4	I	Female	Small Town	1	2 to 5	UK	45 to 50
5	I	Female	Rural	3	26 to 30	UK	50 to 55
6	I	Female	Small Town	4	6 to 10	UK	50 to 55
7	I	Female	Rural	6	2 to 5	UK	50 to 55
8	I	Female	Rural	6	0 to 1	UK	25 to 30
9	I	Female	Small Town	6	6 to 10	UK	40 to 45
10	I	Female	Rural	6	11 to 15	UK	40 to 45
11	I + O	Female	Small Town	7	6 to 10	UK	35 to 40
12	I + O	Female	Other Urban	5	11 to 15	UK	45 to 50
13	I	Female	Small Town and Rural	7	0 to 1	UK	25 to 30
Parents							
Participant	I or O	Gender	Location	Area	Employment	Ethnicity	Age range
1	I	Female	Other Urban	1	project coordinator	UK	30 to 35
2	I	Female	Other Urban	1	self employed	UK	30 to 35
3	I + O	Female	Rural	5	carer	UK	25 to 30
4	O	Female	Other Urban	5	shop worker	UK	30 to 35
5	I + O	Female	Small Town	7	carer	Eastern European	35 to 40

Health visitors conducting antenatal visits were eligible, while parents were included if over 18, expecting a baby at least 28 weeks of pregnancy, residing in the Health Board area, and receiving routine midwifery care. Recruitment challenges led to amendments allowing health visitors to recruit parents.

3.2 Data collection

Data collection included three antenatal visit observations and semi-structured interviews with participants. Observations captured interactions during visits (Table 2)

while interviews used open questions and focused coding to develop a theory explaining data patterns (Glaser 1978; Glaser 1998).

Table 2 Observation Schedule

UNIVERSITY of STIRLING Observation Schedule IRAS Study Number: 242281 Version: 1 June 2018				UNIVERSITY of STIRLING Observation Schedule IRAS Study Number: 242281 Version: 1 June 2018	
Date:	Location:	ID HV:	ID P:	Descriptive notes including: What occurs? What are the consequences? Why do participants act the way they do?	Reflective notes
Time:	Duration:	/Consent:	/Consent:		
Description of setting: Event: when where why? Atmosphere:					
HV Interaction with P including non verbal: (who does what?)		P Interaction with HV including non verbal: (who does what?)			
Issues raised:		Issues raised:			
When documented: date/time				When documented: date/time	
Memo:					

Page 1 of 2

Page 2 of 2

Within the interviews open questions were asked with a broad interview guide to act as a prompt (Table 3) that became more focused as collected data was coded. Open coding compared codes to form categories and selective coding then refined the coding further to evolve in to a theory that explained patterns and events observed in the data (Glaser 1978; Glaser 1998).

3.3 Ethical Considerations

Ethical approvals were granted by the University of Stirling ethics committee (6th November 2018), North of Scotland Research Ethics Service (17th January 2019, Reference 18/NS/0144), and the local NHS Health Board (19th February 2019). Recruitment challenges led to a category C amendment (9th January 2020) allowing health visitors to recruit expectant parents. Data collection was delayed by the COVID-19 pandemic, changing the study from prospective to retrospective, discontinuing observations and focusing on semi-structured interviews.

3.4 Data Analysis

Grounded theory analysis employed constant comparative analysis, an iterative process of data collection, coding, and analysis to identify relationships and build theory. Theoretical sampling and memoing facilitated refining concepts, achieving theoretical saturation (Glaser 1978; Glaser 1998).

Table 3 Interview Guide

	
Topic Guide for Interviews, October 2018 Version 1	
IRAS Study Number 242281	Participant Identification number:
Research Project Title: <i>An exploration of the process of the health visitor antenatal visit.</i>	
Topic Guide for Interviews	
<i>Unstructured interviews: Guide to be used to help probe participants on key areas identified from analysis of observations of the HV antenatal visit and will be added to the list below:</i>	
<i>Updated key areas in bold from previous interviews to explore</i>	
Key areas:	
Social interaction • Purpose of the visit and what interactions took place. • Relationships between people in the visit and their significance Sharing information/sharing self Trust. Fathers/partners involvement How HVs manage the visit	Notes
Discussion topics (Listed from the observations) for example: • Public health topics Safety Feeding Immunisations	Notes
Attachment/emotional health of baby • Assessment if any and what it included/importance of it. Parenting Domestic violence Mental health COVID-19 Finances • Support –types of support and significance.	
Outcome of the visit from participant perspective	Notes

Figure 1 illustrates the interplay of data collection, comparative analysis, and theoretical sampling as interconnected cogs in a pulley system, driving grounded theory development. Data collection gathers participant input, comparative analysis refines categories, and theoretical sampling identifies new sources to expand concepts. Memoing, represented as a purple pulley, aligns and evolves codes and categories, keeping the system in motion. Continuous inductive and deductive processes, depicted by external arrows, reveal relationships and establish theories. These processes culminate in theoretical saturation, where no new concepts or depth emerge, marking the completion of grounded theory development (Glaser 1978; Glaser 1998).

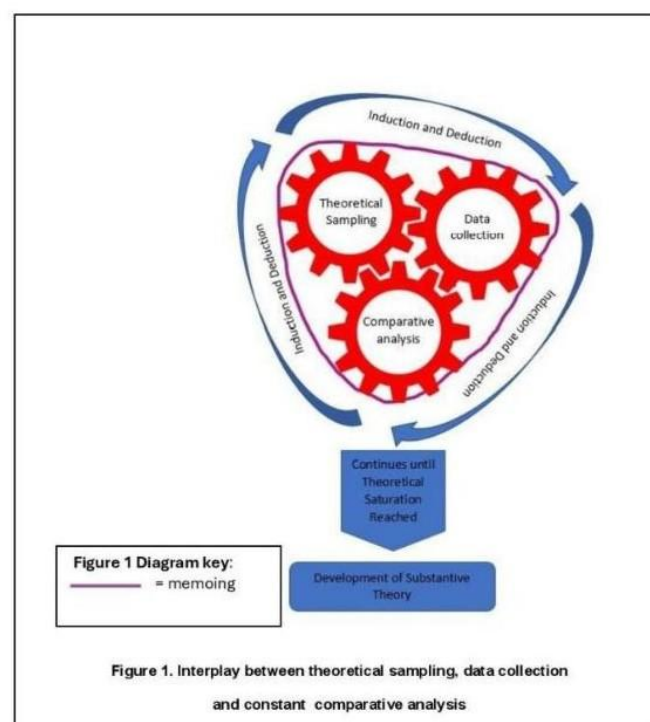


Figure 1 Interplay Between Theoretical Sampling, Data Collection and Comparative Analysis

3.5 Research quality

Research quality adhered to grounded theory criteria: 'fit', ensuring alignment of data and concepts; 'work' and 'relevance', offering practical insights for improving health visitor antenatal practices; 'workability', ensuring theory applicability; and 'modifiability', enabling adaptation as new data emerged (Glaser 1978). Rigorous application of these techniques supported credibility and reduced bias (Elliott and Lazenbatt 2005; Glaser 1978).

4. Findings

The proposed theory identifies the baby's wellbeing as the central concern for both parents and health visitors during antenatal visits. Three main categories developed from the data included; relationship building, assessment, and managing in the visit. The core category of parents and health visitors adjusting to support the wellbeing of the unborn baby focuses on how parents and health visitors adjust to support the wellbeing of the unborn baby (Figure 2 an onion shape diagram demonstrates how the main concern is at the centre of the onion, which is addressed by the core category on the next layer, which combines all the aspects of the main categories in the subsequent layer. The outer layers, subcategories and characteristics, provide more detail about the main categories.

Health visitors build trust through therapeutic relationships, guiding parents to seek advice and support. Parents adapt interactions based on trust and needs, while health visitors tailor assessments and manage advice and support related to individual circumstances. Past experiences of both parents and health visitors influence engagement and the support provided, ensuring holistic care and addressing specific needs during the transition to parenthood.

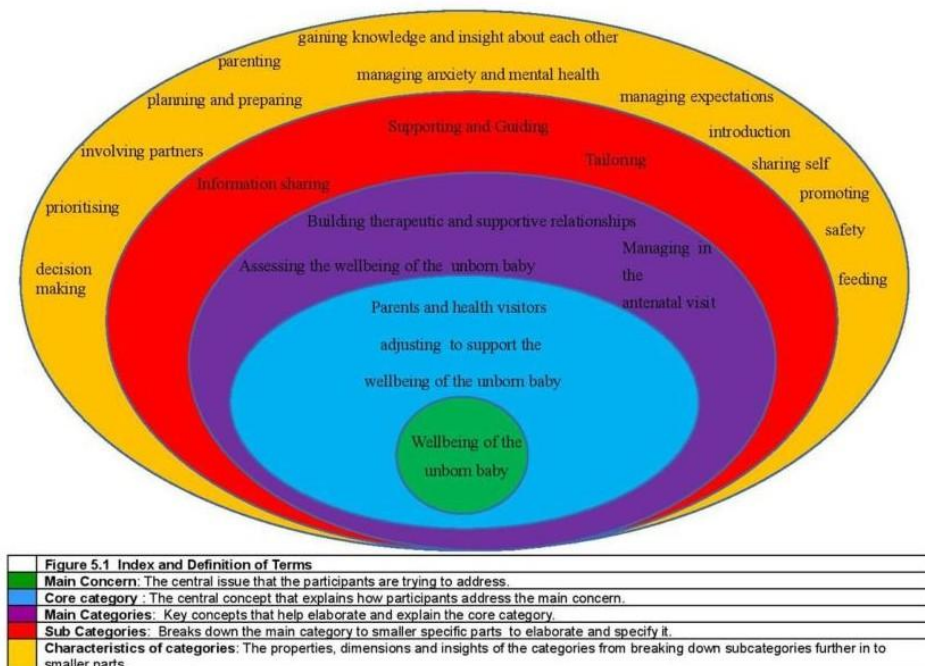


Figure 2 Core category, main categories, subcategories and characteristics of categories.

4.1 Therapeutic and supportive relationship building

Therapeutic and supportive relationship building was identified as central to antenatal visits. Health visitors fostered trust and approachability by tailoring conversations to parental needs and promoting their role during face-to-face home visits. This environment enabled relaxed interactions, encouraging parents to share concerns and seek advice. One health visitor reflected;

“Hopefully build up a level of rapport where there’s trust...and that gives you scope then to offer additional support and information” (A601HV).

Trust and openness were key to parental engagement. Parents adjusted the information they shared based on their trust in the health visitor, with prior negative experiences often shaping their willingness to engage. For example, one health visitor noted,

“By the end of the visit she said, you’ve restored my faith in health visiting” (A702HV).

Sharing personal experiences, or "sharing self," helped health visitors connect with parents while balancing professionalism, with confidentiality reassured to address parental fears, especially in close-knit rural communities. As one health visitor explained,

“Everybody knows you and they are afraid that information will leak out...I stress about confidentiality and reassurance that sharing of information is important and secure” (A501HV).

These therapeutic relationships formed the gateway to assessing the wellbeing of the unborn baby. Health visitors adapted assessments to parental conversations and shared information, with trust and rapport enabling meaningful insights into family dynamics and tailored support. By focusing on relationship building, health visitors effectively supported expectant families and strengthened their role within antenatal care.

4.2 Assessing wellbeing of the unborn baby

Health visitors assessed the wellbeing of the unborn baby by addressing safety, health, and parental lifestyles through holistic, tailored visits. Observing the home provided insight into the baby's living conditions, while conversations explored parents' preparation, mental health, and previous experiences. One health visitor explained:

“We need to know that they are in a safe and warm and comfortable environment” (A101HV).

Discussions about safe sleep and feeding practices highlighted outdated methods, with health visitors offering updated advice empathetically. Health visitors also identified risks like domestic violence and built trust to provide tailored support, ensuring families were prepared for the baby's arrival.

Health visitors assessed parents' preparation for their baby's arrival through discussions about birth plans, practical parenting, and support networks. Parents

demonstrated their readiness, including sibling adjustments and planning postnatal activities. One health visitor shared,

“How are the other children feeling about being prepared for a baby as well? In terms of them going to have to share a room eventually, how are they feeling about that?” (A501HV).

By evaluating these aspects alongside health needs and safety, Health visitors tailored advice and ensured parents felt supported in their transition to parenthood.

4.3 Managing in the antenatal visit

Health visitors managed antenatal visits by establishing connections with expectant parents, tailoring advice, and addressing barriers like work pressures and the COVID-19 pandemic. Flexibility was key, as one health visitor shared:

“I fit in an antenatal visit...because obviously they are working, maybe can get an hour off their work” (A604HV).

Engaging partners revealed mixed success, with some actively participating while others were less involved in discussions about family dynamics and parenting readiness.

The absence of antenatal visits during the pandemic emphasised their importance. Without them, birth visits became longer and more challenging, as health visitors had to build relationships while addressing immediate family needs. One health visitor noted:

“You are starting off on the back foot a bit...trying to establish that relationship between you both” (A502HV).

Preparation included information sharing with midwives, ensuring health visitors understood family situations:

“You are not going in blind because you have got information from the midwife” (A701HV).

Checklists based on national guidelines guided discussions on finances, feeding, and parenting also helped prepare and carry out the visit.

Health Visitors past experiences influenced their focus, such as addressing safety and domestic violence. Normalising domestic violence discussions, like mental health conversations, helped reduce stigma and created openings for expectant mothers to seek support. As one HV explained,

“Discussing all the different areas of domestic violence...kind of normalises it and makes it easier to approach that subject further down the line” (A101HV).

Promoting baby development and emotional attachment included encouraging communication with the unborn baby. Another health visitor shared,

“Introducing the bump to all sorts of situations...develops the baby’s brain development” (A301HV).

These approaches ensured holistic care, empowering parents in their transition to parenthood.

5. Discussion

The antenatal study highlighted the wellbeing of the unborn baby as a primary concern for parents and health visitors, aligning with literature prioritising infant health (Stephen and Nettleton 2022; Deave et al. 2008; Olander et al. 2019). Health visitors used frameworks like GIRFEC and SHANARRI wellbeing indicators to assess wellbeing and promote safe parenting, consistent with midwifery guidance that evaluates foetal and maternal health alongside factors like mental health and social circumstances (Scottish Government 2015a; Scottish Government 2022a; NICE 2021a).

Therapeutic relationship building emerged as a key aspect of antenatal care. Health visitors built trust through effective communication, flexibility, and partnership approaches while adapting to parent-led interactions, extending postnatal evidence (Cowley et al. 2013; Cowley et al. 2014; Sturley et al. 2022). Relationships needed to be established before assessing needs, contrasting with postnatal findings. Challenges included balancing trust-building with professional boundaries, especially for first-time parents unfamiliar with the health visitor role (Antonytheva et al. 2020; NMC 2018; McLeish et al. 2020). Insights from programmes like FNP reinforced the importance of empathy and non-directive approaches in fostering relationships (Day 2013; Day and Harris 2013; Scottish Government 2015a).

Assessment during antenatal visits allowed health visitors to observe family health, relationships, and lifestyles, guided by tools like the My World Triangle, though these lacked specific focus on unborn babies (Scottish Government 2015a; Aldgate and Rose 2008). Safety was a key focus, addressing topics like safe sleeping, feeding, and parental lifestyle impacts, which complemented early intervention roles and offered new insights into safeguarding unborn babies (Cowley et al. 2013; Heinonen 2021). Mental health concerns, such as antenatal anxiety, were addressed, recognising their impact on child emotional wellbeing (O’Connor et al. 2002; Norhayati et al. 2015). Limited partner engagement restricted holistic family assessments, though when involved, partners provided valuable insights into family dynamics (Vipham 2023; Monaghan and Owen 2012).

Managing antenatal visits involved tailoring care to individual parental needs. Effective information sharing with midwives was essential for timely assessments, though communication challenges persisted, highlighting the need for collaboration (Aquino

et al. 2018; Monaghan and Owen 2012). Health visitors balanced structured assessment guidance with personalised approaches to enhance engagement (Institute of Health Visiting 2019). Flexible scheduling improved visit uptake, aligning with pregnancy stages and parental circumstances, while also addressing barriers to partner involvement (Olander et al. 2019; Bateson et al. 2017; Baldwin et al. 2017).

The COVID-19 pandemic challenged traditional antenatal care, with health visitors adopting digital communication methods to compensate for the loss of face-to-face visits. This period saw increased parental mental health challenges and social isolation, underscoring the need to sustain antenatal support even during crises (Burrows et al. 2022; Jia et al. 2020; Harville et al. 2023). Parental trust was affected by previous negative experiences, stressing the importance of clear communication and understanding parental perspectives to foster engagement (Donetto et al. 2013; Olander et al. 2019). Tailored support addressed breastfeeding, safe parenting, and mental health promotion, aligning with national priorities to reduce health disparities and foster lifelong wellbeing (Victora et al. 2016; Scottish Government 2019; UNICEF 2018).

The study also emphasised the emotional demands on health visitors, recommending restorative supervision to build resilience and support their wellbeing (Wallbank and Woods 2012; NHS Education for Scotland 2022; Stephen and Nettleton 2022). These findings reinforce the value of holistic, supportive, and adaptable antenatal care focused on promoting the wellbeing of the unborn baby and meeting the diverse needs of families.

6. Limitations

Participants were purposively recruited to the study but there was difficulty recruiting parents compared to health visitor participants. The resulting sample size of parents was small, with only 6 parents recruited which included one partner. Age differences and gender could not be explored further as anonymity of participants details needed to be prioritised due to the small number of participants and the potential for recognition within the research study setting.

Views were mostly from UK born parents in the study who conversed in English and over the age of 18 years as reflected in the geographical homogeneity of the research area (Scottish Government 2023). The study findings reflected the characteristics of the people within the study population rather than broader populations and was therefore unable to generalise to other populations (Lewis et al. 2013). Participants responses from the health visitor antenatal study may differ from other ethnic groups, differing ages and differing genders of parents. Recruitment to the study was related to adult expectant mothers' childbearing age whilst their partners could potentially be of a wider age range. Inclusion to a broader more heterogenous sample may lead to further development and widening of the themes identified within this study.

The substantive theory derived from the CGT approach is specifically relevant to the area of study, namely health visitor practice, and does not assert broader applicability to other fields (Glaser 1998).

A potential limitation of grounded theory is the risk of researcher bias arising from their professional experience and pre-existing knowledge of the research field. However, professional experience helps make researchers theoretically sensitive (Holloway and Wheeler 2010) and could also be seen as a strength in developing the grounded theory method. Attempts to limit researcher bias included their workplace and immediate team being excluded from the study. Through documenting thoughts and decisions in memos and their research journal the researcher utilised reflexivity and theoretical sensitivity to recognise significant data and the understanding of meanings Glaser (1978). Additionally research supervisors closely monitored the process, reviewed interview transcripts, and provided guidance on data collection to further minimise bias.

7. Implications for Practice

This study highlights the importance of health visitors in antenatal visits, focusing on supporting unborn babies' wellbeing. Building trust through therapeutic relationships is central to effective assessments and parental engagement. Health visitors should address past experiences, promote their role, and tailor visits for both parents. The pandemic highlighted the need for alternatives to face-to-face visits to sustain support. Clinical supervision helps health visitors manage emotional challenges, ensuring effective practice and safeguarding their wellbeing. Prioritising antenatal visits is crucial for early intervention and comprehensive family support.

8. Conclusion

The study highlights the essential role of health visitors in antenatal home visits, supporting parents and unborn babies during the transition to parenthood. Prioritising antenatal visits, even amidst workload pressures, is crucial for effective practice (Morton, 2024). Building therapeutic relationships fosters parental trust and engagement, with health visitors encouraged to explore parents' past experiences to better understand their needs and address health and wellbeing concerns.

National guidance emphasises opportunities for health visitors to "truly connect" with families during the antenatal period (Scottish Government, 2015a). Strengthening the role of antenatal visits within the Universal Health Visiting Pathway would particularly benefit first-time parents and those already familiar with services. Limited engagement by mothers and partners indicates a need to promote health visitor roles, while tailored visits addressing partner needs and midwife collaboration are recommended to enhance involvement.

The study highlights the impact of the COVID-19 pandemic on maternal health and social isolation, which restricted face-to-face visits. Exploring safe, alternative methods to build therapeutic relationships during crises is critical for supporting parental mental health. Additionally, health visitors face emotional challenges, requiring effective clinical supervision to maintain their wellbeing and high professional

standards. These findings reinforce the need to enhance antenatal visits and therapeutic relationships to improve health visitor effectiveness and improve outcomes for unborn babies and their families.

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